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Institutional marginalisation and student resistance: barriers to learning about culture, race and ethnicity

Jane H. Roberts · Tom Sanders · Karen Mann · Val Wass

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Abstract Although education about culture, race and ethnicity has increasingly been viewed as an important addition to the medical undergraduate curriculum, internationally the evidence of its effectiveness is mixed. Research to date fails to show why. We chose to explore how contrasting approaches to learning about cultural diversity impacted on medical students. The views of second year students towards teaching about cultural diversity at two UK medical schools, with differently structured curricula, were explored using a series of focus groups (7). The findings, using a methodology based on a combination of grounded theory and thematic analysis identified two potentially competing views espoused by the students at both sites. First, they claimed that although cultural diversity was important, their medical schools marginalised and failed to adequately support effective teaching. Second, in contrast, they claimed that the medical school was an ‘inappropriate’ setting for successful teaching about cultural diversity. Students did not consider the subject matter to be of central relevance to biomedicine. They felt it should be learnt experientially in the workplace and socially among peers. These narratives represent two potentially conflicting standpoints, which might be understood through the sociological concept of ‘habitus’, where students conform to the institution’s dominant values in order to succeed. The tensions identified in this study cannot be ignored if effective learning about race,
The literature describes a range of approaches to introducing cultural diversity into the medical curriculum: (1) promoting cultural awareness and sensitivity through appealing to ethnic diversity (Kai et al. 2001) (2) teaching students ‘propositional’ knowledge that prioritises certain cultures and health beliefs, previously criticised for perpetuating cultural stereotypes (Frank and MacLeod 2005), (3) adopting a reflexive and critical response to health inequalities and social injustice, (Frank and Maclead 2005; Wear and Aultman 2005), (4) using the concept of ‘cultural competency’ (Betancourt et al. 2005) and (5) focusing primarily on ‘cultural safety’ to ensure all providers can work in a culturally “safe” “manner” (Gray et al. 2003). Little is known about which strategies are most effective or when to implement them in the curriculum (Brach and Fraser 2000). There is a dearth of evidence about effective learning outcomes. In practice, education about cultural diversity is directed at students early in their education (Loudon et al. 1999). Beagan (2003a) for instance, reported a study of teaching ‘culture and ethics’ to first and second year undergraduates which showed little impact on behaviour or attitude. Research shows that as students progress through medical school their cynicism about psychosocial issues increases (Wolf et al. 1989). In brief, the outcomes of cultural diversity education are inconsistent. Further, much of the evidence comes from North America, which may be less applicable to the European context (Loudon et al. 1999; Champaneria and Axtell 2004).

More detailed exploration of how best to encourage ‘cultural awareness’ in the undergraduate curriculum is required. One possibility is to examine how the social practices and behaviours of medical undergraduates help to promote or undermine successful implementation of learning. Certain core beliefs may be devalued, whilst others are reinforced. In this paper Bourdieu’s (1977, 1990) concept of habitus is used as a means of exploring this central question and of interpreting the findings. The habitus represents the social structure which students inhabit. Through their engagement with it they gradually adopt the values of the medical school. Social and educational theorists, such as Bernstein.
(1996) and Bourdieu and Passeron (1977) for example, show how the dominance of certain pedagogic discourses in people’s daily lives makes them difficult to resist, especially if individuals are unaware of their coercive properties. This idea has important implications for the successful implementation of learning in the undergraduate curriculum.

Early patient contact in medical education is growing in popularity with some evidence that this may contextualise and strengthen learning about behavioural and social sciences (Dornan and Bundy 2004; Dornan et al. 2006). A recent systematic review concluded that ‘early clinical experience’ fosters social responsiveness within medical education (Littlewood et al. 2005). The present study aimed to explore the impact on students of two contrasting pedagogic approaches to undergraduate learning about cultural diversity. Student experiences at a school offering early patient contact in the first 2 years were compared with one using paper-based patient scenarios only.

Methods

An exploratory, qualitative research method was used adopting an ‘inductive’ approach to data analysis and theory generation (Lingard et al. 2008). We examined in depth the way in which students made sense of their learning experiences relating to cultural diversity.

Study setting

Two medical schools in the north of England with contrasting curricula were chosen. School A admits approximately 400 students annually and is situated in a large campus within a major city of a dynamic culturally diverse population. The curriculum, developed in 1994, is problem based. Learning objectives about diversity are integrated within paper based PBL cases based on a series of clinical index situations. All cases contain some aspect of psychosocial learning of which approximately 10% relates to ethnicity, race or culture. The students have occasional lectures but none specifically on cultural diversity. At the time of the study there was no contact with patients until year three. Tutors are predominantly basic medical scientists who have no medical training.

In contrast, School B admits approximately 100 students annually and is located within a small university campus outside a predominantly white socio-economically deprived town. The course was established in 2001 and remains affiliated to a larger regional medical school. The medical curriculum is designed around a systems based and integrated approach delivered through lectures, laboratory sessions and small group work. One module, the Personal and Professional Development (PPD) module, is entirely delivered by practising doctors, largely General Practitioners, and taught in stable small groups of 10–12 students. One session was allocated to specifically explore work in a culturally diverse society. Students have early patient contact from the beginning of the programme and conduct a Community Placement Project where all students work as volunteers for 60 h (over 12 months) in a health, education or social services agency.

Sampling process

Both schools approached teaching and learning through small group work, either PBL (School A) or small groups for PPD teaching (School B). In both schools, these
pre-existing groups had been running for 6 months prior to the study. They were closed, stable groups specifically allocated to ensure a demographic mix of ethnicities, gender and age. The seven selected groups were recruited pragmatically drawing on the support of the programme manager at site A and group tutors at site B. The existing groups were invited to participate, as we anticipated that students already familiar with each other were more likely to engage with sensitive topics than a group of unfamiliar ‘strangers’ (Barbour and Kitzinger 1999).

Participants

We aimed to recruit four groups per school but ceased recruitment after the seventh focus group as data saturation was reached. Each focus group had six to nine participants. Table 1 describes their demographic details. Self-reported ethnicity was used and grouped as a binary expression: either White British (WB) or Ethnic Minority (EM).

Focus group process

Focus groups were conducted at each site over a 3-month period, in small teaching rooms familiar to the students. Discussion was audio-recorded after seeking informed written consent from all participants and facilitated by JHR and VW. A topic guide was developed from the pre-existing literature. Full ethical approval was obtained from the University Ethics Committee at each school.

Data analysis

The focus groups were transcribed verbatim. Data analysis began on completion of each discussion, allowing insights and emerging ideas to be introduced in subsequent discussions (Strauss and Corbin 1998). Open coding was used to create the initial concepts and categories. These were then discussed until consensus was reached. Data collection continued until no new themes emerged. Using the constant comparative method, similarities and differences between the data were identified and coding was used to refine the analysis. The data were reviewed externally for credibility and trustworthiness by a medical sociologist (TS) and a medical educationalist (KM). Verbatim quotes are included below and are coded by school (A or B), focus group (1–7), gender (M or F) and ethnicity (WB or EM).

Table 1  Demographic details of participants

<table>
<thead>
<tr>
<th></th>
<th>Sample school A</th>
<th>Sample school B</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number tutorial groups</td>
<td>4</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Number students</td>
<td>30</td>
<td>19</td>
<td>49</td>
</tr>
<tr>
<td>Age years (range)</td>
<td>21.7 (19–30)</td>
<td>20.0 (19–29)</td>
<td>20.9 (19–30)</td>
</tr>
<tr>
<td>Female</td>
<td>20 (67%)</td>
<td>14 (74%)</td>
<td>34 (69%)</td>
</tr>
<tr>
<td>Male</td>
<td>10 (33%)</td>
<td>5 (26%)</td>
<td>15 (31%)</td>
</tr>
<tr>
<td>Ethnic minority students</td>
<td>12 (40%)</td>
<td>8 (42%)</td>
<td>20 (40.8%)</td>
</tr>
</tbody>
</table>
Results

Two major themes, common to both sites, emerged: (a) ‘institutional marginalisation’ of the subject, and (b) ‘student resistance’ to formal learning about cultural diversity. Learning within peer groups seemed to represent a more relevant and authentic alternative for the students.

Theme 1: institutional marginalisation of learning about cultural diversity

Students in all seven groups claimed that their institutions were failing to provide a learning environment which encouraged constructive discussion about culture. They recognised that cultural competence was essential for their future professional practice but felt that their school placed a much lower priority on this:

It might be important to us but I don’t know whether it’s important to everybody because it’s not explicitly expressed as a prerequisite or as a learning objective or as an exam question [B, 2, F, WB]

At both sites students stated that tutors viewed the topic as unimportant. Students from school A consistently reported that minimal time was dedicated to the ‘psychosocial’ objectives within a PBL case as tutors accorded them a low priority:

All I’m saying is that in PBL it [psychosocial issues] kind of gets pushed to the last five minutes of a two and a half hour overall session in the week, so its just done superficially [A, 1, M, E]

Some stated that their schools were reluctant to debate contentious and emotive subject matter such as race and ethnic identity:

Maybe that’s the issue, the medical school does not want to get into what could be a potentially divisive discussion and wants to leave it unspoken? [A, 2, F, WB]

Although PBL cases included learning outcomes to help students understand the epidemiology and sociology relating to cultural diversity issues, (at School A), they were marginalised, reproducing the feeling amongst students that the subjects were anecdotal and not scientific. Others claimed that cultural diversity was not promoted strongly enough during PBL, raising doubt about its relevance to clinical practice and encouraging students to speculate about its role:

My tutor didn’t say anything so presumably that means that it wasn’t on the tutor’s notes [A, 3, F, WB]

One of the dangers of student debate within PBL groups was that discussions took extreme opposing views, encouraging students to view racial and ethnic questions in simplified ways:

You can get very polarised views which I think need to be diffused a lot more… [A, 4, M, EM]

Students from School A claimed that tutors failed to facilitate effective debate and provided limited direction for discussion:

They don’t even say ‘well what do you think racially’ or ‘what do you think this is trying to stress’, they don’t try at all… [B, 4, F, WB]
School B students frequently claimed that during small group discussions the subject of cultural diversity was addressed in an “ad hoc” manner and only raised if the tutor had a specific personal interest in the subject. This resulted in significant variation between the groups, with some students potentially missing key learning opportunities:

But that was very much down to the clinician who ran the session rather than it being written into the curriculum... I think that was because the external speaker who came to do that session had thought, “Oh this is a really interesting lady and she would be great to speak to the students”. But it wasn’t part of the curriculum. It’s like the learning objective again. It’s almost like by chance that just happened to be that person that ran that session [B 2 F WB]

Thus, students’ evaluation of the tutor’s views towards learning about cultural diversity seemed to be influential in impacting on their subsequent attitudes, not least in relation to ‘assessment driven learning’. At both schools the apparent marginalisation of the subject encouraged strategic learning. In particular, the lack of overt assessment of cultural diversity issues led students to view the subject as peripheral, promoting a highly selective learning model:

To be honest it’s one of those things you don’t get examined on so you’re not likely to look into it [A, 3, M, WB]

Students acknowledged that evaluating attitudinal development was difficult. By failing to assess the psychosocial elements of the curriculum the implication was that ‘hard’ biomedical knowledge was more important. Students disputed this stance but admitted, given the quantity of material they needed to cover, that biomedical topics took priority. It seems that the perceived institutional marginalisation of learning about cultural diversity may contribute to a negative shift in students’ attitudes.

Theme 2: student resistance to formal learning on cultural diversity

Although students claimed that both of their medical schools posed a major barrier to learning about cultural diversity, they in turn showed signs of individual resistance towards the topic. They not only blamed the institution for marginalising learning about cultural diversity, but also expressed doubt about the appropriateness of the medical school as the correct setting to successfully support learning. They sought to promote their own peer group as the most effective forum for achieving this goal:

A lecture of one or two hours is not going to change (those students)...I think the greatest cultural exposure is through university and meeting people from different backgrounds [B, 2, M, EM]

All focus groups referred to the existence of informal student peer groups. This was positively portrayed as enriching the learning environment:

The place we most found out about different cultures and stuff is through university and meeting people from different backgrounds [B, 2, M, EM]

Students identified their peer group as a potentially valuable resource for learning about cultural difference, albeit one that was rarely utilised routinely, precisely because of students’ reluctance to engage in a dialogue about these sensitive issues:
I sometimes think that in a culturally diverse group that we often have we don’t talk amongst ourselves. For example, the fact that you’ve both got hijabs, I don’t know enough about Islam for instance and how you both react regarding abortion [student referring to two classmates in PBL group wearing hijabs]. I think we have a lot of resources within the group and we don’t really use you enough [A, 3, F, WB]

Students expressed frustration with both the theoretical delivery of social and behavioural science teaching, which they felt failed to highlight the practical relevance to medicine, and with the curriculum content’s separation from the realities of daily life:

Psychosocial tends to be very unpopular. It is put across in a very counter intuitive way. It’s all about (psychological) models, not people [B, 4, F, W].
But you can discuss them (models) until you are blue in the face, but until you actually see people coping with illness then you don’t really appreciate it [A, 2, M, EM]

Students also made the important distinction between increasing awareness and learning about diversity. They attached more importance to the former:

You can’t learn this out of a book. You’ve got to learn it for yourself. You can’t teach it…you get this learning from our own personal experiences and from working in groups [B, 4, M, WB]

A more positive view reflected the importance of ‘learning in the real world’:

I only go to PBL because I have to. I try and learn as much as I can but I won’t go there to learn about culture…. [A, 3, M, EM]

This perspective was represented at both institutions from those students who had experience of working outside of the medical school in healthcare settings.

On the wards you get people from Chinese descent who have lived in Britain for 30 years but don’t speak a word of English. You get to see how it really is, (the medical school) isn’t really the life of Britain as it really is [A, 2, M, WB]

They felt this gave them an important insight into issues surrounding ethnic difference and health inequality which they did not gain from their medical studies. The clinical environment presented other challenges such as discrimination, experienced or at times witnessed by students. Several students claimed to have seen such discrimination directed, for example, at doctors who had qualified in India. They felt that their medical education should prepare them to handle such experiences but claimed this was not the case.

Several students suggested ways in which learning about cultural differences could be made more clinically relevant, by taking an epidemiological approach and looking at patterns of health and illness across ethnic groups, rather than using clinical vignettes which encouraged stereotyping. Students at both institutions claimed that case scenarios often unwittingly led to negative and derogatory images or were simply misleading; for example if a PBL case described a patient as ‘Asian’ it implied that the patient was Muslim. They also spoke of extreme cases being quoted rather than more moderate positions and of polarised discussions which ignored the heterogeneity of minority cultures in the UK. Students, usually from ethnic minority groups, suggested that understanding equitable access to healthcare might be a more productive route into understanding cultural diversity and its impact on health and would certainly be clinically relevant:
Something I read recently in ‘Hospital Doctor’ was to do with how Bangladeshi patients are treated for cardiovascular diseases in East London and they have a much higher incidence of mortality related to CHD as opposed to people who are of white origin [A, 1, M, EM].

It was suggested that a greater emphasis on epidemiological research evidence would help to move the discussion towards more objective territory, minimising the use of subjective judgements involving ethnicity.

**Discussion**

This study highlights the challenges of learning about cultural diversity in medical schools. Its interpretation presents a way forward. We hypothesised that a curriculum offering early patient contact would provide a richer environment for learning about cultural diversity. Our findings showed that, despite the contrasting pedagogies at the two schools, similarities in students’ views outweighed any differences. Students at both schools perceived a factual knowledge-based approach to learning about cultural diversity to be counter productive. Lectures and PBL cases were criticised for stereotyping and failing to facilitate constructive discussion about the rich complexity of human relations. Early patient contact was viewed as positive but unpredictable. At both sites, students who had worked in health care placed great value on this as a source of learning. Personal experiences with peer groups were considered a more appropriate foundation for understanding cultural difference.

The implication is that medical education does not address the issue of cultural difference, where life experience can offer this more adequately. The drive for clinical competence must consequently not lose sight of the need to provide a culturally and socially informed medical education in which students acquire reflective and critical skills and learn to apply these within diverse local settings. However, many academically high achieving students entering medicine are already located in a class structure which is then perpetuated within the medical school itself. This may insulate them from exploring and understanding cultural difference solely through individual exposure. Individuals’ experiences of ethnic difference are not the same as learning about them through formal avenues. This suggests that a medical education which largely leaves students to ‘learn from experience’ is not preparing them to treat such knowledge critically.

The coexisting narratives of ‘institutional marginalisation’ and ‘student resistance’ espoused by our students challenge our understanding of how students learn about cultural diversity and the strategies needed to optimise teaching. Our findings depict students’ views. They do not necessarily directly reflect their experiences. However, they do highlight students’ perceptions and attitudes, and offer an indication of their actual experiences. The stated tension between ‘institutional marginalisation’ and ‘student resistance’ portrays the complexity surrounding these issues. Any analysis has to assume that ‘medical school’ and ‘student’ culture are inseparable. Both influence each other to produce the processes and values found in contemporary medical education settings, which is central to any interpretation of the findings.

The processes by which values and opinions are reproduced within student communities are frequently subtle, hidden, and operate at an informal level (Lempp and Seale 2006). Our students seemed to ‘blame’ the institution for ‘blocking’ effective learning on cultural diversity, whilst simultaneously supporting the dominant value of biomedicine. This is not surprising, since our students are embedded in the medical school culture,
where training is geared towards ‘fitting in’ (Beagan 2003b; Lingard et al. 2003; Light 1970). The apparently contradictory relationship between the demands of the institution and student culture is inherently reciprocal. As Lave and Wenger (1998) suggest, full participation in the social life of a ‘community of practice’ depends on the degree to which individuals adopt its dominant values and progress along a trajectory towards full ‘legitimate participation’. These paradoxical student narratives may be an expression of a desire to conform to two competing discourses; one driven by explicit institutional demands, and the other by the hidden curriculum. Students resolved this tension by general consensus that there is a need to increase awareness about cultural issues outside of the medical school context.

The theory generated from our data states that students’ informal social networks provide a more powerful and pragmatic source of insight into difference than psychosocial theories taught in medical school. This suggests that medical students may feel ‘alienated’ by the approach of formal teaching programmes. Mishler (1981) suggests that the medical school is charged with the task of equipping students with the necessary skills and knowledge. This often demands a strategic approach which, given the diverse range of academic subjects that students are already required to learn, prioritises the basic clinical sciences. Mishler also claims that learning is a social process that is contextually grounded in student experience, oriented to developing understanding, and not only to acquiring the basic skills and knowledge. Our data show that our students seemed to accept the ‘bio-medical’ paradigm by resisting knowledge that fell outside of it (e.g. social sciences). At the same time they viewed their own informal experiences of cultural diversity as a valuable contribution to their learning. Although they acknowledged the need to be culturally aware and develop some understanding of the human sciences, they did not hold them in the same regard as the biomedical sciences. Consequently, medical schools need to re-orientate education on both elements (knowledge and experience) to ensure that students are well prepared to practise in a culturally diverse clinical environment. This is important if they are to recognise how socio-cultural influences affect individual patients in different local contexts. There is a need for further research to explain the causes of student resistance to the social and behavioural sciences education, building on the findings presented here, where individual experience of cultural diversity seems to play a greater role than knowledge-based learning.

Bourdieu’s (1977) concept of ‘habitus’ offers another interpretation of the tension between institutional norms and student culture. Habitus is related to an individual’s disposition. It is generated by someone’s place in the social structure. By ‘internalising’ the social structure and one’s place within it, an individual recognises what goals are achievable and seeks to change behaviour accordingly (Dumais 2002). The medical school is the habitus where students recognise that conformity raises the chances of success (Bourdieu 1977, 1990). Non-conformity, on the other hand, may result in slow progression, exclusion or failure. Our coexisting discourses could be conceived as resistance by students to learning about issues that are not, or do not appear to be, supported by the institution’s dominant values to which they must aspire if they are to succeed. According to Bourdieu (1977, 1990) this leads to the reproduction of an inequitable ‘social structure’ where biomedical values dominate. Such findings are mirrored in the education literature (Bernstein 1996), where blame for ineffective delivery of learning becomes attributed to students’ apparent resistance rather than to any failure on the part of the school to educate students about the subject. If effective teaching and learning about cultural diversity are to be realised, the institution needs to positively demonstrate its validity.
This may not be enough. Students operate in an informal world where support for, or resistance towards, cultural issues is tempered not only by formal institutional practice but also by the student community. It is at the level of the hidden curriculum that strategies capable of influencing student behaviour need further development (Cribb and Bignold 1999). The lack of discussion and openness, perceived as marginalisation of the subject by the school, is simultaneously perpetuated by students’ own perceptions of the uncertainties surrounding cultural boundaries. They can be reluctant to engage in debates which risk causing offence (Roberts et al. 2008). The medical curriculum places conflicting demands on students to learn about biomedicine and the social and behavioural sciences. The tension is frequently resolved in favour of the former as knowledge of the biomedical sciences is perceived by students to be generally more important to realising their goal of becoming a clinician. A greater understanding of the student behaviours that facilitate or inhibit these factors is needed, including the impact of the informal peer networks that students develop.

There were limitations within our study methodology. Our findings reflect a particular intersection between year two students situated in northern English medical schools and two White British, female medical researchers (JHR and VW). Whilst focus groups have the advantage of promoting discussion in a form which mirrors the naturalistic setting of small group learning with which the students were familiar, they can disadvantage the quieter student or one whose views run counter to the prevailing position. The facilitators adopted a neutral stance whilst accepting that no one is value free. Much of the discussion in each group arose spontaneously or developed gradually of its own accord, and, as transcriptions confirm, with little prompting. This suggests that the opinions expressed were the students’ own. In-depth individual interviews would have added to our data but were not feasible within our time frame as School A was about to introduce early patient contact into the curriculum.

Research conducted about the place of cultural diversity in the medical curriculum can conclude with a summary of insurmountable obstacles. Whilst we identified barriers to effective learning our findings do suggest a way forward. Work-based learning (WBL) offers rich opportunities for mirroring ‘the real world’ to learners. Those students in our study who worked in real life settings ‘saw life as it was in the raw’. Yet rarefied experience in the work place can often miss the point or sanitise the messy reality of the medical world. Thus, learning about ethnic difference through WBL will be central. We are increasingly aware that a student’s experience must be supported by reflection and discussion after the event otherwise learning opportunities may be lost (Dornan et al. 2007). Maximising the opportunities for small group discussion facilitated by well-briefed tutors who value the subject matter is crucial. Using existing student friendship groups is an option but has limitations as more challenging discussion often sits outside of the comfort zones such groups create. Our findings illustrate the apparent marginality of students’ opinions and experiences in the design of the curriculum. Student input into curriculum design should therefore be actively encouraged in an equitable and voluntary capacity, offering a valuable resource to students and tutors.

Conclusion

Despite obvious differences in the formal delivery of teaching the results of this study showed an unexpected consensus of student opinion with similar themes consistent across the schools. Understanding cultural diversity is recognised as important for future work but
there is dissonance and debate amongst the student population as to how this might best be achieved. There is an urgent need to explore the views of tutors as well as students. The tensions we present here between the formal and informal curriculum must be challenged, debated and addressed. Ignoring them will do no more than delay progress in equipping students with the knowledge, skills and understanding required to function in a culturally diverse world.

Acknowledgments We thank all the students who took part in the study and the staff at both medical schools for their help with organisation, particularly Dr. Ioan Davies.

Appendix

Topic guide part 1

Now, we’re going to turn our attention to your experiences of studying medicine at A/B

Students: Have you covered topics in your PBL group which refer to cultural issues for patients and doctors?

If so, how was it done?

Expand: relevant? enjoyable? useful?

Have your friendships with fellow students played a part in your understanding of cultural issues?

Have you or your family any healthcare experiences of intercultural care which have taught you something?

B students

How did you find the PPD session on attitudinal awareness and barriers to communication? Expand: relevant? enjoyable? useful?

Have your friendships with fellow students played a part in your understanding of cultural issues?

Have you had much experience meeting patients from different cultural backgrounds to yourself?

What have you learnt from this?

Have you or your family any healthcare experiences of intercultural care which have taught you something?

Part 2

We would like you to comment on the following words of phrases as your thoughts focus. There are no right or wrong answers and we are not looking for dictionary definitions. Please feel free to contribute. Four ‘flashcards’, with the words: “race”, “ethnicity”, “culture”, “cultural diversity”, were then raised consecutively.

Closure

References


Institutional marginalisation and student resistance


