Cultural diversity training for UK healthcare professionals: a comprehensive nationwide cross-sectional survey

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ABSTRACT – Healthcare inequalities within the UK based on patients' ethnicity have been found over the last five years in a large number of medical specialties. One possible explanation for this lies in ignorance of ethnic minority healthcare needs among professionals. Cultural diversity programmes have been shown to improve patient outcomes including compliance, yet these are not as yet requirements for any UK healthcare professionals with the exception of psychiatrists. This paper documents the frequency, regional variation, characteristics and motivations for cultural diversity training through a questionnaire survey of the educational leads of every UK medical school, postgraduate deanery and schools of nursing, physiotherapy, occupational therapy, speech and language therapy, and pharmacy. The results showed a wide variation in teaching practices between healthcare professions and geographical regions. This study provides evidence for the need for national guidelines to incorporate cultural competency training by all UK healthcare professional training bodies.

Introduction

Ethnic minorities account for approximately 8% of the total population of the UK, equivalent to 4.6 million people,[1] yet their quality of healthcare has been found to be inferior compared to white Caucasians in diseases including heart disease,[2] stroke,[3] cancer,[4,5] HIV,[6] prenatal care,[7] and mental health.[8] In order for medical education to meet the goal of improving healthcare for the whole population, training needs to incorporate the principle of individualising care, including recognising the specific health needs, values and communication issues of ethnic minorities.[9–13] Although UK healthcare professional training bodies in medicine, nursing, physiotherapy, occupational therapy, speech and language therapy and pharmacy have all issued general guidelines that encourage equality and diversity appreciation in educational curricula,[14] there are currently no requirements for teaching centres to provide formal cultural diversity training. In this study the nationwide frequency, characteristics and motivations for formal cultural diversity teaching for the main types of UK healthcare professionals are documented. It was hypothesised that regions of the UK that have relatively small proportions of ethnic minorities would be less likely to feature cultural diversity training within their healthcare programmes.

Methods

Search strategy

Health professional courses for the 2006/7 year were identified through the Universities and Colleges Admission Service (UCAS) – the sole UK central organisation through which applications are processed for entry to full-time undergraduate courses, higher national diploma and university diploma – in the following subjects: medicine, physiotherapy, nursing, occupational therapy, speech and language therapy, and pharmacy. The names and contact addresses of the dean or director of medical education (or equivalent) for each training programme were subsequently identified. The list was complemented with information from the following databases: the membership list of the Council of Heads of Medical Schools, the Council of Deans and Heads of UK University Faculties for Nursing and Health Professions, the Chartered Society of Physiotherapy, the Royal Pharmaceutical Society of Great Britain, the European Network of Occupational Therapy in Higher Education and OTdirect (occupational therapy resources on the web), and the Royal College of Speech and Language Therapists. A list of postgraduate medical deans was also obtained from the Conference of Postgraduate Deans of the United Kingdom homepage.

Questionnaire

Questionnaires were sent with an accompanying letter that specified the nature of the survey and the reasons for the interest in identifying cultural diversity programmes. If a response was not received the deputy head for that establishment was contacted, or, failing this, the relevant heads were emailed. The

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exact position of each respondent was recorded. The responders were identified as the deans, clinical directors, heads or coordinators of education, or their deputies in 82% of responders; the remainder were identified as divisional heads, senior lecturers or other staff members. The questionnaire contained 11 questions, eight of which could be answered by ticking the most appropriate box:

- Would you describe the ethnic and/or cultural makeup of your region as diverse?
- Are you aware of the percentage of minority ethnic groups that make up your local, student and patient populations (with estimates required if known)?
- Do you offer your students educational programmes on ethnic/cultural diversity during their training? If no, are you anticipating establishing one in the next year?
- What was the motivation for offering this kind of educational programme to your students?
- Is the offered programme optional or required?
- At which stage of the training is this programme offered?
- State the number of hours undertaken on this programme.
- Is the programme organised as a lecture; seminars; role play; intercalated BSc; small group; video; presentations; research project; other?
- Are the students formally assessed on the content of the programme, and is this via oral or written assessment?
- How long have you been offering this programme?
- Are teaching staff for your programme made up of volunteers, expert lecturers on community studies, or other types of staff?

Statistical analysis

Tests of chi-squared, correlation and logistic regression were implemented in SPSS 15.0 for Windows. Local ethnic minority percentages were obtained from the 2001 national census.[1] For the analysis of regional variation of programme frequency a 11 × 2 contingency table was constructed representing each UK region; an iterative subtraction procedure enabled regions showing differences from the mean to be identified.

Results

The response rate was 86.7% from undergraduate medical schools; 94.7% from postgraduate deaneries and 62.8% from allied health disciplines (Table 1). Provision of a dedicated cultural diversity teaching programme was found in 70.1% centres. The frequency of programmes was less in pharmacy schools (8.3%) than other teaching centres (pooled frequency: 76.0%; $p<0.01$), but was not significantly different between other centre types. Of the 41 centres (out of 137) that did not provide a programme, seven acknowledged that they anticipated establishing one in the following year (of which three were undergraduate medical schools, and three were postgraduate medical schools). Where programmes were provided these had been in

Table 1. Frequency and characteristics of cultural diversity programmes grouped by type of teaching centre.

	Undergraduate medicine	Postgraduate medicine	Nursing	Physio-therapy	Occupational therapy	Speech and language therapy	Pharmacy
Centres responding (n)	26	18	39	19	14	9	12
Programme rate (%)	76.9	72.2	65.0	63.2	71.4	77.8	8.3*
Projected rate (%)	88.5	88.9	65.0	63.2	78.6	77.8	8.3*
Years established (median)	5	10	5	6	5	9	1
Required (%)	95.7	66,7*	97.0	100	100	100	100
Assessment (%)	76	29*	74	62	67	100	0
Years/total course	3.13/5	1.5/3	1.07/3	2/3	2.27/3	2.14/3	4/4
Number of hours (95% CI)	16 (±9.3)	6.9 (±4.5)	46 (±23)	48 (±56)	29 (±29.6)	18 (±11)	8
Teaching format (%):							
– lectures	50	43	75	62	73	57	0
– small groups	82	93	78	54	64	57	100
– role play	46	43	31	23	36	14	0
– seminars	32	43	64	62	73	100	100
– other eg video, presentation, project	36	57	61	46	45	71	0
Teachers (%)							
– paid experts	75	92	87	83	67	80	No answer
– volunteers	30	23	29	25	17	0	No answer

*Difference between type of teaching establishment: $p<0.05$.

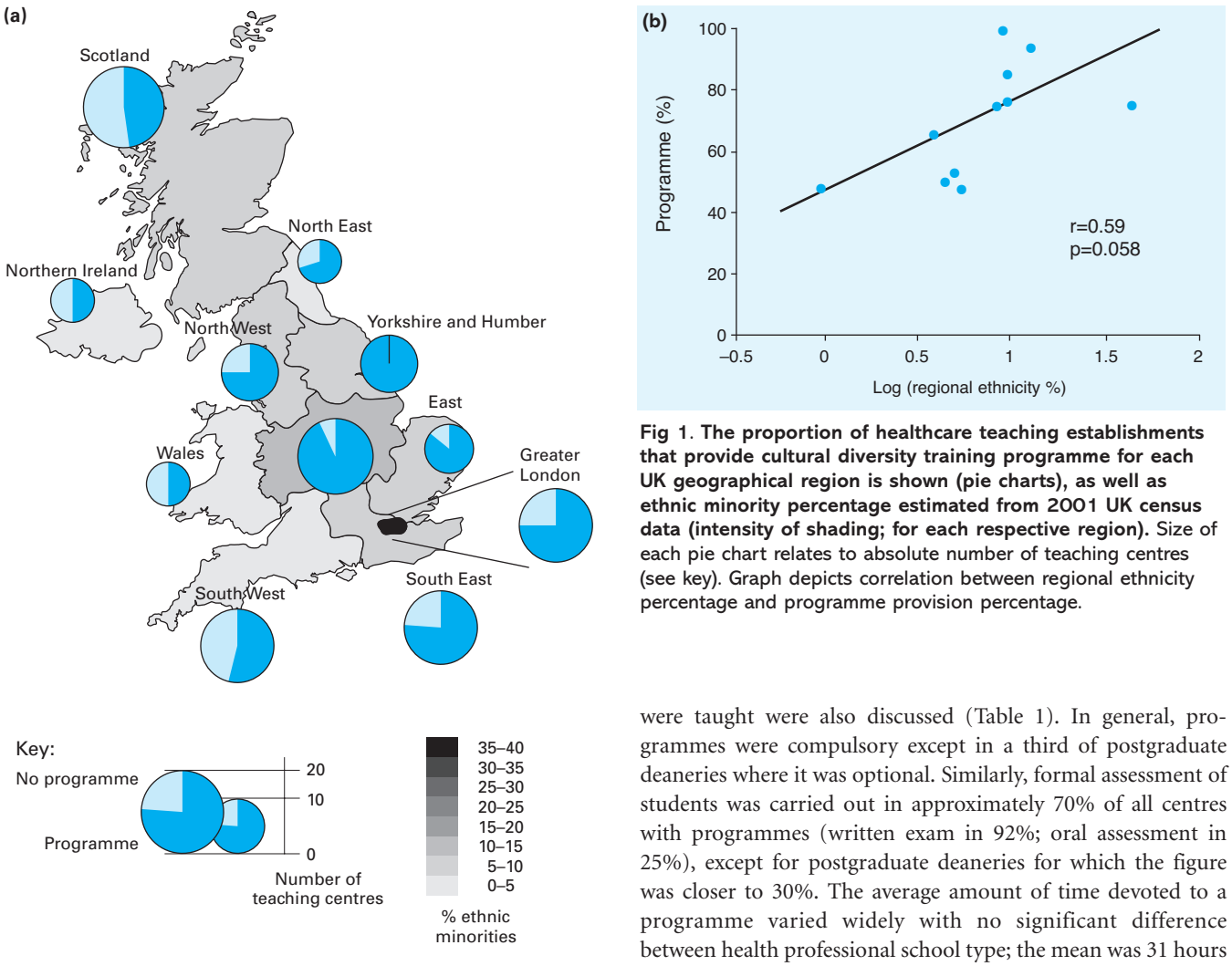

Fig 1. The proportion of healthcare teaching establishments that provide cultural diversity training programme for each UK geographical region is shown (pie charts), as well as ethnic minority percentage estimated from 2001 UK census data (intensity of shading; for each respective region). Size of each pie chart relates to absolute number of teaching centres (see key). Graph depicts correlation between regional ethnicity percentage and programme provision percentage.

place for a median of five years (no difference between teaching establishment type).

Programme frequency varied according to region ($p<0.05$; Fig 1) due partly to a significant decrease from the average in Scotland and significant increases from the average in the Midlands and Yorkshire and Humberside. There were no significant regional variations in school type or response rate that might account for regional differences in programme frequency. A correlation between regional programme frequency and regional ethnic minority percentage estimated from 2001 national census statistics showed a positive trend ($r=0.59$; $p=0.058$; Fig 1).[1] When teaching centres were asked whether in their opinion the local region was ethnically diverse there was no relationship between this response and programme provision. Similarly, estimation of the local ethnic minority percentage for each of the overall students' and patients' populations did not predict programme provision. However, centres that were unable to provide an estimate of the ethnic minority percentage for the local and patient populations were less likely to provide programmes than centres who did supply this information ($p<0.05$).

The structure of cultural diversity programmes where these were taught were also discussed (Table 1). In general, programmes were compulsory except in a third of postgraduate deaneries where it was optional. Similarly, formal assessment of students was carried out in approximately 70% of all centres with programmes (written exam in 92%; oral assessment in 25%), except for postgraduate deaneries for which the figure was closer to 30%. The average amount of time devoted to a programme varied widely with no significant difference between health professional school type; the mean was 31 hours (range: 2–200 hours). However, 32% of centres with programmes did not answer this, with two thirds of these centres making comments to the effect that their programmes were integrated within other programmes (eg problem-based learning) or variable. Programmes that taught ethnic minority health issues were incorporated into at least half the number of years of duration of each health professional course type. The most common teaching methods employed were small group (75%) or lectures (62%), although a wide range of practices were documented including role play, video, home and community visits, and appreciation of literature, music and poetry (the latter solely for nursing and physiotherapy students). Teaching was carried out by expert, paid lecturers on community studies in 81%, by volunteers in 21%, and by other types of teacher in 18%. Finally, we asked the educational leader for each medical course type to describe the reasons for establishing the cultural diversity programme; representative responses are listed in Box 1. The predominant reply referred to the utility of educating health professionals in ethnic diversity in terms of overall patient care and workplace communication (in 77% of respondents), with only a minority (15%) citing formal requirements laid out in guidelines, for example, from the General Medical Council (GMC).

Discussion

Cultural diversity programmes for healthcare professional trainees are not universal with approximately 25% of teaching centres not providing one. The frequency of programme provision was not significantly different between health professional types, except pharmacy, where only 1/12 (8%) schools provided cultural training. The estimate of cultural diversity training in medical schools (77%) is only slightly greater than that from a 2003 survey of UK and Irish medical schools (72%), in spite of the GMC publishing in 2005 a set of educational guidelines that included the need to reflect patient-centred care, equality, and valuing diversity.[14,15] Similar sets of principles that encourage cultural awareness within training have been issued by professional bodies representing the other main categories of healthcare professionals including pharmacists.[14]

UK regions in which ethnic minorities account for only a small relative percentage of the population (<5%) are less likely to have healthcare schools that teach cultural diversity than regions with a higher ethnic minority representation. Educational centres in the former regions may take the attitude that there is little practical need to add a separate component to their syllabus that deals with minority groups; they may also have difficulty in recruiting teachers of ethnic minority issues or finding patients from ethnic minority backgrounds. However, this position fails to consider the absolute numbers of ethnic minorities in these regions which are still relatively large (eg over 50,000 people of Asian origin in Scotland[1]), and the fact that for certain diseases, for example cardiovascular diseases, ethnic minorities are disproportionately affected. Furthermore, given the mobility of the workforce it is likely that significant numbers of trainees move between areas of different ethnic proportions. Indeed, the possibility that ignorance of health-related cultural matters may partly contribute to inconsistencies in cultural diversity training was suggested by the finding that teaching centres that did not know about the ethnic makeup of their local population were less likely to provide a cultural training programme.

Even in those centres where cultural diversity training does take place, the structure, methods and amount of teaching varies widely. This suggests that if professional healthcare bodies were to try to regulate cultural diversity training practices it would not simply be sufficient for centres to 'tick the box' but to substantiate this by satisfying a minimum of core learning objectives. One explanation is that no general agreement exists on what material constitutes a satisfactory syllabus. Although various model curricula have been proposed (Box 2) these have, so far, not been incorporated into directives from the various UK professional training bodies.[10–13] In fact, the motivation for establishing cultural diversity training cited by most educational leads lay in centres' own appreciation of cultural-specific healthcare needs, rather than because of heeding guidelines from professional bodies.

Our results suggest that training of all major UK healthcare professionals in cultural diversity issues is inadequate. Although it is possible that schools that do not provide a cultural diversity programme incorporate some ethnic-related issues within their existing curricula, without a dedicated cultural diversity syllabus it is likely that trainees will fail to acquire the skills required to deal with ethnic minority healthcare.[9–11] To encourage a health service that is accessible and effective for the whole population

Box 1. Examples of replies to the question, 'What was the motivation for offering a cultural diversity programme to your students?'.

Undergraduate medical schools

- 'To deal with attitudes, raise awareness, and inform on diversity – part of personal and professional development'
- 'Requirement by General Medical Council (GMC) (*Tomorrow's Doctor,* 2003) for all medical schools, and is specifically looked for by GMC QABME team. In any case it is best practice'
- '"Practice of medicine in a multicultural society" is a learning outcome in *The Scottish Doctor*'
- 'To make students more sensitive to issues of equality and diversity, in response to Northern Ireland becoming more multicultural'

Postgraduate medical deaneries

- 'To enable diverse learners to achieve effective communication and awareness in diverse communities'
- 'This is a key competency for junior doctors'
- 'An obvious need with a multicultural population of patients and young doctors'

Nursing/therapists

- 'Cultural diversity is important in an area where ethnic minorities may be isolated, and where staff are educated for national workforce'
- 'To ensure they are able to demonstrate cultural awareness in year 1, cultural sensitivity in year 2, cultural competence in year 3'
- 'Changes in legislation. Complaints from students regarding staff attitudes'

QABME = Quality Assurance of Basic Medical Education.

Box 2. Example of a cultural competency curriculum for healthcare workers. Adapted from References 18 and 19.

1. Definitions and models of illness, disease and sickness
2. Role of culture on patients' understanding of sickness and health, and on attitudes of healthcare workers to this, eg by getting each student to present one real-case example, culture-dependent taboos, avoidance behaviours etc
3. Communication skills: interviewing techniques, use of interpreters, use of video feedback and role play; challenging inherent biases and prejudices
4. Influences of culture and race on disease spectrum, presentations and treatments, eg disproportionate frequency of diabetes, cardiovascular disease, tuberculosis and osteomalacia in South Asian populations, dermatology considerations in dark-skinned individuals
5. Cultural rules about the deceased in transition from death to burial
6. Alternative medicine in a historical and cultural perspective
7. Immigration and refugee issues: laws, practical solutions for health problems, communication
8. The situation of women and children in developing countries

and to reduce nationwide inconsistencies in training, UK regulatory professional healthcare bodies, for example the GMC and the royal colleges, are urged to consider cultural competency to be a requirement for all healthcare professional trainees. This standard has already been set for all USA medical schools,[16] as well as for UK postgraduate psychiatry trainees.[17]

Conflict of interest

PS is a founding trustee of the national charity South Asian Health Foundation, an organisation which seeks to improve the health of South Asians living in the UK.

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