Background

In multi-ethnic societies, providing effective healthcare is challenged by various aspects of cultural diversity, such as epidemiological health differences between populations, communication barriers and differences in religion, socio-economic status and ethnic background.[1] During the past decade, various studies have demonstrated that the increase in cultural diversity in many patient populations presents specific challenges to healthcare providers.[2,3] For instance, ethnic minority patients in developed countries, visit the physician more often[4], have longer visits[3] and are less satisfied with the physician-patient contact.[5-7] In addition, language barriers have been shown to diminish healthcare outcomes[6], and some ethnic groups have prolonged hospital stays and more unplanned readmissions.[3]

To provide good quality of care, physicians need to be able to acknowledge, recognize and deal with these challenges. Therefore, cultural diversity should be addressed in medical training.[8-12] In multi-ethnic countries, cultural diversity is considered an essential topic in society,[9,12,13] which needs to get attention in medical training to prepare students for their work as physicians. [13]

To ensure adequate attention to cultural diversity, cultural diversity training should be anchored in strategic curriculum documents for medical education in multi-ethnic countries. Ten to fifteen years ago, overviews of curricula of medical education in the United States of America (U.S.A.), Canada, the United Kingdom (U.K.) and the Netherlands showed that cultural diversity training was scarcely addressed and that students’ preparation for cultural issues was inadequate.[1,10,14] Since then, however, cultural diversity in medical education has been identified as a point of interest in the Netherlands, as in many other Western countries. [2,10,14,15] Also, in recent years, there have been several occasions for revising the content of programs and for including cultural diversity in the curriculum documents. For example, in the Netherlands, the training programs for undergraduates were recently inspected and the curriculum documents for postgraduates were recently revised.[16]

Since cultural diversity training is considered essential for physicians[9,12,17], it is important to know if cultural diversity has gained more attention in curriculum documents over the last years. Insight
into the current status of cultural diversity in strategic curriculum documents is required to assess whether the conditions for effective curriculum development in this area are met. The aim of this study was to assess the formal status of cultural diversity training in a multi ethnic country. In particular, we studied the formal status of cultural diversity training in the Netherlands, a country with 17 million inhabitants, 3.5 million of whom are members of ethnic minority groups.[18]. To do so, we conducted a document analysis focusing on what is currently postulated about cultural diversity in strategic curriculum documents in the Netherlands. The question that guided our research was: To what extent and how is attention to cultural diversity ensured in the strategic curriculum documents that guide medical education in the Netherlands?

Methods

Setting

We conducted this study on curriculum documents of the Netherlands, as a case of a country with a culturally diverse patient population and recently revised curriculum document for medical education. Medical education in the Netherlands consists of undergraduate and postgraduate medical training. The 6-year undergraduate training is provided by 8 universities and consists of 3 years of bachelor studies and 3 years of master studies. The duration of the postgraduate specialty training varies from 3 to 6 years. Dutch undergraduate and postgraduate medical curricula are described in strategic curriculum documents. These documents describe the mission and vision for the training programs and the requirements that should be fulfilled at the end of the programs, using the roles described by the Canadian Medical Education Directives for Specialists (CanMEDS). These roles are: Professional, Communicator, Collaborator, Manager, Health advocate, Scholar and Medical expert[19]. The strategic curriculum documents do not necessarily represent the curriculum that is actually taught and received; however, the content and quality of the curriculum that is taught is guided by
the planned curriculum that is recorded in the strategic curriculum documents, [20] since the
planned curriculum is used to construct and evaluate the curriculum that is taught.[21]

Design
To describe the formal status of cultural diversity training in medical education, we performed a
document analysis for undergraduate medical education, as well as separate analyses for each
specialty in postgraduate medical education. For the analyses, we used the educational framework of
the Accreditation Council for Graduate Medical Education (ACGME),[22] which focuses on three
domains: objectives, methods and evaluation. Objectives are the competences (knowledge, skills and
professional behavior) that have to be acquired by the trainees. The training methods explain how
these competences should be attained, and evaluation indicates how achievement of the objectives
should be examined.

The three domains are generally presented in this systematic order,[22] and their inclusion can be
considered a requirement for adequate curriculum design.[23] For example, a competence described
in the curriculum document of the postgraduate training for gynecologist is ‘the support of a
physiological delivery’. The objective for this competence is that residents demonstrate to support an
uncomplicated delivery without supervision. The training method used is the exercise on the
 phantom, and the final evaluation consists of practical exam on the phantom.

Procedure
The strategic curriculum documents were retrieved through internet searches in February and March
2013. Documents that were not available on the internet were requested from program directors by
e-mail.[24-26] On the advice of program directors of the undergraduate medical education, we also
retrieved the national blueprint (a national policy document for medical undergraduate education)
[27] and the accreditation reports that Quality Assurance Netherlands Universities (QANU) made of
the eight universities that provide a medical curriculum. The accreditation reports of medical
education contained evaluations of all the bachelor and master programs.[24] One university’s
undergraduate accreditation report was not available at the moment of analyzing the data. Instead,
this university provided a summary of the cultural diversity objectives mentioned in their
accreditation report.

Analysis

The first author (EP) screened the strategic curriculum documents for fragments on cultural diversity.
For the purposes of this study, cultural diversity was defined as a difference in ethnic background
between a physician and his or her patient. Text fragments of the documents which mentioned
cultural diversity (i.e. diversity, cultural, intercultural, ethnicity) were sorted into the three domains
of the ACGME framework, objective, method and evaluation.[22] Doubts concerning the inclusion of
text fragments and their position in the framework were discussed with co-authors JF and KL. Any
disagreement about inclusion and position in the framework was resolved through discussion with
the entire research team.

Results

In total, 52 documents were analyzed. For undergraduate education, we analyzed one national
document, 7 regional curriculum accreditation reports and one summary. For postgraduate
education, we analyzed 31 national curriculum documents and 12 regional curriculum documents.
Text fragments about cultural diversity were found in 33 of these documents. In 6 of these, a specific
text referred to cultural diversity. In 2 out of 52 documents, cultural diversity was referred to in all
three domains, objective, training method and evaluation, and in the appropriate sequence. A
summary of the findings is presented in table 1.
The Dutch national blueprint for undergraduate medical education was found to contain several objectives regarding cultural diversity. These objectives are formulated within the CanMEDS roles of Communicator, Medical expert and Health advocate. For example, in the description of the role Communicator, cultural diversity is specified as “The student adequately handles diverse groups of patients, such as children, elderly, men, women and patients from different cultural backgrounds”. Attention to training methods was not found in the blueprint. It contained the recommendation that requirements, which should be fulfilled at the end of the programs, should be realistic and trainable, but no description is given of training methods. Regarding evaluation, it contained an appendix with a skills list that takes cultural aspects into account (evaluation). For example, “Does the student indicate the influence of ethnic diversity on the healthcare process?”

Compared to the national blueprint, fewer references were found in the accreditation reports. Of 7 regional accreditation reports and one summary of an accreditation report on undergraduate training, 3 did not mention cultural diversity, whereas 5 did address themes concerning cultural diversity. The cultural diversity themes described in these 5 documents were ‘learning medical ethics and diversity management’, ‘acquiring cultural competence’, ‘offering obligatory education about cultural diversity’ and ‘global health training’. Three of these 5 documents contained a small section that defined the term ‘cultural competence’.

**Cultural diversity in curriculum documents for postgraduate education**

*General practitioner*

Two out of 8 regional strategic curriculum documents for the specialty ‘general practitioner’ contained a description of cultural diversity themes. One of these described the “changing population’s demands on care”, but this objective was not followed by a description of methods or evaluation. The other document contained a training method description referring to an elective course on multicultural care, which was not followed by an evaluation nor preceded by objectives. The other 6 documents contained no reference to cultural diversity training.
The national curriculum document on the specialty of social medicine is split into two documents, a manual and a curriculum. One of these, the manual, cultural diversity was addressed. This description was placed among the objectives, as part of the role of Communicator. It was not followed by a description of a training method or an evaluation.

There are 4 national and regional strategic curriculum documents for the specialty ‘nursing home physician’, all of which offered a description of the role of Communicator in the context of a different cultural background of the patient (objective). These documents contained no fragments concerning methods or evaluation of cultural diversity training.

The regional strategic curriculum document for the specialty ‘disability medicine’ mentioned one CanMEDS role in the context of cultural diversity training; the role of Health advocate. This was followed by a brief reference to training method, “The student integrates development and implementation of general medical insights with population-specific characteristics”, without any reference to evaluation.

Ten out of 28 curriculum documents for clinical residency training did not mention cultural diversity. Cultural diversity was mentioned in 18 of the 28 documents on clinical residency training. In 17 of these 18 documents, cultural diversity objectives were described. These were formulated within various roles: Collaborator, Professional, Medical expert, Communicator, Health advocate or Reflector, which is a newly coined role. In 4 documents the objective was followed by a method, and
in 2 of these, psychiatry and emergency medicine, the objective and method were followed by an evaluation. The training methods were the Mini-Clinical Evaluation Exercise (Mini-CEX) and “The student should see a diverse patient population”. The evaluation consisted of observing the student in the context of cultural diversity, and of considering: “Does the student recognize culture-specific presentations?”

One of the 18 documents only described a method (“The student should see a diverse patient population”), which was not preceded by an objective nor followed by an evaluation. In 2 of the 18 documents, cultural competence was generally mentioned as necessary for a physician.

Discussion

This document analysis provided an impression of the formal status of cultural diversity in medical education in a multi ethnic country. We discovered that only half of all strategic curriculum documents contained references to cultural diversity training. Cultural diversity aspects were more prominently described in the curriculum documents for undergraduate medical education than in those for postgraduate medical education. The most specific information about cultural diversity was found in the blueprint for undergraduate medical education. In the postgraduate curriculum documents, attention to cultural diversity differed among specialties and was mainly superficial.

We found a remarkable absence of a systematic sequence of training objectives, training methods and evaluation, while this is regarded as important for adequate curriculum design.[22] For the undergraduate blueprint, the lack of this systematic sequence confirms that this is not a complete guideline for curriculum design. Its intended nature is to serve as guide with requirements that should be fulfilled at the end of the programs, while the responsibility to realize training methods is left to the universities. However, the systematic sequences were also lacking in most of the other documents, whose main purpose is to guide the design of an effective curriculum.

Besides, the content of cultural diversity training items was mainly described superficially, with the exception of the undergraduate blueprint. For national documents, a general presentation of these
items may be adequate, since they are intended to provide general guidelines. However, the regional
documents also mainly contained superficial information.

Our findings are in line with the studies by Dogra et al. and Lu et al., who also described a remarkable
absence of clearly described content for cultural diversity training in other countries, for example
Taiwan, the US and Canada.[28,29] Explanations for the missing content provided by the authors
could be the challenges for the construction of a curriculum in ethnically diverse countries
[14,15,28] and lack of universal core contents and standards. Another reason might be competition in
an overloaded curriculum. [29] Furthermore, there is no clear consensus about the content that
ought to be included in a cultural competence curriculum for physicians.[30]

One of the strengths of our study was that it was performed in a country with recently modernized
curricula, which could be assumed to be updated according to recent insights into the requirements
of a multi-cultural patient population. Our findings can serve as a basis for further research on the
actual frequency and quality of cultural diversity training in medical education. Especially since, not
mentioning cultural diversity in curriculum documents (planned curriculum) does not necessary
equals no attention the subject in the taught curriculum. For example, in some hospitals, physicians
attend local cultural diversity training programs [31], even though many medical education programs
have no guidelines on how culture and diversity should be understood and embraced in the
curriculum. Furthermore, documents do not reflect the actual frequency and quality of cultural
diversity training in educational practice, since they often contain abstract formulations. Therefore,
our study may not reflect the reality of training in actual practice. On the other hand, the fact that
cultural diversity is mentioned in the curriculum documents does not ensure that attention is given
to this subject in actual practice. Medical education curriculum designers within a multi-ethnic
country should address cultural diversity training in the documents describing the new curriculum.
Yet, also a proper educational approach is important for translating cultural diversity objectives to
actual practice.
In conclusion, the importance of cultural diversity training has transpired into Dutch undergraduate curriculum documents over the past ten years, although the vague and abstract terms used in these documents still need to be translated into practical guidelines for curriculum design. In postgraduate curriculum documents, there is little to no evidence that recent innovations in the Dutch medical curriculum have included improved attention to cultural diversity training, even though it is widely acknowledged to be necessary for all physicians who wish to deliver the highest quality of care. Thus, despite public recognition that cultural diversity competences are important for doctors in a multi-ethnic society, this recognition alone has not been sufficient to ensure adequate attention to cultural diversity training in medical curricula.

Acknowledgments: The authors wish to thank Lisette van Hulst for editing the manuscript.

Funding/Support: None

Ethical approval: Not applicable

Declaration of interest: The authors declare that they have no financial competing interests and no non-financial competing interests. The authors alone are responsible for the content and writing of the paper.
Table 1:
Summary of number of documents with text fragments regarding cultural diversity training in medical education.

<table>
<thead>
<tr>
<th>Training</th>
<th>Total documents (nat/reg *)</th>
<th>In n documents fragments of cultural diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undergraduate training, national</td>
<td>1 (nat)</td>
<td>Objectives (O) 0 0 0 Evaluation (E)</td>
</tr>
<tr>
<td>Undergraduate training, visitation accreditation</td>
<td>8 (reg)</td>
<td></td>
</tr>
<tr>
<td>Graduate training: social medicine</td>
<td>2 (nat)</td>
<td></td>
</tr>
<tr>
<td>Graduate training: nursing home physician</td>
<td>4 (1 nat/3 reg)</td>
<td></td>
</tr>
<tr>
<td>Graduate training: general practitioner</td>
<td>8 (reg)</td>
<td></td>
</tr>
<tr>
<td>Graduate training: intellectual disability physician</td>
<td>1 (reg)</td>
<td></td>
</tr>
<tr>
<td>Graduate training: clinical residency training</td>
<td>28 (nat)</td>
<td></td>
</tr>
</tbody>
</table>

* national/regional
† In n documents a combination of objective, methods and evaluation was mentioned in one sequence.


