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COMMENTARY

Response to Cross-cultural medical education and training: thoughts from the UK

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Reitmanova (1) questions the justification for cross cultural medical education (CME) in Slovak medical schools given that they cover a country which is relatively culturally homogenous. Compelling arguments are then presented as to why Slovak medical schools need to start paying attention to this issue. In this response, I present some findings from work undertaken in the UK to enable the Slovak community to relate their developments to other contexts.

The General Medical Council (GMC) which governs medical education in the UK introduced *Tomorrow's Doctors* as far back as 1993 (2). One of the main attitudinal objectives outlined in that document was

"At the end of the course of undergraduate medical education the student will have acquired and will demonstrate attitudes essential to the practice of medicine including respect for patients and colleagues that encompasses, without prejudice, diversity of background and opportunity, language, culture and way of life". (2)

The revised version in 2002 contained similar principles that of ensuring that patients receive equitable quality care. The statements in both versions of *Tomorrow's Doctors* were made without further clarification or expansion (2, 3). The attributes expected of doctors are not dissimilar to those expected of anyone complying with equal opportunities legislation that applies in the UK (4). It is important to note that whilst this principle was laid in the policy document, there is little evidence that it was meaningfully implemented in medical schools (5). There were gaps in the way GMC policy document was translated into operational policy which lead to a lack of coherence in the development and delivery of CME. This was also observed in a cross sectional survey of CME in UK medical schools which found that 72 % of schools reported some CME teaching but that there appeared to be a great deal of uncertainty about what constituted CME (6). This finding compared less favourably with the US but more favourably than Canada. So whilst CME had developed in the UK it was rather fragmented with little consistency in how it was taught or assessed.

Reitmanova (1) suggests that CME should start in the clinical years. I would suggest that it needs to start earlier and enables students to have opportunities to consider their own world views and how these might impact on the clinical care they will provide. This was confirmed in a study with medical education stakeholders – there was strong agreement that cultural diversity needs to be a part of the core curriculum and not an optional module (7). Participants were uncertain where in the curriculum it should be taught, but generally felt that it should be taught early. There was clear consensus among stakeholders on how the subject should be taught, although little of it was based in any theoretical framework. Nevertheless, cultural diversity teachers particularly felt that cultural diversity as a curricular subject lacked credibility with staff and students. This was consistent with a review which found that CME teachers generally had low status in medical schools (8)

There is a need to develop diversity education within a coherent educational framework based on a clear rationale about where and why it is being taught (9). These are important issues for the Slovak schools to consider as would how they are going to assess the subject if it is incorporated in medical curricula (10).

There will also be a need to have clarity about the purpose of CME. If it is about improving the clinical experience of patients, Slovak medical schools might want to take a more individual patient based approach rather than providing students information about groups (9). This would also challenge the notion that apparent cultural homogeneity negates the need for CME. There will be huge diversity even within seemingly similar people. Nowhere is this more apparent than in my clinical discipline of child psychiatry. Even people, who have similar cultural and educational backgrounds, will understand mental health differently and therefore the acceptance of treatment options is variable.

Slovak medical schools have an exciting opportunity to develop their curriculum and in the area of CME, whilst considerable work has been undertaken in the US with some in the UK and other countries, there is still some way to go. Collaboration with colleagues in the US, Canada and Australia has shown that the issues facing us all are not dissimilar and there is much to be gained from debates such as the one that Reitmanova has initiated with her timely paper.

References

1. Reitmanova S. Cross-cultural medical education and training. *Bratisl Lek Listy* 2008, 109 (2), 82–87.

2. General Medical Council. *Tomorrow's Doctors.* 1993 London: General Medical Council.

3. General Medical Council. *Tomorrow's Doctors.* 2002 London: General Medical Council.

4. Dogra N (2004) *The learning and teaching of cultural diversity in undergraduate medical education in the UK.* PhD Leicester: University of Leicester

5. Dogra N and Williams R. Applying policy and evidence in developing cultural diversity teaching in undergraduate medical education in the UK. Evidence and Policy, 2006, 2,4; 463–77

6. Dogra N, Conning S, Gill PS, Spencer J & Turner M (2005) Teaching of cultural diversity in medical schools in the United Kingdom and Republic of Ireland: cross sectional questionnaire survey, *British Medical Journal,* 19; 330 (7488): 403–4. Epub 2005 Jan 11.

7. Dogra N. Cultural diversity teaching in the medical undergraduate curriculum. *Diversity in Health and Social Care.* 2005, 2,3; 233–245.

8. Dogra N & Karnik N (2004) Teaching cultural diversity to medical students, *Medical Teacher,* 26, 8: 677–680.

9. Dogra N (2003) Cultural Competence or cultural sensibility? A comparison of two ideal type models to teach cultural diversity to medical students. *International Journal of Medicine,* 5, 4: 223–231.

10. Dogra N and Wass V. Can we assess students' awareness of 'cultural diversity'? A qualitative study of stakeholders' views. *Medical Education,* 2006, 40,7: 682–690