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Decolonising medical curricula through diversity education: Lessons from students

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Abstract

Introduction: The General Medical Council (GMC) expects that medical students graduate with an awareness of how the diversity of the patient population may affect health outcomes and behaviours. However, little guidance has been provided on how to incorporate diversity teaching into medical school curricula. Research highlights the existence of two different models within medical education: cultural competency and cultural humility. The Southampton medical curriculum includes both models in its diversity teaching, but little was known about which model was dominant or about the students' experience.

Methods: Fifteen semi-structured, in-depth interviews were carried out with medical students at the University of Southampton. Data were analysed thematically using elements of grounded theory and constant comparison.

Results: Students identified early examples of diversity teaching consistent with a cultural humility approach. In later years, the limited diversity teaching recognised by students generally adopted a cultural competency approach. Students tended to perceive diversity as something that creates problems for healthcare professionals due to patients' perceived differences. They also reported witnessing a number of questionable practices related to diversity issues that they felt unable to challenge. The dissonance created by differences in the largely lecture based and the clinical environments left students confused and doubting the value of cultural humility in a clinical context.

Conclusions: Staff training on diversity issues is required to encourage institutional buy-in and establish consistent educational and clinical environments. By tackling cultural diversity within the context of patient-centred care, cultural humility, the approach students valued most, would become the default model. Reflective practice and the development of a critical consciousness are crucial in the improvement of cultural diversity training and thus should be facilitated and encouraged. Educators can adopt a bidirectional mode of teaching and work with students to decolonise medical curricula and improve medical practice.

Introduction

It has been 20 years since the General Medical Council (GMC), the UK organisation responsible for regulating doctors and medical education, published the first edition of *Tomorrow's Doctors* (GMC 1993), its guidance for standards and outcomes in UK undergraduate medical curricula. The inclusion of cultural diversity among the recommendations outlined in this document served as a significant driver towards the incorporation of the teaching of this topic across medical schools in England, Northern Ireland, Scotland and Wales. The most recent version of *Tomorrow's Doctors* (GMC 2009) places even greater emphasis upon diversity than the two earlier editions (GMC 1993, 2003) and the GMC have emphasised their commitment to promoting diversity and equality in all their policies and practices (GMC 2010). However, they have provided little guidance on how best to incorporate diversity teaching into medical school curricula. Consequently, medical schools in the UK interpret GMC guidance in different ways, resulting in non-standardised content and delivery (Dogra & Karnik 2004; Dogra et al. 2005; Bentley et al. 2008).

The global picture shows changes in demographic trends indicating increasing culturally diverse populations. This is exemplified by the expected increase in the minority population in the US to 48% with Latinos representing 24.4% of the total population (Kratzke & Bertolo 2013). In the anticipation of such forecasts, the Liaison Committee on Medical Education requires medical schools within both the United States and Canada to demonstrate compliance in student development of cultural competency skills (Lypson et al. 2008).

Cultural competency training has been developed to equip medical professionals to proficiently acknowledge, appreciate and work effectively amongst the culturally diverse populations they serve. Within the last decade, the research invested in this training and its evaluation has become expansive due to the mixed reports of delivery, challenges and effectiveness.

Two crucial factors that have been recognised in the successful implementation of cultural diversity training at the undergraduate level are solid institutional commitment and shared buy-in from students and faculty members (Chun 2010). These measures help to ensure that a consistent message is delivered from all facets of education.

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Practice points

- Medical curricula should signpost cultural diversity training more clearly. It has to boldly identify and discuss culture and consider its impacts on patient care.
- It is important to be aware that diversity education may unintentionally send a message to students that diversity issues and patients' perceived differences are a problem and thus reinforce neo-colonial ideas and practices.
- Cultural issues and diversity training can be hung onto the scaffold of patient-centred care, and therefore be referred to on an iterative basis throughout medical education. Such practice is aligned with the cultural humility approach.
- A consistent approach to cultural diversity needs to be adopted by all stakeholders contributing to medical education so as to avoid mixed messages
- Reflective practice and the development of a critical consciousness are crucial in the improvement of cultural diversity training.
- Educators should consider adopting a bidirectional mode of teaching where appropriate and work with students to decolonise medical curricula.

Various models to achieve cultural competency have been applied in the development of medical curricula including those designed by Campinha-Bacote (2002), Purnell (2002), Leininger (2002) and Suh (2004).

One particular educational model developed by Tervalon and Murrray-Garcia (1998) challenged the concept of learning a finite body of knowledge typically expected by the cultural competency models. Instead, a cultural humility approach is advocated. This model encourages a self-reflective process which challenges power imbalances in interactions between patients and clinicians and facilitates awareness of one's own and others' cultural beliefs and practices.

A cultural humility approach furthermore emphasises the uniqueness of each individual and thereby every individual patient interaction has to be considered and dealt with sensitively and culturally appropriately (Tervalon & Murray-Garcia 1998; Kumagai & Lypson 2009).

In Figure 1, we highlight the key characteristics of the cultural competency and cultural humility models. As this figure shows, there is in fact some overlap between the two and this convergence is similarly reflected in Table 1. As can be observed, these components can be categorised as cultural competency, cultural humility or a blend of the two. The distinction between the two models may in fact be more conceptual than practiced and this leaves capacity for blending the best of the two approaches.

Another perspective is that if one is providing patient-centred care then one is self-reflective and approaches each interaction as unique and informed by the patient's own beliefs, attitudes and norms. Patient-centred care, which has been a movement to overhaul the authoritative approach often adopted by clinicians, emphasises the importance of the patient's perspective and understanding the patient within his or her psychosocial context (McCormack et al. 2011). In this way, the concept of cultural humility is already embedded. Maizes et al. (2009, p. 281) elegant description captures the essence of this connection:

> The truly competent physician is one who sits down, senses the "mystery" of another human being and offers with an open hand the simple gifts of personal interest and understanding.

Chun (2010) likewise argues that if a provider is professional and has excellent interpersonal and communication skills, cultural diversity does not need to be taught separately.

As an example of an institution delivering diversity training, Southampton Faculty of Medicine runs diversity as a theme across its undergraduate programme. As such, it is taught at various times during each year of study on multiple platforms ranging from lectures to clinical skills and case-based discussions which incorporate both cultural competency and humility conceptual approaches. Little is known, however, about students' experiences and perceptions of diversity teaching including their encounters with the two conceptual models and the degree to which they are blended. The main aim of this study is to explore undergraduate medical students' accounts of diversity education and their experience of the pedagogic processes utilised in its delivery in order to contribute some guidance for best practice in this area. Toward this end, we were particularly interested in gaining a deeper understanding of the benefits and limitations of the cultural competency and cultural humility models of diversity.

Methods

Fifteen semi-structured, in-depth, one-to-one interviews were conducted between March and April 2012 with students from years three and four of the five-year BMBS degree programme. A systematic random sampling technique was used to recruit participants from a list of all students enrolled in years three and four of the programme. Ethics approval was granted by the Faculty of Medicine's Research Ethics Committee.

Interviews were chosen over focus groups or questionnaires due to the sensitive and personal nature of the topic. This method furthermore enabled the interviewer to address the research questions while having the flexibility to explore and probe issues of particular relevance to each participant and those issues identified as salient during the iterative research process.

Six females and nine males were interviewed, representing British, Mediterranean, African and Asian backgrounds. The interviewer (MN) was of White British origin with dual Middle-Eastern nationality, raised and educated in the UK and, at the time of the research, was in the fourth year of the BMedSc programme. Saturation was reached at 15 interviews, the point at which no new themes emerged. On an average, the

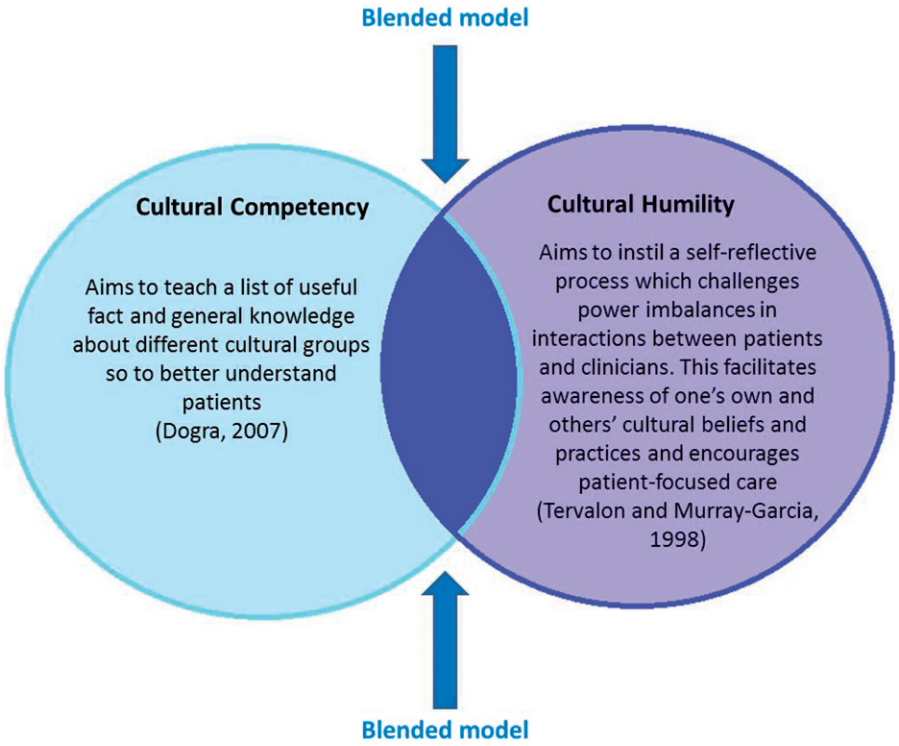

Figure 1. Key characteristics of cultural competency and cultural humility models.

interviews lasted 52 min. They were audio-recorded and transcribed verbatim. Pseudonyms were used and identifying features removed to ensure linked anonymity.

Elements of grounded theory and constant comparison were used to identify and develop themes iteratively from ongoing data collection and analysis (Glaser & Straus 1967; Maykut & Morehouse 1994). This methodology allowed for complex exploration of the meanings, experiences and views of students toward diversity as well as conceptual development. The process involved a manual line-by-line examination of each transcript by the interviewer and coding of the emergent issues into themes. The data were then triangulated via investigator triangulation, as all co-authors analysed the anonymised verbatim transcripts. Team discussions led to the expanding and collapsing of themes and refinement of the coding scheme. The key themes emerging from this data are the problem of difference, problem solving through diversity education, learning in the clinical context and the experience of being different. Each of these themes is discussed below.

Results

The problem of difference

When asked to provide definitions of cultural diversity, all 15 students framed their responses around notions of difference, as the following typical quote illustrates:

> So I guess it would mean broadly, just differences between people, how people stand out from one another, what makes them unique or not, different from different backgrounds and that kind of thing. (MS1)

Participants spoke positively about the value and richness that diverse populations generally bring to life in the UK. However, when asked to discuss examples of diversity within the clinical context, they nearly always emphasised problems or conflict created for healthcare professionals due to patients' perceived differences from them:

> I think that a language barrier can be one important for a doctor because obviously in the UK, you might have patients from areas where they don't speak English and they've just moved to England, so obviously that can be problematic for the doctor because the patient can't communicate and it would be difficult to get the point across. (HH1)
>
> . . . or it could simply be something like religious conflict between the doctor and the patient, which you hope wouldn't become an issue but sometimes you can't avoid. (SC1)

Students gave numerous personal examples of awkward, difficult clinical situations due to what they felt were diversity issues of patients. Most situations related to difficulties in communication:

> So what happened was a lady came into the clinic and she spoke very little English and that created a barrier between the lady and the doctor couldn't understand the complaint of the patient, so there

Table 1. Summary of some of the theoretical models of cultural competency and their key attributes.

Cultural competency	Cultural humility	Blended	Source
Cultural knowledge: seeking and obtaining sound educational foundation about diverse cultural and ethnic groups	Cultural awareness: self-examination and in-depth exploration of own cultural and professional background	Cultural encounters: process that encourages healthcare provider to directly engage in cross-cultural interactions with patients from diverse cultural groups	The Process of Cultural Competence in the Delivery of Healthcare (Campinha-Bacote 2002)
	Cultural skill: ability to collect relevant cultural data regarding individual patients' presenting problems and accurately perform a culturally based physical assessment Cultural desire: motivation of the healthcare provider to want to, rather than to have to, engage in the process of becoming culturally aware, knowledgeable, skilful and familiar with cultural encounters		
	Openness (to respect diverse cultural groups)	Ability (to provide proficient and effective healthcare and resolve cultural differences)	Model of Cultural Competence Through an Evolutionary Concept Analysis (Suh 2004)
	Flexibility (to adapt to different situations involving other cultures)		
	Preservation and/maintenance (decisions that maintain and preserve desirable and helpful values and beliefs)	Accommodation and/or negotiation (aid in adaptation and transaction for care that is fitting for the culture of the individual, families or groups) Repatterning and/or restructuring; involves mutual decision-making as a practitioner modifies or changes their care to achieve better health outcomes	Leninger's Theory of Cultural Care, Diversity and Universality (Leininger 2002)
Having skills, knowledge and understanding about another culture that allows healthcare providers to assess and intervene in a culturally acceptable manner	Developing an awareness of one's own existence, sensations, thoughts and environment without letting it have an undue influence on those from other backgrounds		The Purnell Model of Cultural Competence (Purnell 2002)
Knowledge about the diverse culture means you know what questions to ask	Accepting and respecting cultural differences		
The totality of socially transmitted behaviour, patterns, arts, beliefs, values, customs, life ways and all other products of human work and thought characteristics of a population that guides its worldview and decision making			

were difficulties with him conveying the message to the patient. (ME1)

There was a woman from Portugal, she couldn't speak English so the whole consultation had to through a phone interpreter . . . the difference there, there is a lack of rapport between the doctor and the patient because it is between the phone, I mean they do say everything they want to say and they get it translated but you don't build up that relationship and I could see it in that consultation. It wasn't the same as let's say your average white British person communication during a consultation. (SA1)

Problem solving through diversity education

Given that the participants regarded diversity as creating problems for them, both now and in their future practice as doctors, it is unsurprising that they typically welcomed some cultural diversity training in the curriculum. They identified the main advantages of this to be the acquisition of information to help them to better manage patients:

> We should just have knowledge of the key issues and how that's applicable to our working lives, and knowledge of cultural diversity issues that we are most likely to encounter. (AW1)

While acknowledging the value of diversity education as a means of helping them deal with what they considered to be difficult consultations, the vast majority of students were unaware that diversity was a theme in the curriculum and most students were initially unable to point out where it was taught. When probed, however, they could recall some examples of diversity teaching in the first two, largely pre-clinical, years. Here, they vaguely identified some sociology, clinical ethics

and communication lectures although they were unable to describe any particular content. When further questioned about the approach adopted by teachers delivering diversity-related content in the early years, students felt that it was more akin to the cultural humility model of diversity than the cultural competency one. Some participants recognised that a blended approach was also evident.

> The lectures on sociology and clinical skills there has been more emphasis on cultural humility, more of what you think rather than what I like you to think. There has been an element of both, but more of cultural humility. (PH1)

While students appreciated that their teachers in the early years adopted a cultural humility model and attempted to encourage reflective practice they also recognised the grave limitations imposed by the lecture format upon the effectiveness of such teaching.

> I don't think you can really learn communication skills in lectures . . . .They are not real life, so I think that you need to have some real life experiences of talking to other people or to put that into practice. (KR1)

The most cited example of diversity education occurring in the later clinical years was a communications' lecture featuring role-playing titled 'Dealing with Difficult Situations'. Although the students clearly found this session extremely helpful, it had the unintentional effect of further representing diversity as a difficulty or problem to be managed.

While lectures were perceived to be the most common method of diversity education across the curriculum, all the participants agreed that it would be much better to learn about this topic in wards and surgeries, where they could gain practical experience and learn by doing.

> It would really help, if you have some sort of teaching, not lecture based but just on the wards with the doctors . . . the main points that you need to pick up on are on the wards, for example take a history from patients and then come back and discuss it with me and for example the patient can't speak English and then you are faced with a difficult situation and you try and deal with it and then you go back to the doctor and you just describe what you thought about the challenge. (HH1)

Learning in the clinical context

Unfortunately, students could not recall any diversity teaching occurring in the clinical context.

> Cultural diversity issues have never been on the agenda . . . there has been no emphasis whatsoever on cultural diversity on the wards. I can't think of any example to be honest. (PH1)
>
> I don't really think that I have been taught about cultural diversity on the wards by a doctor. (NK1)

At the same time, the majority of the participants believed that this omission to be understandable and justifiable given the limitations of time and resources imposed upon doctors.

Although students were unable to identify formal diversity teaching on the wards, they observed and learned from consultations where cultural diversity issues appeared to be relevant. Students described the approach adopted by doctors here as typically more akin to cultural competency than to cultural humility.

> It is quite difficult because lots of doctors deal with patients in different ways. I think it's probably a mix of both [cultural humility and cultural competency] if they have time, but if time is limited then the cultural competency method comes across a lot more, just because they've got limited time and all they can see is a patient's case notes which is a list of facts and then they move onto the next one . . . in the majority of cases I see the cultural competency approach because doctors are always busy. (SC1)

As this quotation illustrates, although participants noted some evidence of a blended model being adopted by clinicians, the cultural competency approach was much more common. Students generally accepted that the cultural competency model was more practical, even necessary, due to the busy nature and demands of clinical work. The effect of this was to leave students sceptical about how realistic it was to implement cultural humility in clinical practice. Although the majority of students claimed that they would prefer to adopt a cultural humility or blended approach, once they became doctors they believed it would be necessary for them to adopt a cultural competency approach.

> It [cultural humility] is more theoretical. If it happened as it should, it would be very useful and have a better outcome but because it is impractical and difficult to apply this approach in the actual setting . . . and also it's quite time consuming . . . what I am saying is that this approach is not very practical in that setting. (MB1)

One student did, however, reflect on how cultural humility in the clinical context could be applied:

> Taking a look at the patient and having an overview of who they are before you go and talk to them and having spoken to the other doctors about why that patient might be there, as well as their experiences with that patient and kind of visualising your past experiences and how you dealt with them, and then kind of adapting as you go along. (KR1)

When probed further as to how cultural humility might be best demonstrated in clinic settings, students suggested that doctors could role model reflective practice:

> It depends on the doctor as well, as some doctors are willing to teach and some are not, so it comes down

> to the doctors as well. So there are some doctors that might pay attention to the cultural diversity and if they have a patient with some difficulty of some sort then I think that some of them would be willing to share that with the medical students in order for them to gain some experience. (HH1)

Most memorable to students, however, were their observations of what they perceived to be unprofessional behaviour exhibited by senior medical staff involving diversity issues:

> It was with a consultant, he was a nice guy and everything, and I was sitting in on the clinic and he was reading the name of the patient and it was obviously a more Asian name and he came out and said, even before the patient came in and he had never met them, "OK, you are going to see an Asian lady; can't speak English and is coming with a very manly husband. And she will ask her husband what they need to do." And he said, "Yes, come in" to the patient, and there was actually this lady who had trouble speaking English and had a manly husband next to her telling her what to do. And he looked at me and smiled as if, "See, I told you." (HA1)

Although students believed that these incidents were wrong, they felt unable to say anything for fear of receiving a poor grade or being humiliated. They observed that nobody else, including other doctors, challenged the practitioner in question. Such situations served to further demonstrate the futility of cultural humility in clinical practice and compound the apparent dissonance between early years lecture-based and later years clinical undergraduate learning environments.

The experience of being different

Students who were most enthusiastic about the importance of diversity education and the cultural humility approach, in particular, were typically those who self-identified as belonging to minority groups. They explained that their location within society meant that they have had to reflect upon and negotiate their own encounters with prejudice and discrimination. Such experiences, they believed, gave them better insight into society and the needs of patients from diverse backgrounds.

> I am from a background where English is not my first language and I had to learn the English language and I have the problem with difficulty in speaking to people and the problem of miscommunicating information to people, even though that's not what I meant. So I try to see if a patient, who doesn't speak the language, or who is from a different culture, I try to look at them in a way that I was, how I would like to be perceived . . . if you come from a different background or have a rich background in terms of you speak different languages, you've experienced different cultures, it would only help you to become a better doctor and communicating with other people. (ME1)

Discussion

While the first author of this paper was in the early stages of the research reported here, a senior consultant asked him what the study was about. When told that he was exploring diversity in the curriculum, the doctor retorted, 'Oh, you have drawn the short straw. Was this the last available option?' There were similar encounters with other clinicians, demonstrating a lack of faculty buy-in or support for diversity issues. Under such circumstances, the effectiveness of training endeavours is compromised. The students interviewed for this study were generally supportive of cultural diversity education and the cultural humility or blended approaches in particular. However, the findings suggest that their enthusiasm is likely to subside as they become increasingly enmeshed in the culture of medicine.

Although they struggled to identify examples of diversity teaching, the participants generally believed that such teaching would be helpful to them because they expected patients' differences to cause them difficulties in communicating with them. While they preferred the cultural humility and blended models that were taught to them in the early years, their observations on wards and in surgeries demonstrated that such approaches were impractical in the 'real world' of busy doctoring.

Students felt that stereotyping was inappropriate. There appeared to be a consensus among them that a more positive approach would be one which allows for individualistic contributions and draws upon experiences and commonalities of cohorts or cultures while avoiding stereotypes (Bazaldua & Sias 2004). A patient-led consultation through the employment of the cultural humility approach was considered to fit best with the model of patient-centred care. McCormack et al. (2011) describe one of the domains of patient-centred care as the exchange of information, encompassing elements of exploring knowledge, beliefs and information need and preferences. These processes will inevitably help to identify and address some of the key elements of cultural diversity, and should consequently be present in all patient–clinician interactions that claim to follow the patient-centred care approach.

On the wards the reported behaviour was that which reflected the power gradient between healthcare professional and patient, and therefore contradicted with the messages delivered through earlier teaching. In their critical review of anti-racist and multi-cultural teaching, Narin et al. (2004) acknowledge that clinical and classroom experiences may not marry well and recommend that this issue be further explored.

Our findings echo those of White et al. (2009) revealing the conflict felt by students as a consequence of the discrepancy between what they were taught in the first two years about patient care and what they observed in clinical practice during their third year. Beagan (2003) similarly observed a disjuncture between what students were taught in their preclinical years about diversity and what they later saw on the wards. She concludes that when teaching diversity, it is imperative that

students see what they are formally taught being practiced by clinical teachers. Dogra et al. (2005) also highlights the need for medical teachers to review and reflect on the cultural diversity training both vertically and horizontally throughout the curricula, taking into consideration every point of contact with the student.

The importance of clinicians mirroring earlier teaching is illustrated by Phillips and Clarke's (2012) research showing that when role modelling of professional attitudes toward diversity issues contradicts those stated in the formal curriculum and with learners' own values, learners typically conform to the world of the clinician because that is where both their future and power rest.

A recent systematic review of role modelling (Passi et al. 2013, p. e1423) recommends that because role modelling has a profound effect on the professional behaviours of students, institutions must adopt strategies promoting a 'culture of excellence in doctor role modelling' including faculty development programmes. Our research demonstrates a need for staff development on diversity issues so as to ensure consistency and bring about institutional change. However, careful thought must be given to the design and delivery of such programmes because this study also found that the educational message students received about diversity was largely one of *difference*. The emphasis on difference is consistent with a cultural competency model where general facts about different cultural groups are taught.

Postcolonial scholars have argued that cultural competency reinforces a key facet of imperialism – the belief that 'the colonized possess a series of knowable characteristics and can be studied, known and managed accordingly by the colonizers whose own complicity remains unmasked' (Razack 1998, p. 10). The cultural humility approach is more aligned with the aims of a post-colonial perspective. In general terms, postcolonialism is an academic field that critiques and responds to colonialism and its legacies, drawing attention toward how contemporary conditions and power relations are linked with the history of colonialism. It aims to change society by exposing and disrupting systems and practices that maintain neo-colonialism and produce transformative knowledge instead.

Postcolonial scholars working within the field of education advocate decolonising curricula by revealing and unsettling pedagogical practices that uphold neo-colonialism (Ahluwalia 2009). Recent work on narrative provides some steer as to how we might begin to decolonise medical curricula. For example, Rees et al. (2013) explored written narratives of medical students' most memorable professional dilemmas. They suggest that medical educators can serve as role models by helping students to develop strategies enabling them to act when faced with unprofessional practice. Key to this process, the authors suggest, is a willingness of educators to share their own narratives of professional dilemmas including discussions of how these impacted upon their emotions. This research complements Alsharif's (2012) recommendation that cultural humility be taught through health professional educators' sharing of their own narratives around issues of cultural diversity with students. In our study, there was an isolated report of this happening, where a mentor in the clinical setting shared their own experiences to illustrate a cultural issue and describe how it shaped the interaction.

> Like, I knew this Indian doctor in my MIP [clinical] session and he was a fantastic surgeon and he said to me that sometimes patients refuse to be treated by him, even though he is a fantastic cardiothoracic surgeon. But he is professional to the extent where he doesn't' say 'That lady, how can she reject me? That evil woman!', because that's where professionalism comes in. He'll always say, 'Well, it's nice to meet you' and walk away. And I think that takes a lot of discipline and you have to grow up in that sort of environment to acquire that sort of skill. To walk away without feeling the hurt and ranting at somebody else. (HA1)

Kumagai & Lypson (2009) take this idea further, arguing that educators should not only disclose their narratives but also adopt a bidirectional mode of teaching wherein the lived experiences of students are valued as educational resources when learning about diversity. In order for this to occur in ways that do not simply reproduce existing power relations, the authors recommend that a critical consciousness be adopted. They write that the development of critical consciousness is fostered through a 'reflective awareness' of power, privilege and inequities lodged within social relationships. Faculty development sessions, Kumagi and Lypson conclude, must model such an approach.

Our study found that students who self-identified as belonging to a minority group believed themselves to have unique and important insight into diversity issues. These students appear to have undertaken more conscious self-examination to recognise attitudes, values, language and perceptions that have shaped their individual and collective cultures. It is claimed that through this process cultural sensitivity is achieved via the combination of cultural knowledge and awareness. Culturally sensitive practitioners are then better equipped to routinely apply culturally appropriate healthcare interactions and practice (Wells 2000; O'Connell et al. 2007). Following Kumagai & Lypson's (2009) recommendations, these students' critical consciousness should be further nurtured and their value as teachers as well as learners recognised. We could start by asking students to join medical educators in the design and delivery of faculty development programmes on diversity that expose power relations and challenge dominant cultural norms and practices. Together, we can work towards establishing a collective buy-in to the concept of cultural of humility across medical education. This study thus advances our understanding and practice of diversity education in medicine by suggesting how we might begin to decolonise medical curricula.

Conclusions

We used pedagogical theories underpinning cultural diversity education to understand our findings of how cultural diversity teaching was experienced by students. We have highlighted

the impact of three models of cultural diversity education and identified that while the cultural competence approach reinforces notions of difference consistent with neo-colonialism, the cultural humility model aligns with patient-centred care. The close identification of cultural humility with the current best practice should facilitate the incorporation of cultural diversity training into medical curricula. Although a blended model is possible, the challenge is to ensure the right 'mix', so that cultural competency elements maintaining neo-colonialism do not dominate.

Further to this our findings suggest some key recommendations for educationalists in the design and implementation of cultural diversity education within medical curriculum. Medical curricula must be bold and embrace cultural diversity education in the classroom and on the ward. Teachers should signpost examples of cultural humility for students and link it to patient-centred care, since its very essence is to help to address the power imbalance in the patient–clinician dynamic and improve tailored care. Self-assessment by students must be encouraged and facilitated to achieve a greater understanding of one's own cultural standing. The critical consciousness applied in this process can be a useful resource in the development of contextualised and engaging cultural diversity training. Medical educators need to ensure that there is a communication between the various stakeholders within the different environments of learning to ensure institutional commitment to an agreed cultural diversity message. This should help to ensure that students are exposed to effective and sensitive practices that are consistent throughout their medical education. Where there are discrepancies, acknowledgement, evaluation and reflections of these differences can provide for learning and reflective opportunities.

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