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

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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,

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25 ethnicity and culture is to be achieved. Early introduction to understanding the delivery of
26 health care to diverse populations is needed. This should be accompanied by more open
27 collaborative debate between tutors and students on the issues raised.

28 **Keywords** Medical education · Problem based learning · Cultural diversity ·
29 Hidden curriculum · Qualitative methods

Introduction

31 Globalisation has transformed the task for health professionals of providing appropriate,
32 effective and evidence-based health care. National recommendations for medical schools
33 in the UK (GMC 2003), USA (Department of Health 2000), Canada (Health Canada 2001)
34 and Australia (CDAMS 2006) refer to the importance of developing 'culturally aware'
35 doctors able to recognise the socio-cultural determinants of health alongside the traditional
36 biomedical view of disease. Recent reform of undergraduate medical education has started
37 to reflect the increasingly global context. A survey showed that 72% of UK medical
38 schools include some teaching about cultural diversity (Dogra et al. 2005). However,
39 confusion exists around the terminology employed, where different terms are frequently
40 used interchangeably (Aldieh and Hahn 1996; Roberts et al. 2008). In this paper we use the
41 term "cultural diversity" to embrace all teaching and learning relating to race, ethnicity
42 and culture.

43 The literature describes a range of approaches to introducing cultural diversity into the
44 medical curriculum: (1) promoting cultural awareness and sensitivity through appealing to
45 ethnic diversity (Kai et al. 2001) (2) teaching students 'propositional' knowledge that
46 prioritises certain cultures and health beliefs, previously criticised for perpetuating cultural
47 stereotypes (Frank and MacLeod 2005), (3) adopting a reflexive and critical response to
48 health inequalities and social injustice, (Frank and Macleod 2005; Wear and Aultman
49 2005), (4) using the concept of 'cultural competency' (Betancourt et al. 2005) and (5)
50 focusing primarily on 'cultural safety' to ensure all providers can work in a culturally
51 "safe" "manner" (Gray et al. 2003).

52 Little is known about which strategies are most effective or when to implement them in
53 the curriculum (Brach and Fraser 2000). There is a dearth of evidence about effective
54 learning outcomes. In practice, education about cultural diversity is directed at students
55 early in their education (Loudon et al. 1999). Beagan (2003a) for instance, reported a study
56 of teaching 'culture and ethics' to first and second year undergraduates which showed little
57 impact on behaviour or attitude. Research shows that as students progress through medical
58 school their cynicism about psychosocial issues increases (Wolf et al. 1989). In brief, the
59 outcomes of cultural diversity education are inconsistent. Further, much of the evidence
60 comes from North America, which may be less applicable to the European context
61 (Loudon et al. 1999; Champaneria and Axtell 2004).

62 More detailed exploration of how best to encourage 'cultural awareness' in the
63 undergraduate curriculum is required. One possibility is to examine how the social prac-
64 tices and behaviours of medical undergraduates help to promote or undermine successful
65 implementation of learning. Certain core beliefs may be devalued, whilst others are
66 reinforced. In this paper Bourdieu's (1977, 1990) concept of *habitus* is used as a means of
67 exploring this central question and of interpreting the findings. The habitus represents the
68 social structure which students inhabit. Through their engagement with it they gradually
69 adopt the values of the medical school. Social and educational theorists, such as Bernstein

70 ([1996](#)) and Bourdieu and Passeron ([1977](#)) for example, show how the dominance of certain
71 pedagogic discourses in people's daily lives makes them difficult to resist, especially if
72 individuals are unaware of their coercive properties. This idea has important implications
73 for the successful implementation of learning in the undergraduate curriculum.
74   Early patient contact in medical education is growing in popularity with some evidence
75 that this may contextualise and strengthen learning about behavioural and social sciences
76 (Dornan and Bundy [2004](#); Dornan et al. [2006](#)). A recent systematic review concluded that
77 'early clinical experience' fosters social responsiveness within medical education (Little-
78 wood et al. [2005](#)). The present study aimed to explore the impact on students of two
79 contrasting pedagogic approaches to undergraduate learning about cultural diversity.
80 Student experiences at a school offering early patient contact in the first 2 years were
81 compared with one using paper-based patient scenarios only.

82 Methods

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

86 Study setting

87 Two medical schools in the north of England with contrasting curricula were chosen.
88 School A admits approximately 400 students annually and is situated in a large campus
89 within a major city of a dynamic culturally diverse population. The curriculum, developed
90 in 1994, is problem based. Learning objectives about diversity are integrated within paper
91 based PBL cases based on a series of clinical index situations. All cases contain some
92 aspect of psychosocial learning of which approximately 10% relates to ethnicity, race or
93 culture. The students have occasional lectures but none specifically on cultural diversity.
94 At the time of the study there was no contact with patients until year three. Tutors are
95 predominantly basic medical scientists who have no medical training.
96   In contrast, School B admits approximately 100 students annually and is located within
97 a small university campus outside a predominantly white socio-economically deprived
98 town. The course was established in 2001 and remains affiliated to a larger regional
99 medical school. The medical curriculum is designed around a systems based and integrated
100 approach delivered through lectures, laboratory sessions and small group work. One
101 module, the Personal and Professional Development (PPD) module, is entirely delivered by
102 practising doctors, largely General Practitioners, and taught in stable small groups of
103 10–12 students. One session was allocated to specifically explore work in a culturally
104 diverse society. Students have early patient contact from the beginning of the programme
105 and conduct a Community Placement Project where all students work as volunteers for
106 60 h (over 12 months) in a health, education or social services agency.

107 Sampling process

108 Both schools approached teaching and learning through small group work, either PBL
109 (School A) or small groups for PPD teaching (School B). In both schools, these

110 pre-existing groups had been running for 6 months prior to the study. They were closed,
111 stable groups specifically allocated to ensure a demographic mix of ethnicities, gender and
112 age. The seven selected groups were recruited pragmatically drawing on the support of the
113 programme manager at site A and group tutors at site B. The existing groups were invited
114 to participate, as we anticipated that students already familiar with each other were more
115 likely to engage with sensitive topics than a group of unfamiliar 'strangers' (Barbour and
116 Kitzinger 1999).

Participants

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

Focus group process

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

Data analysis

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

Table 1 Demographic details of participants

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

138 **Results**

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

143 Theme 1: institutional marginalisation of learning about cultural diversity

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

148   It might be important to us but I don't know whether it's important to everybody
149   because it's not explicitly expressed as a prerequisite or as a learning objective or as
150   an exam question [B, 2, F, WB]
151

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

155   All I'm saying is that in PBL it [psychosocial issues] kind of gets pushed to the last
156   five minutes of a two and a half hour overall session in the week, so its just done
157   superficially [A, 1, M, E]
158

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

161   Maybe that's the issue, the medical school does not want to get into what could be a
162   potentially divisive discussion and wants to leave it unspoken? [A, 2, F, WB]
163

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

170   My tutor didn't say anything so presumably that means that it wasn't on the tutor's
171   notes [A, 3, F, WB]
172

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

176   You can get very polarised views which I think need to be diffused a lot more…
177   [A, 4, M, EM]
178

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

181   They don't even say 'well what do you think racially' or 'what do you think this is
182   trying to stress', they don't try at all… [B, 4, F, WB]
183

184 School B students frequently claimed that during small group discussions the subject of
185 cultural diversity was addressed in an "ad hoc" manner and only raised if the tutor had a
186 specific personal interest in the subject. This resulted in significant variation between the
187 groups, with some students potentially missing key learning opportunities:

188 But that was very much down to the clinician who ran the session rather than it being
189 written into the curriculum……. I think that was because the external speaker who
190 came to do that session had thought, "Oh this is a really interesting lady and she
191 would be great to speak to the students". But it wasn't part of the curriculum. It's like
192 the learning objective again. It's almost like by chance that just happened to be that
193 person that ran that session [B 2 F WB]
194

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

201 To be honest it's one of those things you don't get examined on so you're not likely
202 to look into it [A, 3, M, WB]
203

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

210 Theme 2: student resistance to formal learning on cultural diversity

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

217 A lecture of one or two hours is not going to change (those students)…I think the
218 greatest cultural exposure is through university and meeting people from different
219 backgrounds [B, 2, M, EM]
220

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

223 The place we most found out about different cultures and stuff is through our friends.
224 If you want to know something, if you are close enough to your friends you ask them,
225 'do you find that offensive?' [B, 4, F, WB]
226

227 Students identified their peer group as a potentially valuable resource for learning about
228 cultural difference, albeit one that was rarely utilised routinely, precisely because of stu-
229 dents' reluctance to engage in a dialogue about these sensitive issues:

230 I sometimes think that in a culturally diverse group that we often have we don't talk
231 amongst ourselves. For example, the fact that you've both got hijabs, I don't know
232 enough about Islam for instance and how you both react regarding abortion [student
233 referring to two classmates in PBL group wearing hijabs]. I think we have a lot of
234 resources within the group and we don't really use you enough [A, 3, F, WB]
235

236 Students expressed frustration with both the theoretical delivery of social and behav-
237 ioural science teaching, which they felt failed to highlight the practical relevance to
238 medicine, and with the curriculum content's separation from the realities of daily life:

239 Psychosocial tends to be very unpopular. It is put across in a very counter intuitive
240 way. It's all about (psychological) models, not people [B, 4, F, W]
241 But you can discuss them (models) until you are blue in the face, but until you
242 actually see people coping with illness then you don't really appreciate it [A, 2, M,
243 EM]
244

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

247 You can't learn this out of a book. You've got to learn it for yourself. You can't teach
248 it…you get this learning from our own personal experiences and from working in
249 groups [B, 4, M, WB]
250

251 A more positive view reflected the importance of 'learning in the real world':

252 I only go to PBL because I have to. I try and learn as much as I can but I won't go
253 there to learn about culture…. [A, 3, M, EM]
254

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

257 On the wards you get people from Chinese descent who have lived in Britain for
258 30 years but don't speak a word of English. You get to see how it really is, this
259 (the medical school) isn't really the life of Britain as it really is [A, 2, M, WB]
260

261 They felt this gave them an important insight into issues surrounding ethnic difference
262 and health inequality which they did not gain from their medical studies. The clinical
263 environment presented other challenges such as discrimination, experienced or at times
264 witnessed by students. Several students claimed to have seen such discrimination
265 directed, for example, at doctors who had qualified in India. They felt that their medical
266 education should prepare them to handle such experiences but claimed this was not the
267 case.
268 Several students suggested ways in which learning about cultural differences could be
269 made more clinically relevant, by taking an epidemiological approach and looking at
270 patterns of health and illness across ethnic groups, rather than using clinical vignettes
271 which encouraged stereotyping. Students at both institutions claimed that case scenarios
272 often unwittingly led to negative and derogatory images or were simply misleading; for
273 example if a PBL case described a patient as 'Asian' it implied that the patient was
274 Muslim. They also spoke of extreme cases being quoted rather than more moderate
275 positions and of polarised discussions which ignored the heterogeneity of minority cultures
276 in the UK. Students, usually from ethnic minority groups, suggested that understanding
277 inequitable access to healthcare might be a more productive route into understanding
278 cultural diversity and its impact on health and would certainly be clinically relevant:

279 Something I read recently in 'Hospital Doctor' was to do with how Bangladeshi
280 patients are treated for cardiovascular diseases in East London and they have a much
281 higher incidence of mortality related to CHD as opposed to people who are of white
282 origin [A, 1, M, EM]
283

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

Discussion

288 This study highlights the challenges of learning about cultural diversity in medical schools.
289 Its interpretation presents a way forward. We hypothesised that a curriculum offering early
290 patient contact would provide a richer environment for learning about cultural diversity. Our
291 findings showed that, despite the contrasting pedagogies at the two schools, similarities in
292 students' views outweighed any differences. Students at both schools perceived a factual
293 knowledge-based approach to learning about cultural diversity to be counter productive.
294 Lectures and PBL cases were criticised for stereotyping and failing to facilitate constructive
295 discussion about the rich complexity of human relations. Early patient contact was viewed
296 as positive but unpredictable. At both sites, students who had worked in health care placed
297 great value on this as a source of learning. Personal experiences with peer groups were
298 considered a more appropriate foundation for understanding cultural difference.
299 The implication is that medical education does not address the issue of cultural dif-
300 ference, where life experience can offer this more adequately. The drive for clinical
301 competence must consequently not lose sight of the need to provide a culturally and
302 socially informed medical education in which students acquire reflective and critical skills
303 and learn to apply these within diverse local settings. However, many academically high
304 achieving students entering medicine are already located in a class structure which is then
305 perpetuated within the medical school itself. This may insulate them from exploring and
306 understanding cultural difference solely through individual exposure. Individuals' expe-
307 riences of ethnic difference are not the same as learning about them through formal
308 avenues. This suggests that a medical education which largely leaves students to 'learn
309 from experience' is not preparing them to treat such knowledge critically.
310 The coexisting narratives of 'institutional marginalisation' and 'student resistance'
311 espoused by our students challenge our understanding of how students learn about cultural
312 diversity and the strategies needed to optimise teaching. Our findings depict students'
313 views. They do not necessarily directly reflect their experiences. However, they do
314 highlight students' perceptions and attitudes, and offer an indication of their actual
315 experiences. The stated tension between 'institutional marginalisation' and 'student
316 resistance' portrays the complexity surrounding these issues. Any analysis has to assume
317 that 'medical school' and 'student' culture are inseparable. Both influence each other to
318 produce the processes and values found in contemporary medical education settings, which
319 is central to any interpretation of the findings.
320 The processes by which values and opinions are reproduced within student commu-
321 nities are frequently subtle, hidden, and operate at an informal level (Lempp and Seale
322 2006). Our students seemed to 'blame' the institution for 'blocking' effective learning on
323 cultural diversity, whilst simultaneously supporting the dominant value of biomedicine.
324 This is not surprising, since our students are embedded in the medical school culture,

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Institutional marginalisation and student resistance

325 where training is geared towards 'fitting in' (Beagan 2003b; Lingard et al. 2003; Light
326 1970). The apparently contradictory relationship between the demands of the institution
327 and student culture is inherently reciprocal. As Lave and Wenger (1998) suggest, full
328 participation in the social life of a 'community of practice' depends on the degree to
329 which individuals adopt its dominant values and progress along a trajectory towards full
330 'legitimate participation'. These paradoxical student narratives may be an expression of a
331 desire to conform to two competing discourses; one driven by explicit institutional
332 demands, and the other by the hidden curriculum. Students resolved this tension by
333 general consensus that there is a need to increase awareness about cultural issues outside
334 of the medical school context.

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

357 Bourdieu's (1977) concept of 'habitus' offers another interpretation of the tension
358 between institutional norms and student culture. Habitus is related to an individual's
359 disposition. It is generated from someone's place in the social structure. By 'internalising' the
360 social structure and one's place within it, an individual recognises what goals are
361 achievable and seeks to change behaviour accordingly (Dumais 2002). The medical school
362 is the habitus where students recognise that conformity raises the chances of success
363 (Bourdieu 1977, 1990). Non-conformity, on the other hand, may result in slow progression,
364 exclusion or failure. Our coexisting discourses could be conceived as resistance by students
365 to learning about issues that are not, or do not appear to be, supported by the institution's
366 dominant values to which they must aspire if they are to succeed. According to Bourdieu
367 (1977, 1990) this leads to the reproduction of an inequitable 'social structure' where
368 biomedical values dominate. Such findings are mirrored in the education literature
369 (Bernstein 1996), where blame for ineffective delivery of learning becomes attributed to
370 students' apparent resistance rather than to any failure on the part of the school to educate
371 students about the subject. If effective teaching and learning about cultural diversity are to
372 be realised, the institution needs to positively demonstrate its validity.

373   This may not be enough. Students operate in an informal world where support for, or
374 resistance towards, cultural issues is tempered not only by formal institutional practice but
375 also by the student community. It is at the level of the hidden curriculum that strategies
376 capable of influencing student behaviour need further development (Cribb and Bignold
377 1999). The lack of discussion and openness, perceived as marginalisation of the subject by
378 the school, is simultaneously perpetuated by students' own perceptions of the uncertainties
379 surrounding cultural boundaries. They can be reluctant to engage in debates which risk
380 causing offence (Roberts et al. 2008). The medical curriculum places conflicting demands
381 on students to learn about biomedicine and the social and behavioural sciences. The
382 tension is frequently resolved in favour of the former as knowledge of the biomedical
383 sciences is perceived by students to be generally more important to realising their goal of
384 becoming a clinician. A greater understanding of the student behaviours that facilitate or
385 inhibit these factors is needed, including the impact of the informal peer networks that
386 students develop.

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

399   Research conducted about the place of cultural diversity in the medical curriculum can
400 conclude with a summary of insurmountable obstacles. Whilst we identified barriers to
401 effective learning our findings do suggest a way forward. Work-based learning (WBL)
402 offers rich opportunities for mirroring 'the real world' to learners. Those students in our
403 study who worked in real life settings 'saw life as it was in the raw'. Yet rarefied expe-
404 rience in the work place can often miss the point or sanitise the messy reality of the
405 medical world. Thus, learning about ethnic difference through WBL will be central. We
406 are increasingly aware that a student's experience must be supported by reflection and
407 discussion after the event otherwise learning opportunities may be lost (Dornan et al.
408 2007). Maximising the opportunities for small group discussion facilitated by well-briefed
409 tutors who value the subject matter is crucial. Using existing student friendship groups is
410 an option but has limitations as more challenging discussion often sits outside of the
411 comfort zones such groups create. Our findings illustrate the apparent marginality of
412 students' opinions and experiences in the design of the curriculum. Student input into
413 curriculum design should therefore be actively encouraged in an equitable and voluntary
414 capacity, offering a valuable resource to students and tutors.

Conclusion

416 Despite obvious differences in the formal delivery of teaching the results of this study
417 showed an unexpected consensus of student opinion with similar themes consistent across
418 the schools. Understanding cultural diversity is recognised as important for future work but

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419 there is dissonance and debate amongst the student population as to how this might best be
420 achieved. There is an urgent need to explore the views of tutors as well as students. The
421 tensions we present here between the formal and informal curriculum must be challenged,
422 debated and addressed. Ignoring them will do no more than delay progress in equipping
423 students with the knowledge, skills and understanding required to function in a culturally
424 diverse world.

427 **Appendix**

428 **Topic guide part 1**
429 Now, we're going to turn our attention to your experiences of studying medicine at A/B
430 **Students**: Have you covered topics in your PBL group which refer to cultural issues for
431 patients and doctors?
432 If so, how was it done?
433 Expand: relevant? enjoyable? useful?
434 Have your friendships with fellow students played a part in your understanding of
435 cultural issues?
436 Have you or your family any healthcare experiences of intercultural care which have
437 taught you something?
438 **B students**
439 How did you find the PPD session on attitudinal awareness and barriers to communi-
440 cation? Expand: relevant? enjoyable? useful?
441 Have your friendships with fellow students played a part in your understanding of
442 cultural issues?
443 Have you had much experience meeting patients from different cultural backgrounds to
444 yourself?
445 What have you learnt from this?
446 Have you or your family any healthcare experiences of intercultural care which have
447 taught you something?
448 **Part 2**
449 We would like you to comment on the following words of phrases as your thoughts
450 focus. There are no right or wrong answers and we are not looking for dictionary defini-
451 tions. Please feel free to contribute. Four 'flashcards', with the words: "race", "ethnicity",
452 "culture", "cultural diversity", were then raised consecutively.
453 **Closure**

454
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456 **References**

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