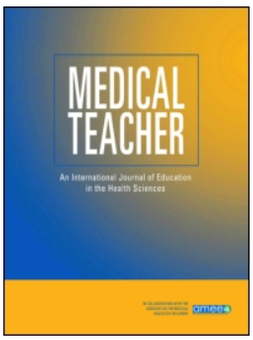

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AMEE GUIDE

# Teaching diversity to medical undergraduates: Curriculum development, delivery and assessment. AMEE GUIDE No. 103

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## Abstract

The aim of this Guide is to support teacher with the responsibility of designing, delivering and/or assessing diversity education. Although, the focus is on medical education, the guidance is relevant to all healthcare professionals. The Guide begins by providing an overview of the definitions used and the principles that underpin the teaching of diversity as advocated by Diversity and Medicine in Health (DIMAH). Following an outline of these principles we highlight the difference between equality and diversity education. The Guide then covers diversity education throughout the educational process from the philosophical stance of educators and how this influences the approaches used through to curriculum development, delivery and assessment. Appendices contain practical examples from across the UK, covering lesson plans and specific exercises to deliver teaching. Although, diversity education remains variable and fragmented there is now some momentum to ensure that the principles of good educational practice are applied to diversity education. The nature of this topic means that there are a range of different professions and medical disciplines involved which leads to a great necessity for greater collaboration and sharing of effective practice.



## Introduction

### Definitions of diversity

Consensus on definitions in this field can be difficult to achieve. In this Guide, diversity is not limited to viewing individuals as only being defined by a particular ethnic or racial group. The term diversity is not synonymous with "multicultural"; we extend diversity to include all facets that define the way individuals perceive themselves us, so that there is no requirement to have ethnic diversity for cultural diversity to be present. This Guide views any difference as diversity. It does not make judgments about different groups but accepts that there is diversity within society and that future doctors need to be able to deal with diversity. It is not within the scope of this Guide to debate the various definitions of diversity but we justify the definition we suggest as being appropriate for our educational objectives.

We argue that to recognise diversity and the issues that it raises, students and teachers need to have some understanding of their perspectives and their own sense of what culture means to them and the context in which they work.

The following definition of culture was agreed as a useful definition by Diversity in Medicine and Health (DIMAH) (www.dimah.co.uk):

### Practice points

- It is important to review the terminology around diversity and ensure it is clear and appropriate for its function.
- Diversity teaching needs to be an integral part of the curriculum rather than as an add-on.
- With forethought and planning diversity can be integrated into the curriculum, enhancing the curriculum and broadening the students' experience of practice.
- Diversity teaching needs clear learning outcomes which are relevant to clinical practice.
- Always consider a range of teaching and assessment strategies including reflection in practice.
- Provide a safe learning environment but be prepared to challenge students to push themselves.

Culture is a socially transmitted pattern of shared meanings by which people communicate, perpetuate and develop their knowledge and attitudes about life. An individual's cultural identity may be based on heritage as well as individual circumstances and personal choice and is a dynamic entity.

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It is this variation of factors and the meanings that individuals take from them that leads to diversity in populations and their understanding of health and illness.

Diversity education is based upon the premise that:

- Each person is unique and complex and cannot be placed in a "pigeon-hole" based upon any one facet of their culture or background.
- Healthcare professionals, educators, students and patients all make assumptions about others and we need to be aware of this so that we can challenge ourselves and minimise the impact assumptions have on our interactions.

### What is diversity education?

Diversity education is a clinically relevant, principle-based approach which aims to train future healthcare practitioners who

- Engage in continuous professional development through lifelong reflection on practice which is rooted in self-awareness of one's own perspectives and behaviours, how these arise and how they may impact on others.
- Demonstrate a patient and person-centred approach to interactions based on attitudes of respectful curiosity and empathy.
- Demonstrate flexible, non-judgemental practice which takes into account a patient-view of their illness and health needs.
- Demonstrate respect for colleagues, peers and patients who are or may appear to be different or have different perspectives from their own.

Diversity education is not:

- Political correctness.
- Superficial tokenism.
- Just about ethnicity.
- A tick-box or an endpoint exercise.
- Teaching stereotypical, categorical information.
- Forcing certain attitudes.
- Separate from teaching aims in consultation skills, ethics and professionalism and clinical practice.

It is with these principles in mind that this Guide is written.

### The relationship between diversity and equality

Diversity and equality are often combined in everyday use and often the focus tends to be on equality. Fair Access to Professional Careers (Independent Reviewer on Social Mobility and Child Poverty 2012) highlighted that medical schools in the UK had made considerable progress in increasing access to women and those from ethnic minority groups but that those from low socioeconomic groups were still at some disadvantage. This demonstrates that medical schools were addressing some issues of equality of opportunity but it does not mean that curricula addressed diversity and respect for differences. Eva (2015) noted that although the call for papers on equality and diversity by medical education was deliberately broad in focus, the vast bulk of the submissions received highlighted some aspect of the admissions and selection processes used by medical schools to ensure equality rather than addressing issues of diversity. Equality may be more readily measured; e.g. data can be collected regarding individuals with the protected characteristics under the 2010 Equality Act. There is clearly a need for curricula to address issues of equality and ensure that students are aware of the legal context in which they work. However, as future practitioners, it is equally important that they are comfortable with the diversity they will encounter in practice and able to reflect on how their own perspectives may influence the care they provide.

## Educational philosophy

In this section, we discuss diversity education from the philosophical stance by first considering the educator perspective and then reviewing positivist and social constructionist approaches.

### The educator perspective

In order for educators to take diversity into account when designing curricula, they need to have some awareness of their own perspectives on their sense of identity and the factors that influence this. Toohey (1999, p. 48) suggested that there are different approaches to teaching (e.g. the traditional or discipline-based approach, the performance or systems-based approach and the socially critical approach) and each has its own way of understanding or interpreting the following educational issues: the view of knowledge, the process of learning (the roles of learners and teachers); the learning goals and how they are expressed; how content is chosen and organised; what purpose does the assessment serve and what methods are used; and what kinds of resources and infrastructure are needed. All these factors are also influenced by the teacher's own perspectives about these issues. The point is that course design is not value free or unbiased as it is dependent on the perspectives held by educators. The question is how the values and ideologies of educators are used to develop the course. Some course designers may, of course, not recognise that their underlying beliefs about the merits or disadvantages of certain approaches influence their choices. Without this awareness the diversity agenda can never be fully incorporated into curriculum design. It is also likely that when designing curricula, many faculties are unlikely to proactively consider diversity issues and there may also be little engagement with students about how to frame some of these debates so that students are not facilitated to explore diversity.

### Positivist approaches to teach diversity

For many of the approaches used to teach cultural diversity, the educational philosophy is based on the position that there are absolute truths to be discovered about the world (Dogra 2003). Many models for teaching diversity translate this into the belief that there are objective fixed truths (that is facts) about cultural groups that can be learned. In programmes using this approach, the education that students receive reveals to them "the truth" about other cultures. The philosophy is compatible with the "biomedical model", in that core

competency can be learned in the same way as medical disorders. That is, culture can be categorised into items in the same way that medical disorders are categorised into underlying diseases that are indicated by signs and symptoms. The principle is that a constellation of particular signs and symptoms lead to the diagnosis of a disorder, although this may not necessarily be the case in practice. Culture is viewed in the same way in that particular signs of how people behave (e.g. the food they eat) or particular characteristics or beliefs, such as skin colour, or views about alternative medicine, are used to categorise people into cultural groups (Deloney et al. 2000). Culture is reduced to specific traits and people's culture is simplified into items that can be observed and learned by outsiders in the form of lists (McGarry et al. 2000; Chirico 2002).

There is also an emphasis on the difference from *us* (a majority) and *them* (the others) (Culhane-Pera et al. 1997). Culhane-Pera et al. (1997) discuss the wish of doctors in training to receive concrete pieces of information from which they can generate "do and don't" lists for use in clinical practice and the need for teachers to resist providing students with such lists. Lists about groups enable students to "pigeon hole" individuals into groups perhaps taking only one characteristic into account and stereotype them based on their own assumptions about the meaning of that characteristic.

These approaches appear to be rooted in the historical context of white domination of disadvantaged minorities and are very race or ethnicity focused. Much of the drive for them has arisen from the growing awareness of inequalities that exist in the prevalence of health problems and health care uptake (Dyson & Smaje 2001). The rationale, in part, is that healthcare provision is planned and delivered without taking into account that different cultural groups may have different needs. There appears to be the view that, if the providers were trained to be culturally competent, some of the health inequalities would be diminished. For example, Cooley & Jennings-Dozier (1998) commented that there is a disparity in the incidence and mortality rates of cancer, especially lung cancer, between African Americans and white Americans. They argue that lung cancer in African Americans has received little attention, and culturally competent programmes are urgently needed to promote lung cancer prevention, early detection and treatment in this population. They conclude that knowledge about cultural differences, respect for individual opinions about health and illness, and ability to negotiate differences are essential qualities for health professionals who serve culturally diverse populations. Information also needs to be provided in a culturally appropriate way, implying that there is a way of providing information to African Americans which somewhat contradicts the statement regarding respect for individual opinions and viewing the patient as unique with their own perspectives.

## Social constructionist approaches

In another approach to teaching diversity, the educational philosophy is rooted in a wider social context and is located within a social constructionist perspective; stating that there is no one absolute truth as the context is relevant. These approaches do not attempt to look for signs and symptoms, which can lead to a classification of an ethnic group or other social category; they avoid reducing "culture" to a list of characteristics. The philosophy behind these models recognises that different people interpret the world differently, so that even two individuals in the same group, who experience the same event, may take very different meanings from it. The philosophy behind this model is that there is no single objective reality to be discovered. It acknowledges that individuals construct their own version of their culture dependent on the various social discourses of which they are aware or in which they participate. These approaches are more interested in the relationship between different components of culture and their meanings to individuals. There is recognition that there are many different viewpoints on society, that one should refrain from passing judgements, and that all are valid with none being superior to another (although this does not necessarily mean all are equally valid).

## The influence of the different approaches

It is perhaps hardly surprising that different educational philosophies view culture very differently (Dogra 2003). In the first approach, culture is perceived as an external characteristic, something that others can see in what people do and how they behave. Culture is perceived as essentially static and individuals viewed static in their cultural belonging. Race and ethnicity are often used interchangeably (Sue 1991; Deloney et al. 2000) and disproportionately emphasised in comparison with other aspects, such as gender and social class. The individual is shaped by their social world and their individual identity is defined by their "ethnic" culture. Differences between individuals are generalised and relationships in society perceived to be between the different groups. This is exemplified by "cultural immersion" programmes which imply that learning about one ethnic family in depth somehow provides knowledge that can be generalised to encounter with others from the same ethnic group (Loudon & Greenfield 1998; Godkin & Weinreb 2001). Whilst there can be benefits to this approach in introducing students to different perspectives, it can also lead to stereotyping and assumptions, e.g. exposure to one Indian family means that the student now knows Indian families.

In more constructivist approaches [e.g. as proposed by Dogra (2003) and more recently by Sears (2012) and Verdonk & Abma (2013)], culture is perceived to be more than someone's ethnicity. Dogra (2003) described culture as internal ongoing dialogue that an individual has with other individuals with whom there may be both similarities and differences. Individuals relate to the world, internally make sense of what they have experienced, and then use this to relate to the outside world. This is conceived as an ongoing cyclical process. Culture is perceived as the meaning that an individual has or gives to certain aspects of themselves and is, therefore, sensitive to differences between individuals. It is a multidimensional construct and ethnicity is one component among many that make up an individual's sense of self including gender, disability, age, sexuality and so on. There is

acknowledgement that individuals may identify their cultural belonging differently from how others might define them, e.g. an institution may define a gay man brought up in the UK by Indian parents as being an ethnic minority. He, himself, however, may define himself more by his sexuality. His clinical needs may be unmet if healthcare professionals persist in only identifying his ethnicity as relevant. Also in different contexts the definition and emphasis will shift; there are many fractured and fragmented selves depending on contexts in which individuals find themselves. The philosophy in this approach is that individuals construct and accomplish their own social worlds and the meanings they give are contextual. In defining culture, the relationship is between individuals rather than groups. In 2012, Sears proposed the intersectionality framework which is consistent with the cultural sensibility approach. Social locations include those defined by race, ethnicity, gender, social class and sexuality, which are experienced multiplicatively, not additively, within a particular social context. Diversity education must go beyond simplified cultural understandings to explore these more complex meanings.

As well as educator perspectives there have been external drivers for diversity education in the context of societal change.

### The drivers for diversity education

Dogra et al. (2010) identify the drivers for diversity education in the UK and North America. In all instances, the professional governing bodies recognised the need to better train doctors to meet the needs of increasingly diverse communities. The drive for health care staff already working in developing services and delivering care to be more aware of the need to provide a range of services for people with different needs has been slower and even more *ad hoc* (Bentley et al. 2008). Turner et al. (2014) reviewed the General Medical Council's (GMC) approach through the various versions of Tomorrow's Doctors and in doing so identified the challenges faced by policy-makers and teachers in this area. Clear conceptualisation of what diversity is and therefore what should be taught was often lacking.

Before we consider a curriculum design exercise it may be useful to help you to consider your own perspectives about culture and how it should be taught.

Exercise 1: Designing and developing diversity education

As a teacher developing diversity teaching it is useful in asking yourself:

- How do I view culture and diversity and how might this influence the kind of course I develop?
- How do I view my own identity?
- What are my expected learning outcomes?
- How do these learning outcomes map onto those expected by governance organisations such as the GMC or other governing/advisory bodies?

## Curriculum design

In this section, we define what a curriculum is and the foundation for a diversity curriculum, with particular focus on patient-centred care, professionalism and health inequalities. The section then considers how to develop a curriculum, as well as who should be involved in the process. It concludes by presenting some suggestions for the learning outcomes and curriculum content.

A curriculum is the way we represent educational ideas in relation to practice (Prideaux 2003). It includes a syllabus which focuses on the content of course teaching. In designing a curriculum, the necessary elements are defined and organised (content; teaching and learning strategies; assessment processes; evaluation processes). A critical decision is how to harmoniously integrate the elements (Clouder 2015). Prideaux (2003) suggests a curriculum model with three key aspects that should follow on from each other:

- The planned curriculum (what is intended by the designers).
- The delivered curriculum (what is organised by the administrators; what is taught by the teachers).
- The experienced curriculum (what is learned by the students).

The hidden curriculum is either that which is not explicit or not formally taught but in areas, such as diversity can be a major factor in student learning (Turbes et al. 2002). In this section, we will describe and discuss the first of these, the planned curriculum.

### Foundations for a diversity curriculum

Medical schools are responsible for providing a curriculum and associated assessments that meet the standards and outcomes set out by national regulatory bodies, such as the UK General Medical Council (GMC 2015). In Tomorrow's Doctors' (TD) (GMC 2003, 2009), the UK GMC emphasises the need for medical education and training to address equality and diversity principles, "such as treating patients fairly, and with dignity and respect". Diversity is a theme that runs throughout TD, from the doctor as a scholar and a scientist, the doctor as a practitioner, to the doctor as a professional. Such education should involve both scholarly education, e.g. exploration of current debates on concepts, such as "disability", "gender" and "race", and training, e.g. workshops exploring cultural influences on communication involving simulated patients.

Different curricula models are used in medical schools, including horizontal, vertical and spiral models. The horizontal model involves links being established between different subjects, e.g. anatomy, physiology and biochemistry, which are taught concurrently. In the vertical model, subjects are studied sequentially and have tenuous links but new areas require good knowledge of previous ones. The spiral approach has elements of both of these models (Harden & Stamper 1999). As discussed above, diversity education is not about ticking a box to show that diversity has been covered, but should be an integrated process across all years of medical training involving different complementary elements. The spiral curriculum is a useful framework for developing a diversity curriculum, as the emphasis is on integrating it throughout the medical curriculum. Given the continuous development of learning with regard to diversity, medical curricula should signpost cultural diversity training, or rather,

boldly identify and discuss culture and consider its impacts on patient care (Nazar et al. 2014).

## Conceptual issues in diversity teaching

As discussed previously, much diversity teaching to date has generally taken a "categorical" approach to developing cultural knowledge. This approach can lead to a "narrow focus on learning cultural knowledge at the expense of promoting a balance with self-reflection upon attitudes and developing generic skills" (Kai et al. 2001a,b). An example of the potential effect of taking a narrow approach is the cultural stereotype held by some health professionals that health interventions to prevent diabetes will be unacceptable to British Bangladeshi Muslims due to fatalistic religious beliefs, which has been found not to correspond with attitudes of Bangladeshis themselves, who acknowledge the need for prevention and would like appropriate support from health providers (Grace et al. 2008). Staff may assume that women wearing traditional clothes in Glasgow may not speak English well as they associate traditional clothing with those that are less well integrated or less acculturated. The woman traditionally dressed may in fact speak English and have a typical Glaswegian accent! This categorical approach to training which focuses on knowledge may merely replace one set of assumptions (based on ignorance) with another (based on generalisation) and thus transforms the practitioner from conscious incompetence back to unconscious incompetence.

Research has found that both health professionals in training and those practicing say that they would like to acquire relevant cultural knowledge about different ethnic groups which may impact on their clinical encounters (Kai et al. 2001a,b, 2007; Shapiro et al. 2006; Dogra & Vostanis 2007). As such, educators should recognise that the "difference" perspective is a common starting point for learners (Kai et al. 2001a,b). However, it is important to balance learning by broadening out such knowledge and consider how it might apply in different contexts, so it is used to explore personal values, increase sensitivity to patient circumstances and cues, and to learn more about an individual's experience of their particular culture, rather being applied as a "one size fits all" label that explains and predicts their behaviour. In considering culture, there can also be a tendency to view "others" as having culture and forgetting that we all have a culture which we may or may not be aware of.

Diversity education in undergraduate medical curricula is underpinned by values and should aim to:

- Enhance all patient–doctor encounters.
- Eliminate health inequities.
- Improve health outcomes of the marginalised and underserved (Dogra et al. 2009).

This highlights issues that should be fundamental to the diversity curriculum, namely, patient-centred care, professionalism and health inequity.

## Patient-centred care

In terms of clinical practice, diversity education is underpinned by models of patient-centred care and shared decision-making, with the emphasis on patients being actively involved in decisions about their care. The diversity curriculum is therefore closely tied to these aspects of education and training. This can be seen in the UK Consensus Statement on the Role of the Doctor which states that:

All healthcare professionals require a set of generic attributes to merit the trust of patients that underpins the therapeutic relationship. These qualities include good communication skills, the ability to work as part of a team, non-judgemental behaviour, empathy and integrity. In addition to possessing these shared attributes doctors must be able to: assess patients' healthcare needs taking into account their personal and social circumstances. (Medical Schools Council 2015).

The GMC in the UK takes early contact with patients by medical students as an indicator of the quality of medical education. Students also regard early patient contact in a positive way. However, a challenge for diversity curricula is that the focus of medical education remains anchored in disease, rather than the patient experience and broader impact on family, community and society (Smith et al. 2014). The intensive nature of medical training and the tendency to learn and be tested on "facts" means that diversity needs to be assertively and explicitly worked into the curriculum to avoid it being side-lined at the expense of areas that are easier to assess.

## Professionalism

Diversity is considered to enhance learning and knowledge, which are necessary for professionalism (Chisolm 2004). Throughout their training, learners need to develop a critical consciousness which is questioning and curious, which is particularly important in developing skills to work with issues of diversity. They need to understand their own biases and prejudices and opportunities for exploring and these must be incorporated into the curriculum (Dogra & Karnik 2003). Students also need to be aware of how institutions may contribute positively or negatively to patient experiences and health outcomes for particular populations, e.g. institutional ageism, sexism and racism.

## Health inequality

Students need to be prepared to care for patients from diverse social and cultural backgrounds and to recognise biases in health care delivery to reduce the impact of these on access and outcomes. One of the overall aims of diversity education is to address the health inequalities that are common in minority and marginalised patient populations (Shaya & Gbarayor 2006). Knowledge and skills are needed in understanding issues at the level of the individual and population. Issues around human rights, structural inequalities, social justice, social accountability and social determinants of health are all relevant to understanding how diversity affects patients and health outcomes. The way in which different elements of diversity (e.g. social class, gender, ethnicity and age) intersect to influence an individual's interpretation of their experiences and views can be addressed through an "intersectional framework" (Sears 2012). This is a useful way of considering

the relationship between the evidence on diversity at population level and patient experiences.

## Building a diversity curriculum

The teaching of diversity comprises only a small component of behavioural sciences which in turn are a minor component (usually less than 10%) of the medical curriculum as a whole. This may be for several reasons. Firstly, medicine is seen as hard science by most medical students and academics so the contribution of behavioural sciences tends to be disregarded or perceived as less important (Dogra & Karnik 2004a). Secondly, there is little in the way of guidance for teachers of diversity to garner faculty support to ensure that the inclusion of diversity is integrated in the curriculum and assessed. Dogra et al. (2010) compared the way in which cultural diversity had been taught in the USA, Canada and the UK and found that although there are similarities, there were also many differences.

The structure of a curriculum should be clearly related to its function. The diversity curriculum must be integrated into the overall medical curriculum, and needs senior level support. It will have a syllabus (course of study) but should not be considered just as a standalone module but more to identify learning needs that can be developed and consolidated throughout undergraduate training and future practice. It is linked to professionalism and is an ongoing issue for personal development and an integral part of delivering high quality clinical care. All the learning outcomes given here will apply throughout professional life in different ways. However, in terms of pre-registration medical training, it is useful to cover some aspects, such as concepts and personal awareness, in the early years and come back to them at different points to assess cumulative learning. They should form a sound grounding for post-registration practice and continuing professional development.

Not all teaching that contributes to diversity education will be formally labelled as such and nor should this necessarily be the case. For example, teaching of the social sciences incorporates topics, such as stigma, health inequality and ethnicity, and aims to contribute to student knowledge about these topics through exploration of concepts, research and policy, in order to develop a critical understanding of the issues that will in turn inform attitudes and practice. Teaching about the locomotor system may highlight issues around the experience of disability. However, this teaching needs to be integrated with student discussion and reflection of the implications for diversity in practice if appropriate attitudes and skills are to be developed.

Diversity teaching involves making students more curious and less accepting. Teaching students how to access and use relevant research evidence is important. Good critical reading of evidence can debunk many stereotypes. All this contributes to higher order thinking and critical consciousness.

It is important to integrate diversity across the entire curriculum in both preclinical and clinical phases rather than consider that a lecture alone will be sufficient. Moreover, it is important not to focus on facts, such as the dietary requirements, of practicing Hindus or Muslims or hope that a half-day workshop on health needs of people who are not heterosexual or a one day field trip to Aboriginal community (Jackson et al. 2013) will be sufficient to deliver the learning outcomes for a diversity curriculum. Curriculum committees need to ensure that there is consistency without repetition and that the teaching sessions enable course outcomes to be met.

### Who should be involved in curriculum development?

It is important to have someone identified as a "diversity lead" so that they are able to map out where and how diversity is taught in the curriculum and ensure regular review. Many schools do have such positions but they are often isolated and a small part of a wider job which can make it difficult to ensure implementation. The position may also be held by part time or junior staff making it difficult to influence the wider curriculum. The very nature of diversity means that a range of staff can be involved in curriculum design and development, with representation from the student body and patients. Diversity of staff reinforces that diversity is both important and affects us all (to counter the effects of the hidden curriculum). There is limited evidence (Dogra 2004) that students value clinical perspectives in diversity education but not who is best placed to facilitate their learning.

Frenk et al. (2010, p. 1293) argued that health professional education has not kept pace with the challenges of health care in the 21st century, *"largely because of fragmented, outdated and static curricula that produce ill-equipped graduates",* and called for dialogue and debate about the design of professional education. Content and structure should be discussed widely and final documents should be agreed with senior staff and signed off. Institutional ownership is also important in creating a safe learning environment (Dogra & Karnik 2004b).

Diversity curricula are supported with knowledge and skills drawn from a wide range of clinical and academic disciplines, such as primary care, psychiatry, palliative care, public health and the social sciences. Each discipline will offer a different lens for understanding diversity. For example, in terms of clinical practice, psychiatry may contribute to teaching about cultural aspects of mental health and clinical implications. Primary care doctors have close contact with patients at all stages of illness and may facilitate insight into family experiences of health and illness, and prevention. Sociology and anthropology have a strong qualitative research base in patient experiences of health and illness. Public health can offer evidence and policy regarding social determinants of health in populations. Health psychology can offer knowledge on health behaviour change. The value of having multi-disciplinary input into designing and delivering a diversity curriculum is that it is more likely to be comprehensive and balanced.

### When in the curriculum should diversity be taught?

An early start to diversity education may be best, especially one which incorporates patient contact so that students have an opportunity to relate the principles of diversity to their future practice. For example, they may see three patients all

having the same diagnosis but in talking to the patients begin to understand that the diagnosis alone does not define the patients and the illness may have very different meanings to them with different impacts on their lives. This enables students to be given a foundation from which to build on. The introductory sessions should enable students to have the opportunity to explore their own perspectives and then start considering how these might impact on the care they provide. It is a subject that could be integrated into may components of the curriculum as long as there is someone who has an overview to prevent unnecessary repetition and ensure meaningful inclusion.

Diversity teaching should run in a co-ordinated and integrated way through the early years which are mainly classroom based (years 1 and 2), into clinical training (years 3, 4 and 5) and ongoing professional development after graduation. This enables reinforcement of earlier learning (Kai et al. 2001a,b). One of the criticisms of diversity education is that when it is included, it is often piecemeal and fragmented with lack of consistency in structure and process across medical schools (Dogra et al. 2005). There is value in setting the culture of medical school from the start (Goldstone & Drake 2000). It should not be included as "bolt on" teaching sessions, which undermines its importance (Hargie et al. 1998; Kai et al. 1999).

When applied to diversity education, the spiral curriculum provides a means of helping students to engage with issues and move through their learning about knowledge and attitudes, building on and applying this knowledge in clinical practice when exposed to diversity issues and through on-the-job learning (Harden et al. 1999; Clouder 2015). Reflection is a key tool and is described in the sections on delivery and assessment below. Significant junctures in the medical curriculum, such as the move from early years' classroom to clinical learning, offer opportunities to explore diversity issues. For example, Shapiro et al. (2006) found that students on clinical placements raised issues about staff attitudes and behaviours regarding diversity but lacked the confidence to challenge them.

There is no evidence about how much taught and self-study time is ideal for diversity education. Anecdotal evidence based on experience indicates that minimum contact time for diversity teaching should be 15 h across the course plus an additional 15 h of independent learning to ensure that the outcomes above can be delivered. This figure is on the basis of at least three hours teaching per year in a formal context. With limited time, staff may find it useful to use one of the protected characteristics enshrined in law to illustrate the impact of diversity on health and illness rather than cover every aspect of diversity.

## Curriculum content

In their Equality and Diversity strategy, the GMC states that they wish to help raise standards in medical education and practice and ensure that doctors have the competence and skills to care for the diversity of the UK's patient population (GMC 2014). There is mention of considering the needs and preferences of patients with protected characteristics as described in the Equality Act 2010; namely age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. The GMC acknowledges that vulnerable groups including children and young people, older people and people with learning difficulties amongst others do not always have their needs met. They note that lesbian, gay and bisexual people, and people at different stages of gender reassignment may get variations in the standard of care they receive from doctors. Furthermore, some groups protected by equality law have substantially poorer health than the general UK population, including travellers, and some black and minority ethnic people. They also note that there is also differential access to healthcare by disadvantaged socio-economic groups, e.g. homeless people.

Given the stated problems associated with taking a categorical approach to diversity teaching, any given set of diversity issues included in a syllabus need to be considered as part of the overall curriculum, as discussed above. Key areas that could be included in a diversity curriculum are shown in Box 1.

Although, core topics should be covered to some extent in each medical school, the range of topics included in curricula will be influenced by factors, such as the local community, in which the medical school is based and key interests of staff. The aim is not to tick off a list of particular topics (or of particular groups), but for students to gain appropriate knowledge, attitudes and skills in caring for all patients as described earlier.

## Learning outcomes

Curricula are built around planned learning experiences with prescribed outcomes so that faculty, students and others are clear about what is to be learnt and how. At the same time curricula need to be flexible and regularly reviewed and updated. Designing a curriculum for diversity teaching involves identifying aims and achievable learning outcomes, and setting out how these will be delivered and assessed. Having a clearly set out curriculum can ensure that there is balance in the range of syllabus content and teaching processes. It will also ensure that all students benefit from diversity teaching (Dogra & Karnik 2003). Box 2 outlines some suggested learning objectives for a diversity curriculum.

**Box 1** Key areas for inclusion of diversity in curricula.

- Key concepts in diversity (of human experience), e.g. culture.
- Equality, equity and discrimination policy.
- National medical/regulating bodies' requirements regarding diversity (e.g. the GMC and Tomorrow's Doctors).
- Particular groups which may be used to illustrate key diversity issues:
  - Disability
  - Social deprivation
  - Gender
  - Sexuality
  - Ethnicity
  - Age
  - Marginalised groups, e.g. homelessness, refugee health
- The fact that people belong to multiple groups.
- Evidence-based practice.

**Box 2** Suggested learning objectives for a diversity curriculum by DIMAH (www.dimah.co.uk).

- Critically examine key concepts related to cultural diversity.
- Explore the meaning of diversity at an individual level and apply to communication with colleagues, peers and patients.
- Explore the meaning of diversity at a population level.
- Evaluate your own attitudes and perceptions (including personal biases) of different groups within society.
- Assess the impact (both positive and negative) of your attitudes on your clinical practice.
- Identify possible examples of prejudice and strategies to challenge this effectively.
- Describe existing equal opportunity legislation.
- Reflect on the relevance of diversity in health and delivery of services.

If planning a spiral curriculum, the learning outcomes can be modulated to reflect levels of learning, showing how concepts are revisited later in the course but at a higher level.

Before students can acquire the understanding of multiple and complex intersectionalities of culture and health, as well as developing effective cross-cultural communication skills they need to be aware of their own biases and prejudices. They also need to acquire understanding regarding how open they are to different perspectives and views and how experience changes their perspectives. Any curriculum programme needs to give students the opportunity to critically examine their own identity and appraise how this identity locates them in relation to their peers, their supervisors and their patients (Beagan 2000).

## Delivery of a diversity curriculum

In this section, we consider how a diversity curriculum based around the learning outcomes above can be effectively delivered but before we do that it is useful to consider why it is important to discuss the importance and relevance of diversity education and how to engage students. We also discuss who should be involved in teaching diversity and conclude this section by identifying methods to teach the different outcomes needed to run successful programmes.

### Why is it important?

It is probably important to start the delivery of any programmes by discussing with students why the subject is important and, as teachers, be prepared to debate the issue with students rather than be defensive. Diversity is important because it is everyone's human right to be looked after and cared for equitably. Also taking a patient-centred approach enhances patient experience and may also positively influence health outcomes including quality of life (Bauman et al. 2003). There is also a professionalism driver, since it is an expectation of the GMC, the regulatory body in the UK, that students' address these issues and also usually an organisational one to ensure legislation is complied with. Other countries may well have similar drivers (Dogra et al. 2009). It is also well acknowledged that most complaints about doctors relate to issues of communication rather than practice and thus an awareness of diversity issues can reduce the risk to practitioners of complaints (Levinson et al. 1997).

### Engaging students

Unsurprisingly, students will have a diverse range of views about the necessity of diversity education in the curriculum (Dogra & Karnik 2003). Some may feel threatened by the idea and some may feel it is unnecessary as they are already familiar with the subject matter. As we suggested previously, having an open debate with students about why diversity education matters and how it relates to improving their clinical practice can be a useful tool in engaging with them. If teachers are able to be open and model willingness to be challenged this may help to engage students. It is also important that the approach by diversity teachers does not assume that students are a homogenous group with identical experiences or that they will be negative about diversity. Dismissing student perspectives because they are different from that of the teacher serves as poor modelling.

### Who should teach diversity?

Compared to more discrete subjects, such as physiology or sociology, there is less clarity on who is best placed to teach about diversity to medical students. Dogra (2004) found that amongst stakeholders there was a wide range of responses about who should teach. However, a key point was that students and clinicians wanted the teaching to be clinically relevant. There is no doubt that this is an area where the broad range of stakeholders in medical education [academic staff (from a range of different disciplines), clinical staff, patients and students] may all usefully contribute to an educational programme. It can also be difficult as not all teaching that considers diversity is labelled as such. It may be incorporated as an element in many different parts of the curriculum. However, there needs to be clarity about the purpose of their involvement and those delivering it need to be comfortable about the potential sensitivities the subject may raise and how to manage these.

Teaching formats in medical education can and should be varied as to accommodate different learning styles and it is important to be aware of this when developing curricula regarding diversity. Students need to be allowed to voice their own opinions and discuss diversity issues in safe learning environments (Dogra et al. 2009).

### How should diversity be taught?

Given the complexity of the subject the full range of teaching methods can be used as long as the method matches the learning outcome. Most of the teaching formats available have a part to play in curriculum delivery and we will go through each method in turn and identify how it can be used. As well as the method the context in which it is applied can be useful and the opportunities to deliver the curriculum in formal educational settings, community and clinical placements need to be maximised. However, to achieve this diversity teachers require the full support of the faculty. Table 1, to be found in the Supplementary Materials section, offers some suggestions

as to how the learning outcomes highlighted above might be effectively delivered.

## Teaching formats

Diversity teaching requires the use of a range of teaching formats so that students can increase their knowledge, explore attitudes and develop skills. Teaching formats include collective and personal learning (including reflection). Diversity teaching can be delivered through a range of standard teaching formats. There is however little evidence to indicate which teaching methods are most effective to deliver training as few programmes have been formally evaluated.

### Lectures

The value of lectures in higher education is much debated and the limitations of this approach as a key teaching format are well known (e.g. see Davis et al. 1999). Reviews of research over several decades have concluded that lectures are effective at presenting information and providing explanation in medical education (Brown & Manogue 2001), but have limited value in changing attitudes. Lectures can introduce the subject and, if used appropriately, provide a framework for opening up learning about diversity. They can introduce students to sources of evidence (including quantitative and qualitative research), historical background to current policy and current debates in medicine including issues related to values (and professionalism). However, lectures need to be linked to opportunities for discussion of issues, e.g. through being connected to issues students explore in problem-based learning scenarios, and other forms of teaching, such as communication skills. Thistlethwaite & Ewart (2003) note that small group work with experienced facilitators is necessary so that students can voice opinions and discuss issues following lectures. In diversity education, lectures may be a useful method to highlight the relevance of diversity education and engage the reluctant or ambivalent student. Where diversity educators are only given a lecture here and there, they may need to be creative and ensure that their lectures are interactive and provide students with the opportunity to review their own perspectives and engage with exploration of the issues.

### Seminars and workshops

Attitude change, a key aim of diversity training, is more likely to be effective by using interactive small group teaching. Dogra (2001) evaluated a seminar programme whose objectives were to encourage medical students to respect differences that exist between different groups of peoples. The programme involved both self-study modules and seminar style workshops of up to 30 students. The evaluation found that this teaching format helped students to meet the aims. However, the author comments that the shift in attitudes may be transient and not long lasting without further reinforcement. This again supports the need for diversity training to spiral through curricula to refresh understanding and encourage deeper learning. Diversity teaching in small groups may also include collaborations with other health and social care students and practitioners and arts-based groups. Although, each learning format, lectures, seminars and field work (experiential learning) have a role to play, deep learning is probably best achieved under small group conditions and in clinical situations where there is direct contact with different communities and people from a range of backgrounds. Small groups enable students to explore their views and challenge each other.

### Clinical communication skills training

Communication skills' training is an important part of diversity teaching and covers a wide range of cultural issues, such as ethnicity, disability and sexuality. Tomorrow's Doctors (GMC 2003) indicated that it was important that medical students were able to address diversity issues as part of their clinical communication skills and gave some quite specific directions as to how they thought this could be achieved. The GMC (2003) encouraged sessions on British Sign Language, deaf blind communication and the use of interpreters with patients who could not speak English. This is an important skill for students to acquire for working with people who are not fluent in the main language of the country. Teaching medical professionals how to use interpreters with workshops and communication skills sessions has been found to increase perceived efficacy in using skills in communicating with patients with limited English, and to equip them with skills in working with interpreters (McEvoy et al. 2009). Students should be given opportunities to practise their communication skills so that they understand others' perspectives through their developing interpersonal communication skills. This may also serve as an example to students on how an understanding of diversity may impact positively on their clinical practice. This should not be restricted to empathy and lower level experiential skills, such as appraisal and expression of emotion, but also reaches the higher level of sophistication with improved understanding and analysis of emotion and regulation with reflection. This higher level sophistication in emotional regulations requires strategic thinking (Mayer et al. 2000) which is directly relevant to health settings. However, communication skills with diverse groups are more than being able to work with an interpreter for those patients for whom in the UK context English may not be their first language.

Hargie et al. (2010), in their survey of current trends in clinical communication training in the UK, commented that diversity issues were most effectively covered in relation to dealing with patients with culturally diverse backgrounds and those with disabilities. These sessions are often run in the early years of the curriculum with little evidence that this was followed through in the clinical setting. McEvoy et al (2009) described a very comprehensive programme at a medical school in the USA with sessions over three years developing skills to work with diverse communities with limited English and this included an ability to explore patient's perspectives and health care beliefs.

There is limited literature regarding diversity and clinical communication teaching and much of it is descriptive. However, Nazar et al. (2014) through a qualitative study to evaluate different cultural diversity models that inform clinical

communication and diversity teaching, found that some teaching leads students to perceive certain patients as problematic. Educators can use this perspective and encourage students to consider how they will rise to this challenge, both from a patient care and personal development perspective, Turner & Dogra (2015) suggest that the way forward is for clinical communication lecturers to consider their own views on diversity and acknowledge that these are likely to be transmitted to students through their teaching. There is a need to build on the one or two specific sessions, that often are not assessed, to integration throughout the clinical communication curriculum.

## Community-based medical education

Current medical training often involves patient contact from the first year, often in community health care settings, such as primary care. The value of community-based teaching is that students can begin to be exposed to diversity issues with a closer link to patients' lives and local contexts. Experiential learning mainly involves field work and practice within communities and medical settings. Experiential learning has been found to help deep learning (Spencer & Jordan 1999; Azer 2009; Dahle et al. 2009; Roberts et al. 2012); this is hard to achieve in the first year since the skills of students are limited. Nevertheless suggestions are made for opportunities during the summer in culturally diverse and deprived areas (Lu et al. 2014). Such education is generally clinician led and involves assignments including essays and reflective writing where students are encouraged to identify a patient case for review and to reflect on their responses and any cultural issues that are relevant. Medical student immersion programmes or student clerkships and electives can also be valuable in learning about diversity issues though this would be difficult to standardise for all students and there is a threat that teaching could lead to a focus around diversity in the context of a certain cultural group rather addressing the broader diversity and intersectional issues.

Although, early exposure to diverse populations in a clinical setting helps to raise their awareness, students from different medical schools may think that direct teaching of the topic is unnecessary within the curriculum, mostly because it is perceived as peripheral compared with more factual subjects but also because it is something best learnt in the field with patient contact (Roberts et al. 2010). Students requested epidemiological data related to the needs of different races and ethnic groups rather than using case studies and role play as these usually led to further stereotyping.

Community exposure (Lu et al. 2014) enables students to challenge their preconceptions and also the notion that there is set information to learn about specific ethnic groups. In working with communities they are likely to witness heterogeneity within groups and begin to reflect on what diversity is and the way different factors interplay with each other, particularly in respect of health care provision and delivery. Howe (2001) found that students perceived increased learning in many of the areas expected and significantly learned from witnessing the impact of a longer term and more personal relationship with patients; the visible impact of social environment on health; the importance of dealing with people rather than diseases, and the use of the whole team for care.

It is important not to anticipate that through community exposure alone students will begin to consider how diversity factors impact on an individual's sense of self and their health. Community exposure is a tool which will be effective if students are appropriately primed for their experiences and the learning outcomes and assessments are in line with the methods used and they are supported and encouraged to reflect on their learning and its impact on their practice as future doctors.

## E-learning

Considerable developments in virtual learning environments (VLEs) mean that there is considerable scope for using them in diversity curricula. They can include: short courses, blogs, discussion groups, reading materials, on-line lectures, webinars and videos. A review of the literature by Chumley-Jones et al. (2002) found that web-based tools are a useful addition to teaching methods and are popular with students. However, they cannot simply just replace traditional methods. Kalet et al. (2005) describe a web-based approach consisting of online scripted videos of case studies to deliver diversity training. Due to the flexibility of e-learning resources, which can provide information to a large number of students over extended periods of time and students can access when it suits them, they can be used to effectively complement other forms of teaching in the spiral curriculum.

Hawthorne et al. (2008) evaluated online training in diversity and on the basis of their outcomes, they argued that this was the way forward given that is easily accessible and affordable in the present climate. They identified that all participants were very positive about the module. There is clearly a place for online modules and they may be excellent at enabling faculty to familiarise themselves with the knowledge components of diversity and equality; e.g. the legislation. These modules can also be good for introducing issues that may be unfamiliar to students. Online modules can help to build their confidence of more challenging areas through paper exercises in preparation for further training. However, there is a danger that online modules can become tick box exercises that encourage the idea that there is some kind of finite knowledge that can be assimilated. This may discourage engagement with the material and limit reflection. Perhaps the most effective modules are those that could be linked to face-to-face work, reflective practice or online discussion. One way to overcome the challenges is to suggest that students undertake the online module in groups so that they are can help each other to really explore the issues and their views of them. Another approach is to only release material to students step by step and ensure that students have to complete tasks to progress. A third approach is to provide e-resources for students to help them to research a particular area of diversity that is of interest to them, stressing the importance of considering all of the key areas and not just focussing on a single issue. This could conclude with a written assessment that summarises their research and reflections.

### The use of case material

Cases can be used in a variety of different situations but are essential in bringing subjects to life as long as they are well developed and integrated into wider teaching, otherwise students may find that they are far removed from real life experiences. It is also important to remember that a clinical case in any clinical context can be skilfully written to incorporate aspects of diversity and ensure it is embedded throughout the curriculum. Using the wide array of social media may enable teachers to access significantly more resources than previously.

### Use of personal development portfolios

Personal Development Portfolio (PDP) with a reflective report which could be assessed as a unit in its own right may be a useful approach to allow students to see for themselves how their learning and perspectives develop as they progress through medical school.

### Student-centred learning and student selected components

Although, all medical students should experience diversity education, opportunities should be made available for students with particular interests in diversity issues to engage in student selected components or electives that enable them to develop their interests. Students may undertake small projects related to diversity or gain clinical exposure that they might otherwise not experience. Enthusiastic teachers may be able to nurture the diversity champions in the future.

### Peer learning

Peer learning is increasingly popular and in some ways diversity is an excellent topic for students to engage with. Dogra (2001) described how students were asked to interview each other by selecting those they perceived to be similar to them and then challenging their assumptions. They were also asked to interview peers that they assumed would be different and conclude by reflecting if they had more in common than perhaps anticipated. Students enjoyed the exercise as they felt it gave them permission to ask questions that social etiquette may consider invasive. They were also able to practice asking potentially difficult or sensitive questions in different ways. It also was an active demonstration of how we all make assumptions and how we can really only know what someone else's perspective might be by asking them and talking about it. It may be difficult to ensure that students are sufficiently challenging of each other. It is perhaps also important to ensure that there is mutual learning and respect rather than assume that the learning is only required by majority groups from minority groups.

### Hidden and informal teaching

Much diversity learning (potentially both useful and not) may happen informally without teachers or students being aware that it is happening; this can have positive and negative effects. Turbes et al. (2002) investigated cross-cultural learning implicit in cases presented in years 1 and 2 at the University of Minnesota. They argued that curricula need to explore aspects of diversity across the medical curriculum to address potential undermining of diversity education. Though the epidemiology of cases was matched to epidemiological research, they warn that unintentional repetition of similar case profiles (e.g. gay man with multiple sex partners) may reinforce stereotypes and could provide inconsistent messages that would undermine formal diversity teaching in the curriculum.

Appendices 1–5 found in the Supplementary Materials section provide examples of programmes that illustrate emphasis on different aspects of diversity and also examples of widely used exercises to help teach diversity.

## Assessment

This section of the Guide considers how existing methods can be applied to diversity assessment. Miller's "pyramid" has strongly influenced assessment in medical education and been used to develop a range of assessment tools to measure knowing, knowing how, showing how and doing (Miller 1990). The GMC (2009) expects medical schools to have an overarching, strategic and systematic approach to assessment and emphasised the importance of each medical school in developing valid and reliable assessment methods that are feasible, fair and cost effective.

Loudon et al. (1999) found that only one in seven of the programmes that they studied included any assessment of the cultural competency part of their programmes. As Dogra & Wass (2006) suggested that the reasons for assessments of diversity issues often being absent may be linked to a lack of clear outcomes. There has also been the question of whether diversity issues can be usefully assessed and that competency-based models of assessment have discouraged critical thinking and paradoxically trivialised (Lurie 2012). However, as Miller & Green (2007) suggested that knowing they were being tested helped students to appreciate the value being placed on the subject. It is unlikely that a single assessment method will be suitable for all learning outcomes (Dogra & Wass 2006). There is a need to develop a range of tools to effectively assess the various components of diversity education (Dogra et al. 2009). More recently assessment guidance by the GMC (2011a) highlighted the need for the inclusion of specific diversity training as part of any assessor examiner training programme. Below we discuss various methods that could be implemented with the attending pros and cons.

### The OSCE

Observed structured clinical exams are one way to assess clinical and communication practices by setting up a series of stations to assess a range of skills. Both real patients and simulated patients are used to create a clinically real situation. Research has shown that with blue printing of OSCEs, training of examiners and simulated patients and a larger number of stations, it is possible to create a relatively objective assessment method to assess a range of skills (Boursicot et al. 2007).

Dogra & Wass (2006) suggested that the OSCE could definitely be one tool to use for assessing whether students knew how to address diversity issues and could also show

how. Altshuler & Kachur (2001) and Rosen et al. (2004) suggested using Culture Competency OSCEs to develop skills through practice and feedback. Betancourt (2003) reinforced this by agreeing that student attitudes' could be assessed as part of certain stations in the OSCE, whilst warning against over simplification of culture or stereotyping. Miller & Green (2007, p. 76) detailed a reflection on a cultural competence OSCE station and recommended that any cultural competence OSCE "*requires careful attention to faculty development' training of standardized patients and preparation of students*". They also reflected after student feedback that there was a need to: *"incorporate social and cultural factors more deliberately into other OSCE stations. A specific OSCE station on cross cultural care cannot happen in isolation, but should be framed carefully in the context of teaching these skills at multiple points in the medical school curriculum*".

The GMC (2009) reinforced the above recommendation, suggesting medical schools should consider including stations where cultural or linguistic difference is a major focus so that students were prepared for working with diverse communities. However, at the same time Hamilton (2009) suggested that scenarios could equally be too complex and unrealistic and would require a level of rapport that would be too difficult to achieve in 10–15 min. He also felt that academics should look at where assessment on diversity happens in the curriculum, suggesting that if students were assessed too early they may be demotivated by the experience. Other reservations about the assessment of ethical issues and professionalism, which are also applicable to assessing diversity, are that some assessments' risk confusing students because they might encourage certainty in responses and are not reflective of the uncertainty and ambiguity in the real world (Wass 2014). Wass (2014) suggests the use of more formative OSCES with stations with different dilemmas through which students could be helped to address the impact of their cultural values and prejudices through feedback.

Summative OSCEs may have a distinctive "fingerprint" that excludes diversity in general as it is often seen as "too difficult" to simulate. This disadvantages candidates from culturally different backgrounds who may have skills in managing diversity not seen as clearly in the majority of other candidates. Workplace-based assessments may be the best way forward to assess this skill in practice (Roberts et al. 2014).

Appendix 6 – found in the Supplementary Material section – provides guidance on how to develop an OSCE station to assess diversity.

### Written assessments

There are now a wide range of written assessments including multiple choice questions (MCQs) and short answer questions, essays or reports and reflective portfolios. Each has merit if appropriately used and any of these assessment methods can also help with the embedding of diversity teaching into different areas of the curriculum.

### MCQs and short answer questions

These have limited role in assessing diversity issues because using these as assessment tools can reinforce the view that diversity education is merely about simply acquiring a body of relevant knowledge. It is important that students know that there are certain groups who will be more at risk or predisposed to certain conditions but if the only diversity assessment is about within a course about specific diseases in relation to certain groups this can lead to "othering", such as Kai et al. (2001a,b) discussed in relation to TB and Asians.

### Reflective portfolios

The GMC emphasises the importance of having assessments that help to develop the reflective doctor who values lifelong learning. The use of reflective portfolio has grown in medical education as the value of reflection has been acknowledged and the skill of reflection is now taught at most schools. This can take different forms, e.g. collections of checklists of observations or experiences (with or without reflective comment from the student), signed debrief of case presentations or learning experiences, or short written pieces (electronic or paper formats) and most medical schools try and instil this approach in some form in their students. The work of Donald Schon *"has been the inspiration to much of the work on reflective practice in the profession"* (Moon 2004, p. 54) and many portfolios would be described as "reflection on action", writing about events after they have taken place. Seeleman et al. (2009) emphasised in their cultural competence framework the importance of embedding reflective practice with cultural competency as a "recurring focal point". Moon (2006) suggests that these methods of assessing student reflections are flawed and would prefer they write an essay and develop an argument using quotes from the reflective writing. This model could be more effective for the development of more critically conscious students who could be asked to reflect on their own practice as well as relate this to the relevant literature.

Appendix 7, found in the Supplementary Materials section, provides an example of reflective writing.

### Questionnaires

Dogra (2001) found that students' attitudes changed positively over a short period when they received diversity training but further work is needed to measure if these changes are sustained. The tool used to measure change served in itself to raise awareness of diversity issues. Whilst questionnaires need to be carefully designed and validated, they can serve as useful self-assessment tools for students and also encourage students to reflect on the issues so that completing them in itself achieves some learning (Dogra & Karnik 2003; Curcio et al. 2012).

## Conclusion

Diversity education has advanced in the last two decades but progress has been slow and is hampered by the ambivalence and/or hostility of senior medical educators and health providers. Diversity teachers are often isolated and may struggle to get heard. This Guide provides support for teachers through systematically covering the educational process from design to delivery with examples. As this Guide shows, there is

a body of literature that teachers can refer to as they develop, deliver and assess curricula. It is important that teachers model the behaviour they expect from students and reflect on their programmes in diversity and in general to ensure that they are dynamic and respond to social change and patient need.

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