tice on curriculum planning needs to be expanded, and the contribution made by community-based general practice teachers needs to be continuously enhanced and supported.

Academic departments of general practice need to redefine why they are in medical schools, and to take encouragement from the fact that their efforts are highly appreciated by the medical students, regardless of their ultimate career choice. At the same time, we need to guard against the wrong conclusions being drawn from research such as that carried out by Dr Morrison and Professor Murray, whose work is important. The challenge now is to describe more fully what made the general practice attachment so positive, and to use this information to change the other parts of the clerkship that are negatively rated.

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Learning for a multicultural society

MEDICAL education has failed to keep pace with the needs of the multicultural population of the United Kingdom.[1] The General Medical Council has clearly endorsed the need for including multicultural health care within the objectives and values of undergraduate education.[2] Last year, a British Medical Association (BMA) report clarified the position at both undergraduate and postgraduate levels.[3] Of the 74% of institutions that replied to their survey, only 42% addressed this issue in any way at all. The report clearly demonstrates the need for training in multicultural health and health care. In addition, it offers guidelines for the development of such programmes.

What is the rationale for education in multicultural health care? First, doctors are not adequately prepared to assess or manage patients from these diverse backgrounds.[1] Both doctors and patients can experience difficulties when dealing with someone from a different ethnic group.[4,5,6] Cultural factors are relevant not only to patterns of disease, but also to communication. The lack of a shared culture means differences in beliefs and expectations, as well as the more obvious language issues.[5,6] Future doctors are expected 'to be more aware and respond sensitively to the culturally determined expectations of their patients'.[7] It is important to remember that learning about the cultural dimensions of health care is not just about 'other' cultures. It is aimed at understanding the cultural constructions of disease, and of the health beliefs and health-seeking behaviours of *all* cultures, including the majority white culture.

Secondly, minority ethnic groups can sometimes receive poor quality health care.[8] To achieve equity within the health service, the needs of all groups have to be addressed.[9] This can only be achieved by rejecting 'colour-blind' approaches and considering cultural differences and needs as an essential factor. Health inequalities are related to economic and social consequences of migration, including limited access to healthcare provision.[10] This is exacerbated by discrimination, professional practice, health workers' attitudes and expectations,[11] and communication difficulties.[5,6]

What issues need to be covered? The health needs of minority ethnic groups can be considered by exploring such factors as health beliefs and practices, expectations of the health service, communication, traditional and alternative forms of health care, family systems, diet, and patterns of illness.[5,6] Two levels of educational needs have been identified.[5] First, there is the conceptual level — for example, the definition of ethnicity and culture, and the different approaches to health, illness and death in different cultural groups. Secondly, there is the practical level — for example, the patterns of disease in different cultural groups, the factors underlying these, and the presentation and appropriate management of disease. More details are given in the BMA report.[3]

Where do we start? Deficiencies exist at both undergraduate[1,3] and postgraduate[12,13] levels. The aim of any educational programme must be 'to provide students with a level of knowledge, sensitivity and awareness from which they can go on to develop and learn for themselves'.[3] This learning needs to continue throughout the professional careers of all doctors and should be included within all accredited training programmes. This will help the profession to respond more effectively to the health care needs of the total population.

Probably the first priority is to include multicultural education in the undergraduate curriculum. Cultural issues have implications for all areas of medicine. Current teaching tends to be opportunistic, taking the form of stand-alone lectures, electives and clinical teaching by enthusiasts. What is needed is a strategic approach, reflecting the multicultural nature of British society throughout the curriculum. This will avoid the implication that minority ethnic groups are marginal or abnormal.

Can it be done? In other professions, such as teaching, health visiting and social work, multicultural aspects are already addressed. For example, in order to gain basic qualifications, social workers and probation officers are required to demonstrate an awareness of cultural issues relevant to their work.[14]

How would this work in medical practice? At undergraduate

level, some initiatives in medical schools have already been undertaken. These include a paediatric course that used case histories of patients to illustrate failed communication between doctors and Asian patients.[15] Another course involved students talking to families from different ethnic groups.[16] This raised the awareness of cultural factors in health, and improved communication skills. An initiative in Canada used local data from patients and doctors to identify barriers to effective health care. Simulated patients were then used to present this information to students in an integrated problem-based course.[4] All innovations need rigorous evaluation before scarce resources are allocated to mainstream development.

What resources are available? When devising undergraduate and postgraduate courses, the experience and knowledge of doctors and students from ethnic minorities, as well as the minority ethnic communities, should be welcomed and taken into account. However, they alone should not be held responsible for the education of others. A number of organisations can offer support and materials.[3,5,17] In addition, the increasing emphasis on community-based teaching offers practical opportunities to gain knowledge and experience of different communities and their health needs.[2]

The BMA report moves the debate forward. Now is the time for action.

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