

# Challenges and Opportunities for Implementing Diversity Competence in a Medical Education Curriculum: A Qualitative Study of Perceptions Among Students and Teachers

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## ABSTRACT

**OBJECTIVES:** Medical education is under continuous pressure to introduce new curriculum content to ensure that physicians possess the competences that the population needs. Diversity competence (DC) is a relatively new area within medicine, challenging the existing curriculum. Frameworks and guidelines have been developed to provide support and assistance to educators in integrating DC into medical programs. However, integrating DC into curriculum has proven difficult and is therefore still not included in many European medical programs. The purpose of the study is therefore to identify the challenges and opportunities for implementing DC including a focus on migrant and ethnic minorities in a medical education program.

**METHODS:** From November 2–20, 2020, focus group discussions with medical students, junior physicians and course leaders were conducted. The participants were recruited via Facebook, newsletters, and emails. Two interview guides were developed and used as guidance for topics to be discussed. The focus group discussions were conducted partly physically and partly digitally. The interviews were transcribed and were analyzed using thematic analysis.

**RESULTS:** Three main challenges and opportunities were identified across the focus groups. Challenges: (i) a disparaging discourse about humanistic and social disciplines within the curriculum, (ii) limited levels of DC among teachers, and (iii) need for institutional support. Opportunities: (i) a clear interest in strengthening teachers' DC levels, (ii) incentives for improving the image of humanistic and social medicine, and (iii) relevant courses for implementing DC.

**CONCLUSION:** Our results showed that action in this area is needed. The themes identified indicated that there are within the curriculum many opportunities to implement DC, but they also illuminated the challenges. The results suggested both a need for focusing on individual competences for medical teachers and students, and also for organizational change and support in favor of DC training.

**KEYWORDS:** Diversity competence, medical education, diversity-sensitive curriculum, diversity training, migrant health, cultural competence, medical students

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## Introduction

Medical education is “in a perpetual state of unrest”<sup>1</sup> affected by societal demands, changing regulations, emerging specialties, and technological advances. Therefore, medical educational programs continually need to make changes introducing new curricula to ensure that the universities educate physicians with the competences that society and the population need.<sup>2</sup> The increasingly diverse societies<sup>3</sup> present a challenge to physicians, who have reported that they lack competences to meet the needs of ethnically diverse patient groups, and experience uncertainty about their capabilities to deliver appropriate care for migrant and ethnic minority patients.<sup>4,5</sup> Migrant and ethnic minorities experience barriers in accessing the healthcare system, including formal (eg, legal restrictions and organizational structures) and informal ones (eg, communication problems, socio-cultural factors, institutional disrespect, and

discrimination).<sup>6,7</sup> Additionally, migrant and ethnic minority patients report lower satisfaction with healthcare encounters than the majority population<sup>8</sup> and studies have documented worse health outcomes, including lower self-rated health among some refugee and ethnic minority groups compared to the majority population.<sup>9,10</sup> Poor health can affect migrant and ethnic minorities' ability to work, to partake of education,<sup>11</sup> and to learn language, leading to lower socio-economic status; and it also affects social relations and ability to participate in societal activities.<sup>12</sup> These all contribute to the marginalization of migrant and ethnic minorities and an increase in societal inequities, disadvantaging society as whole.<sup>13</sup>

The concept of cultural competence (CC) emerged in the wake of the civil rights movement of the 1960s<sup>14</sup> in the United States. CC focuses on awareness of culturally specific habits, beliefs and needs in healthcare. CC has been proposed



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as a strategy to reduce health disparities between different ethnic groups and to ensure the high quality of health services.<sup>15,16</sup> In addition, CC has been suggested as a way to reduce health inequalities for other minority groups such as LGBTQ+.<sup>17,18</sup> CC was introduced into many medical programs in the 1990s and 2000s but it has also been strongly criticized for an excessive focus on culture, seeing culture as static, reinforcing cultural stereotypes and biases, and implying the characteristic of “the other.”<sup>19–21</sup> Further related concepts that emerged after CC was introduced are intercultural competence (focus on interaction and dialogue between different cultures) and Cultural Sensitivity, Difference Sensitivity, and Diversity Sensitivity (awareness of different forms of diversity).<sup>14</sup> A recent study identifies respect, empathy, awareness, self-reflection, and communicative skills associated with knowledge of social determinants of health as key competencies for the diversity-sensitive healthcare professional.<sup>22</sup> This has led to a change from focusing on cultural and ethnic aspects of care to a broader focus on recognizing different forms of diversity that also takes into account the diversity within diversity—sometimes called “super-diversity.”<sup>3</sup> Although the concept of diversity sensitivity focuses on and acknowledges different aspects of diversity, this study will mainly focus on migrant and ethnic minorities due to the fact that the challenges in health care for these groups have been dominating the diversity discourse and research in Denmark. By using the term diversity, we point to the multicollectivity<sup>23</sup> of individual migrant and ethnic minorities and propose an intersectionality-based approach.<sup>24</sup> The term “intersectionality” has evolved to include experiences of multiple “crossing” identities, including race, socioeconomic class, gender, sexual orientation, and more. To operationalize diversity sensitivity as a conceptual framework for learning, we define it as diversity competence (DC) which incorporates the interrelatedness of knowledge, awareness, and skills. These relate to (1) knowledge of concepts related to migration and diversity and their impact on health and healthcare efforts; knowledge about inequalities in disease causes and morbidity and in the effect of healthcare efforts in different patient groups; (2) awareness of one’s own socio-cultural background, identity, bias, implicit prejudices and tendency to stereotype, and how all this affects the interaction between doctor and patients with a background other than one’s own; (3) skills to use DC in the interaction and communication between themselves (the doctor) and the patient. DC aims to improve understanding, interaction and communication between health professional and patients with their individual identities (eg, socio-economic background, age, sexuality, ethnicity, religion or gender).<sup>22,24</sup>

Many governing bodies within medical education have incorporated statements about diversity into their guidelines<sup>25</sup> and organizations like World Health Organization (WHO) endorse the training of students and health professionals in DC.<sup>26</sup> Research also suggests a need for further competence

development in this field.<sup>27</sup> Several frameworks and guidelines have been developed to provide support and assistance to educators in integrating DC into medical training programs.<sup>25,28–31</sup> Furthermore, studies recommend that DC should be integrated throughout the whole curriculum including the biomedical courses, not just as an add-on to the existing curriculum.<sup>28,32</sup> However, integrating DC into curricula has proven difficult due to lack of clarity on learning contents, scheduling and organization; insufficient support from management including allocation of resources; and lack both of competent teachers with expertise in this subject and of evaluation of effect of the educational initiatives.<sup>33,34</sup> Studies suggest that DC is not adequately included in European and Danish medical education, and that there are clear potentials for improvement.<sup>31,33,35</sup> For instance, a recent study found that Danish medical students point out that diversity in skin color was not adequately included in the curriculum and that they feel less confident about diagnosing on skin of color than on “white” skin.<sup>35</sup> A desk review of curriculum and teaching materials from the medical program at the University of Copenhagen (UCPH) also indicated insufficient diversity-related content.

To support the implementation of more diversity-sensitive curricula, it is necessary to illuminate diversity-related content and learning in the current medical schools’ programs and thereby identify existing gaps, challenges, and opportunities for improvements. Important actors in this process are students and course leaders/teachers with key roles and first-hand experience. We therefore designed a qualitative study at UCPH based on the following research questions:

1. How do medical students, junior physicians with recent study experience, and course leaders perceive the content of the existing medical curriculum in regard to ensuring diversity competence for medical doctors?
2. How do medical students, junior physicians and course leaders perceive the opportunities and challenges for ensuring sufficient diversity competence training in the curriculum?

The study results could thereby serve as valuable input for the further process of medical curriculum development at UCPH, as well as inspire and support other medical schools and healthcare educational programs (eg, dental, nursing) in implementing more diversity-sensitive curricula by using UCPH as a case study.

## Methods

To shed light on our research question, a qualitative design was used, with focus group interviews conducted in November 2020 in Copenhagen, which provided the possibility to gain deeper insights into medical students’, junior physicians, and teachers’ (course leaders) perception of the current medical curriculum at

the University of Copenhagen as well as to uncover opportunities and challenges for implementing DC.

### *The setting*

UCPH is Denmark's oldest university, and its Faculty of Medical Sciences (SUND) was established in 1842. The oldest medical program in Denmark, this is seen as being more traditional in its approaches and views on medicine and medical education—as reflected in the curriculum—than some of the more newly established medical programs, such as the University of Southern Denmark and Aalborg University. The medical program at UCPH trains approximately 580 new physicians annually. In 2021, 69% of the students were female, 20% had a background in countries outside Denmark, and 76% had parents of educational attainment up to college or university graduate or PhD level, whereas the percentages for the general population in Denmark are 51%, 15%, and 19% respectively. The medical program consists of 44 courses distributed on a Bachelor's program and a Master's program—each of 3 years. The courses cover behavioral science, social science, preclinical, paraclinical and clinical modules, and a range of elective subjects. The teaching is carried out predominantly through dialogue-based group teaching and exercises supplemented by lectures. Although international staff make up 27% of the total university staff, the teaching is still predominantly carried out by Danish-speaking staff, since the teaching language is Danish, thereby excluding most international staff. UCPH is governed at many different levels, by national laws, guidelines, proclamations, strategies, action plans, and so on. Internationalization and mobility are included in UCPH's strategy, and gender equity is referred to in many guidelines and action plans, but a specific action plan for inclusion and diversity did not exist at the time when this study was conducted. The researchers who carried out this study share similar and rather privileged backgrounds (white, cisgender, and highly educated), and thereby potentially have higher risk of unconscious bias and blind spots, although this is offset to some degree by the first author's and co-authors' many years of working with diversity, equity, and health. The project was presented to the Study Board of Medicine and the Director of the Medical Study Program, which gave important stakeholders the opportunity to comment on and engage in a dialogue with the project researchers. Additionally, this anchored the project at SUND and gave it credibility.

### *Recruitment of participants*

We planned focus group discussions (FGDs) with 3 groups of stakeholders: medical students (MS), junior physicians (JP), and course leaders (CL). We chose FGDs as a method to gain insights into and draw upon the stakeholders' attitudes and experiences with diversity-related content in the existing

curriculum and teaching. Although individual interviews could have provided a more in-depth insight into a particular issue, the FGDs could contribute with more nuanced views providing a fuller and more complete picture, which was what we needed to answer our research question. The group context intended to provide some support and a feeling of being safe, partly by diminishing the pressure for the individual participant to give an immediate response. We chose the 3 stakeholder groups based on the following criteria and reasons: (i) MS enrolled at UCPH up to their fifth to tenth semester, giving them enough experience with the medical program—with many courses fresh in their memory—and thereby the ability to provide insights and opinions about the current curriculum; (ii) JP who graduated from UCPH and who had been working for a maximum of 7 years and could provide insights into how the educational program corresponds with everyday clinical life; and (iii) CL who could provide in-depth knowledge of the content and teaching methods in their own courses, and also a broad overview of other courses and activities from the Medical Program. The CLs had many years of experience as teachers, and they were all still themselves engaged in teaching. The CLs had taught many different subjects, which also allowed them to share insights not just limited to their own current teaching. The CLs were leading courses that varied from clinical medicine and biomedicine to social and humanistic medicine. The MSs and JPs reported based on their own experiences from a broad range of courses across the medical program.

Our recruitment strategy can best be described as convenience sampling and was chosen due to the difficulties of recruiting in the time of crisis (COVID-19) and because the target groups can be characterized as hard to reach. CLs are always busy but were particularly so at that time due to the pressure of reorganizing their courses into online formats, and so on. Medical students as a group are notoriously difficult to recruit due to a very compact and busy study program, with clinical work both as part of their study program, and also as extra jobs.

Different channels for recruitment were used. First, MSs and JPs were recruited through posts about the project in relevant Facebook groups. Secondly, invitations were sent to relevant units at hospitals, to the Department of Clinical Medicine at UCPH, and to student organizations. Additionally, professional, and personal networks were used in order to spread the information about the project and the opportunity to participate. Email was used to recruit CLs responsible for UCPH medical courses with clear relevance for the aim of the study—31 CLs were invited. In total we recruited 16 informants (4 MSs, 7 JPs, 5 CLs), of which 2 were male and 2 had an ethnic minority background (Spanish-Danish and Turkish-Danish). Originally, we had scheduled 3 FGDs, but due to tightened COVID-19 restrictions (eg, quarantining, lockdowns of society, and much illness) we ended up with 4 FGDs with 2 to 6 participants in each group and one individual interview (Table 1). One FGD

**Table 1.** Overview of informants.

INFORMANT MEDICAL STUDENT (MS) JUNIOR PHYSICIAN (JP) COURSE LEADER (CL) <sup>a</sup>	AGE	GENDER	YEAR OF COMPLETED MASTER'S DEGREE, OR PRESENT SEMESTER	MEETING FORM ZOOM (Z) PHYSICAL (P)
MS1	26	F	12th semester	Z
MS2	23	F	5th semester	P
MS3	27	F	10th semester	P
MS4	25	F	11th semester	Z
JP1	29	F	Master's in 2018	Z
JP2	31	F	Master's in 2017	Z
JP3	32	F	Master's in 2018	Z
JP4	30	F	Master's in 2020	Z
JP5	29	M	Master's in 2019	Z
JP6	33	F	Master's in 2015	Z
JP7	37	M	Master's in 2013	Z
CL1		F		P
CL2		F		P
CL3		F		P
CL4		F		P
CL5		F		Z

<sup>a</sup>Information about the CL's characteristics is kept to a minimum due to the small number of CLs in the medical program thus minimizing the risk of breaking anonymity.

was conducted face-to-face; one as a hybrid meeting (simultaneously face-to-face and online); and 2 FGDs and the individual interview were conducted as online meetings. We decided to include the individual interview in the dataset but noting that the nature of the data might differ from that of the others. The analyses later showed that there was not much difference in the themes that emerged. The CLs participated in a separate group, whereas the MSs and JPs were mixed to benefit from their different perspectives on the content of the curriculum and use in the clinic. First and second author that moderated FGDs with the MSs and JPs had no prior relations to them. Some of the MSs and JPs knew each other vaguely from campus and 2 of them were siblings. The CLs and moderators were colleagues at SUND and therefore knew each other vaguely or by name only. In conclusion, we estimate that the pre-existing slight relationships (excluding the siblings) have not affected or hampered the FGDs. For an overview of the recruitment process and FGDs, see Figure 1—A COREQ (Consolidated Criteria for Reporting Qualitative Research) flow chart.

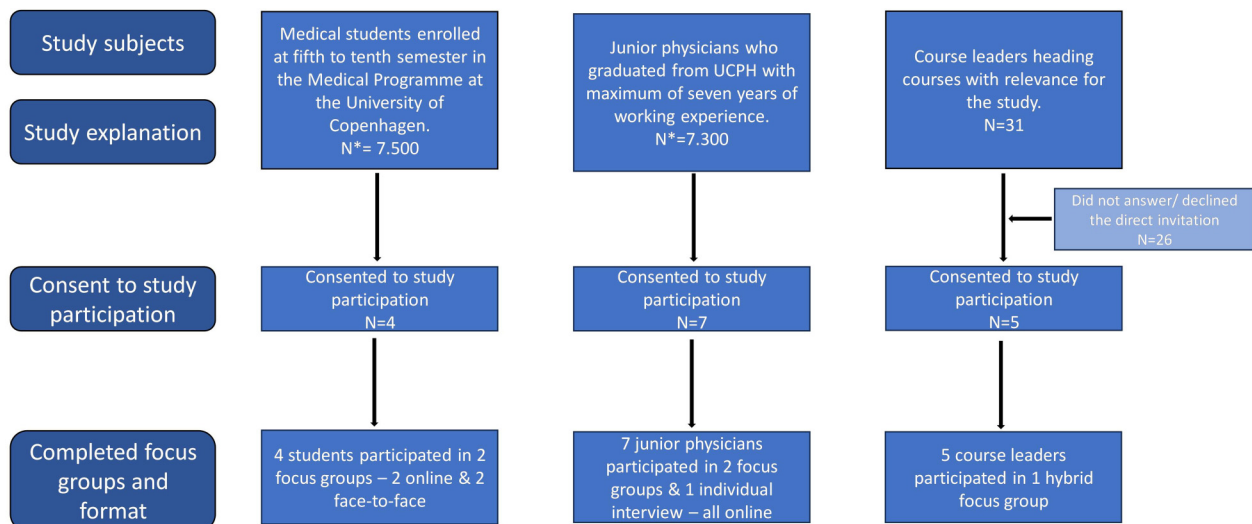
#### *Focus group discussion*

The FGDs were audio-recorded with a digital recorder and the online meetings were recorded by Zoom, where only the audio file was stored.

Two semi-structured FGD guides were developed with questions sorted by themes, but with room for new questions or themes that could arise during the interview. The guide was therefore not final, but used as the starting point as guidance for topics to be discussed. The first and second author developed the guide with inspiration from the DC framework described in the introduction (learning objectives, guidelines, etc)<sup>24,25,28–33</sup> and it was accompanied by a curriculum review providing an overview of the present curriculum. Afterwards the guide was discussed among all authors and revised.

The guide for MSs and JPs included the following main topics: (i) experiences with diversity-related content during medical school, (ii) experiences with DC in clinical work, (iii) inputs for implementation of DC in the curriculum. The guide for the course leaders included the following main topics: (i) diversity-related content in their own courses (and other courses if they could provide insights into these); (ii) their thoughts about teaching methods in relation to DC; (iii) considerations about implementing DC in their courses. As an introduction to the FGDs, the participants were informed of the purpose of the project and presented with the definition of DC (as stated in the introduction, above). Furthermore, the facilitators aimed to create a relaxed and trustful atmosphere by





\*N for medical students and junior physicians is the number of members of the Facebook groups where they were recruited and at the date the invitation was posted.

**Figure 1.** Recruitment and FGDs (COREQ flow chart).

sharing own engagement and experience regarding the topic and stressing confidentiality.

To support the discussion about diversity-related content in the curriculum, the authors could rely on the previous review of the UCPH medical curriculum conducted by the authors. The FGDs were led by a moderator with an additional moderator who was in charge of the technical part of the interview (recording in the face-to-face workshops or handling Zoom). At the FGD with the CLs, all 4 authors participated: the main author led the discussion and the others supported or handled the technical equipment.

The FGDs and individual interview lasted between 30 and 90 min and were conducted in the period November 2-20, 2020. The focus on ethnic minorities is a sensitive issue: however, the researchers have many years of experience of doing research in this field with empathy and respect for the study population. The researchers also have experience regarding teaching sensitive topics, focusing on including all voices and fostering a safe learning environment. The research team therefore felt comfortable and confident in their ability to handle any discussions of sensitive character that might arise during the FGDs, and to ensure a respectful inclusive discussion.

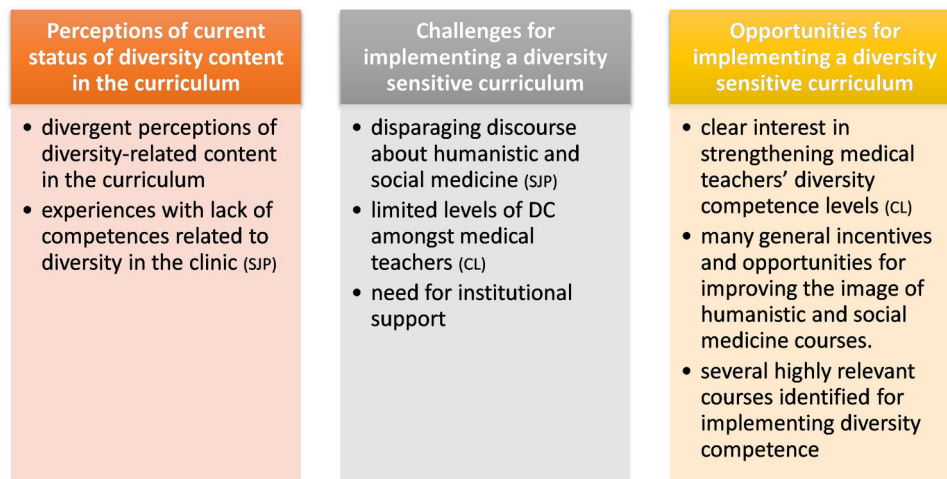
### Analyses

The recording from the FGDs were transcribed verbatim and afterwards subject to thematic analysis<sup>36</sup> to identify any patterns or common topics. Non-verbal communication was not noted in the transcript and was therefore not part of the analyses. Due to the fact that some of the FGDs were conducted online where it was very difficult to register and see body language (some participants only showed their face in the

window), we decided that we would not include this in the analyses. The transcribed interviews were read and thereafter coded and divided into themes by the first author. Afterwards, the second author read the transcribed data and commented on the initial coding and themes. The themes and sub-themes that emerged from the coding were discussed among all co-authors where the focus was on finding any discrepancies or contradictions in the data. After the group-discussion, the first author finalized the analyses. Although the data collection was based on 4 FGDs and one individual interview, new topics did not emerge during the last FGDs. For example, new courses or lectures were not mentioned when asked what diversity-related content the MS and JPs could remember from classes and the same barriers were mentioned, for example, disparaging discourse. More FGDs might have benefited the study and added nuances, but the rich data from the 4 FGDs and individual interviews were sufficient to answer the research questions in this study and we therefore concluded that we had archived saturation in our collection of data.<sup>37</sup> The coding process supported this, since at the final stage of the analysis, pre-identified themes recurred, pointing to a level of saturation and we were confident that our data could provide answers to our research questions. Quotations used in the manuscript are chosen either to elaborate on, or to nuance the themes and sub-themes. The COREQ (Consolidated Criteria for Reporting Qualitative Research) Checklist was also completed (see Supplemental 1).

### Ethics

All participants involved in the study were informed and consented verbally to participate which concurs with the Danish data practices on obtaining consent.<sup>38</sup> The individual



Note: The marking of themes (SJP or CL) indicates that the theme was mainly identified in FGDs from that particular stakeholder group

**Figure 2.** Overview of main themes and sub-themes.

participant's oral consent was recorded by the moderator responsible for the technical part of the FGDs. According to the Danish Act on the Biomedical Ethics Committee System and the Processing of Biomedical Research Projects, the study was not notifiable to the Danish Research Ethics Committee System, as it did not include biological material. The study was conducted in accordance with general ethical codes within the field of research, cf the Declaration of Helsinki. Data was handled in full accordance with the requirements defined by the Danish Data Protection Agency.

## Results

For an overview of themes and sub-themes, see Figure 2. The stakeholder groups of students and junior physicians will be referred to as "SJPs" and the term "informants" will be used to describe the 3 groups collectively. Individual statements will be referred to as by medical student, junior physician or course leader, and quotations will be marked with abbreviation (MS, JP, or CL) and number (see Table 1).

### *Perceptions of current status of diversity content in the curriculum*

*Divergent perceptions of diversity-related content in the curriculum.* When asked if they could point to any DC-related content in the curriculum, most SJPs were hesitant. In general, they found that the medical program lacked diversity-related content. One said, "I actually do not remember at all that there has been anything of the sort." (JP6). After some minutes of discussion, some SJPs could point to a few courses or lectures which had diversity-related contents such as one lecture, use of cases with migrant and ethnic minorities in another course, and a lecture on post-traumatic stress disorder which also touched upon people from "other" cultures.

All course leaders said their courses had diversity content included to some degree. One course leader explained that they worked with diversity by constantly challenging the notion and the perception of the "normal." Other courses focused on social determinants of health which could include "ethnicity." Another course leader found that a very effective entry question for starting a discussion about migration and ethnicity was to ask if students had been patients in a foreign health system, for example when travelling. Yet another course leader said that her course included diversity in all its elements and explained:

*...because it (the course) is about how to learn and understand how people's backgrounds influence them and why they react in different ways, if they have difficulties hanging on to a job, or doing their physical training or whatever they find difficult (CLA).*

Thus, the concept of DC is perceived by participating course leaders to be somewhat covered in the medical program, yet viewed as overlooked or downgraded by participating students and junior physicians. Also mentioned by SJPs as issues that should be included in the curriculum were: different understandings of disease and "health belief models," migrant and ethnic minority patients' expectations of the health system and of health professionals, and incidence rates and risk factors in different patient groups.

*Experiences with lack of competences related to diversity in the clinic.* The SJPs were also asked if they felt they lacked any DC in their clinical work. Almost all expressed frustration with their lack of skills in working with interpreters. Many of them did not know how to book an interpreter and found that the expectation of learning-by-doing in clinical work is not the optimal solution. One elaborated, "...it is not systematized, we do not know anything about it, for what do you do,

*what can you do, should it be a face-to-face interpreter or should it be a telephone-interpreter...?”(JP3).*

Other SJPs said that topics like culture and how to deal with patients and relatives from other cultures should be included in the curriculum. A junior physician described a situation from work where an ethnic minority patient was unconscious; his wife did not speak Danish and there were many other relatives present, and they had to decide about ending the treatment. The junior physician explained, “...in this situation I clearly felt that I was missing some competencies, for example what is about culture and what is the “normal” way for them to handle this, and who should make the decisions...” (JP3).

Further, a junior physician found that she lacked information about where to refer undocumented migrants:

*...I was in a place where someone told me about the Red Cross Clinic for undocumented migrants, but it was a coincident that I received that information...I don't think that it's common knowledge that you can refer people to that place (JP6).*

### *Challenges to implementing a diversity-sensitive curriculum*

*Disparaging discourse about humanistic and social medicine.* SJPs all perceived biomedical disciplines to be taking more space in the curriculum and valued more highly than competences within disciplines such as communication, psychology, and social medicine. The SJPs pointed to a general discourse which undervalues courses designed to instruct students in such competences. Courses covering sociological, communicative, or humanistic approaches to medicine were explained by SJPs as being viewed as less legitimate or serious and talked about as “fly-by-courses” or “conversation-courses,” referring to how they are easy to pass “just by talking.” During the FGDs, these types of competences were referred to as “soft skills” which suggests that competences such as DC are understood as less difficult and less important than “hard” medical competences.

One medical student expressed frustration about how this hierarchy of “soft” and “hard” disciplines shows in the way that biomedical knowledge is over-prioritized in the very tight program for medical students:

*...I still find that the weighting of the biological and natural sciences takes up much more than competences within communication and the science of culture and society and how medicine works in it... (MS1)*

A junior physician pointed out that this is also the attitude reflected by the university, and that you cannot expect the students to be serious and enthusiastic about humanistic and social medicine if the university itself is not. A medical student reported that even the teachers teaching humanistic medicine courses were talking it down: “... the course leader said at the first lecture, that this is a course that you can easily pass, but it's

*difficult to get a high grade... That doesn't exactly make you motivated...” (MS2).*

Some SJPs also indicated that DC is more a personal characteristic, a kind of inherent competence like “being good at talking to ethnic minorities” and therefore not necessary to learn. A junior physician explained:

*The vast majority of doctors are socially conscious, I think. Or know something about society. There are also lots of doctors who are from other ethnic groups themselves. So, I think it would be unnecessary to have to do a course in 'now you must understand that there may be a problem here.' I don't think anyone doubts that there is a problem. And even if they have such doubts, then they can learn it [DC] pretty quickly. (JP7)*

*Limited levels of DC among medical teachers.* The analysis indicated that when it comes to teaching students with increasingly diverse backgrounds, medical teachers have uncertainties and doubts regarding the use of terminology, and when addressing sensitive topics and cases. This is influencing their teaching, choice of content and teaching methods. One course leader explained that some exercises were never used due to considering the sensitivity of the topic and the students' privacy:

*... the students also can be vulnerable; something we have discussed many times is if it would be a good idea to get the students to draw their own family tree and then mark hereditary diseases in the family... (CL5)*

Terminology, specific words, and concepts can be perceived—and impact students—in unintended ways:

*Then you use the term **drug addict** in a lecture, and then after the lecture someone approaches you and says, 'My brother is actually a **an individual with a substance use issue**.' And then you realize that during the whole lecture you've been offending someone. (CL3)*

Another course leader elaborates:

*...if I say **drug addict** during a lecture and then this becomes the only thing that this student can think of, 'That is not the correct term,' then I've lost him [sic] for the whole lecture and there's no reason for that. (CL4)*

Another example of these insecurities came up during a discussion of use and construction of cases. Should cases used in medical education be based on statistical proportionality (the majority) or should they demonstrate the variety and diversity of society? Most course leaders agreed that sometimes you should use the more statistically (stereotypically) based cases, but that it was also a good idea to demonstrate the variety within populations, such as by some (artificially) constructed cases that are superficially very stereotypical, intended to provoke and maybe show the students that when a story unfolds, not everything is what it seems. “...And the whole point of including such a case is that all the prejudice will line up

...’ Yet, “very fast, [this] can lead you to think that you know what it’s about and then it can turn out that it was not what you thought” (CL1). The SJPs also reflected on the use of cases and had difficulties in recalling case examples that included more personal characteristics than gender and age. Some expressed interest in diversifying the cases by including religion, ethnicity and/or sexuality, and so on.

*Need for institutional support.* The topic of lack of institutional support was brought up several times in relation to discussions on how to ensure the implementation of DC training. Several informants stressed that there is a need to put action behind the words by, for example, making courses for medical teachers’ mandatory. One course leader suggested:

*If you really mean this seriously, then maybe you should say – well everyone who is a clinical lecturer or professor, they should simply attend such a course. Two or three hours that are mandatory. (CL3)*

Institutional support was also brought up in the discussions about the disparaging discourse, and the need for the university to have a role in changing this. A junior physician said, “...it also becomes [ie, involves] the university’s attitude, I think. And then it’s also too much to demand of students that they should take it seriously if it’s not taken seriously from the other side [ie, the university]” (JP6).

#### *Opportunities for implementing a diversity-sensitive curriculum*

*Clear interest in strengthening medical teachers’ DC levels.* The informants pointed to several opportunities where the DC levels of the medical students and medical teachers could be improved. The data point towards a clear interest in strengthening the medical teachers’ DC and the course leaders even suggested themselves that DC training should be included in mandatory courses for medical teachers. One course leader said, “To ensure good quality of teaching, it is important that it becomes a university pedagogical initiative” (CL1). Another elaborated that it should be university policy to adapt as society evolves. For course leaders using case studies in their courses, it was suggested that assistance should be provided to check cases included diversity, and to guard against reproducing prejudices.

*Several highly relevant courses identified for implementing DC.* The informants also identified existing courses where they thought it was obvious to implement DC (eg, health psychology, patient contact courses, communication courses). Another opportunity identified was the possibility of strengthening the link between clinical training and theory-based teaching on DC by integrating DC into the teaching instructions used for the clinical training. For example, a case involving patient communication with an interpreter was suggested,

and general interest was expressed in including training on how to work with interpreters in the curriculum.

*Many general incentives and opportunities for improving the image of humanistic and social medicine courses.* SJPs pointed to the clear potential of employing diversity content to improve the image of humanistic medicine and social science courses. One suggestion was to review the placement of these courses in direct relation to clinical training periods and raise the level with more difficult examinations. One medical student explained, “So, first of all, it’s also about what demands you’re met with [in the medical programme], you have to sense that there are some requirements, but it [the training course] must also have some real [examination] requirements which are very high for these courses” (MS2). This quotation highlights the need to acknowledge DC as a legitimate and important competence in the curriculum for students, and the need for medical teachers to give DC greater priority.

## Discussion

Our findings point to opportunities and provide concrete suggestions on how to implement a diversity-sensitive curriculum in medical training, but they also highlight the challenges that need to be overcome to succeed. These challenges relate to general organizational support; improving the discourse regarding the different elements within medical training; teachers’ competences for including a diversity focus within their disciplines; and initiatives that ensure the inclusion of DC key elements, whenever relevant, in specific courses.

The informants’ perceptions of the current state of the curriculum when it comes to diversity-related content also showed that there is a discrepancy between the perceptions of the CLs and the SJPs. For instance, the CLs reported that they considered that there was diversity-related content in their courses, whereas the SJPs were struggling to recall this content. This discrepancy could be due to selection bias, since the CLs who accepted the invitation were heads of courses that already had diversity-related content, and who therefore had a specific interest in the topic. For example, the lecture that was recalled by most SJPs as focusing on migration and health was included in a course headed by one of the participating CLs. The discrepancy could also reflect that some of JPs graduated from the Medical Program some years ago, where diversity might have been a minor issue (supported by the desk curriculum review from 2014) whereas the CLs have the newest and most updated knowledge of content in their courses. However, the MSs were agreeing with the JPs about lack of diversity related content.

A major challenge was the disparaging discourse among students and teachers within the organization regarding humanistic and social medicine. This type of informal “teaching” has been defined as “the hidden curriculum” with a significant impact on medical education, as documented in several



studies.<sup>39,40</sup> The “hidden curriculum” in medical education was first described by Hafferty and Franks as a set of influences that function at the level of the organizational structure and culture, and which impact learning. They argue that “most of the critical determinants of physician identity operate not within the formal curriculum but in the more subtle, less officially recognized ‘hidden curriculum’.”<sup>39</sup> The hidden curriculum not only could counteract some of the values within medicine, but also formal learning objectives within the medical education.<sup>40</sup> For example, empathy is valued as one of the most important characteristics of physicians<sup>22</sup> and is also included in the competence profile for medical students at the UCPH.<sup>41</sup> Yet studies document that the level of empathy among medical students decreases during their medical training.<sup>42</sup> It is suggested that the “hidden curriculum” plays a role in this decline of empathy.<sup>43</sup> Therefore, if universities want to implement a more diversity-sensitive curriculum, it is important to acknowledge the impact of the “hidden curriculum,” since otherwise this could counteract the efforts to engage students, medical teachers, and managers in DC training. Furthermore, to broaden the scope beyond “acknowledging the impact,” universities should strive to change organizational culture towards becoming more diversity sensitive. This requires both a bottom-up and a top-down approach to create a dynamic co-creation process where management, students, and faculty engage in developing the attitudes and knowledge within the organization and for the people in it.

Our analysis also showed how the medical program struggles with a lack of clarity and conceptualization of DC training. This means that although course leaders and students find DC important, it is unclear how it should be taught, articulated, and prioritized within the curriculum. This finding resonates with other studies which show that the lack of conceptual clarity and faculty support—along with high levels of variability in DC programs—challenges their implementation.<sup>33</sup> This highlights the importance of management support and clear instructions for implementing DC in medical curricula. For instance, as stated in the introduction, DC ought to be “woven” into the curriculum as a horizontally essential constituent, rather than offered as “stand-alone” or optional courses.<sup>28,32</sup> This allocates much responsibility to the individual teachers on how to execute this, for which they need management support. Concrete suggestions of support from management could be to provide (funding for) toolboxes (with suggestions for exercises, literature, databases with images reflecting societal diversity, guidelines for how to include diversity in learning objectives, etc) and training that could help teachers review their own teaching materials and learning objectives and provide insights into how to incorporate diversity in courses. Additionally, management also needs to be a driver for motivating teachers to improve and develop their teaching and providing support and inspiration as a motivational factor for the many teachers who aspire to deliver at a high level.

Although the medical program at UCPH is more traditional and has a vast focus on biomedicine, our analysis showed a great potential in that there may be a momentum among course leaders and society for introducing DC into the medical curriculum.

Further, our study showed that CLs are interested in participating in curriculum development and in receiving training—points also documented in a previous study.<sup>44</sup>

Both the literature<sup>33,34</sup> and our findings illustrate the challenges—such as disparaging discourse, lack of management support, and lack of competences among staff—in integrating DC into curriculum, making it difficult to implement changes. Clearly motivated staff and students, however, could be the driving force in a bottom-up process and put pressure on management to take responsibility for setting the strategy and allocating resources which could lead to changes. Based on our findings, we therefore suggest that (i) staff should be offered courses to strengthen their own DC and enhance their ability to include diversity in their teaching—for example, a mandatory course for all current and future staff, or by including DC in the Assistant Professor pedagogy; (ii) the university explicitly and in practical terms should promote inclusive policies and strategies to demonstrate and emphasize DC as important, not only to staff and students, but also to society at large, for example by organizing and allocating funding for inclusive student social environment activities; and (iii) general curriculum revisions should be used as a clear opportunity to promote the weaving of DC into existing courses, for example by strengthening diversity issues in evaluations of student and teacher performances.

### *Strengths and limitations*

This study has several limitations. First, there may be a high risk of selection bias, meaning that the informants might have specific interest in the area. Some of the informants declared themselves as possibly being biased in favor of much more focus on DC than their peers felt was required. However, the interest demonstrated was also reflected among the teaching staff in Denmark and on a European level, pointing to a general motivation for more DC training.<sup>44,45</sup> Secondly, both the research team and most informants had similar backgrounds being highly educated and ethnically Danish: the participating course leaders in particular represented little diversity in terms of educational background, gender, and ethnicity—reflecting the general composition of the group of course leaders at the Faculty. The limited representation of minorities in the project is a clear limitation since their experiences and perspectives could have strengthened the study. However, the students represented somewhat more diversity, since 2 of them had ethnic minority background and 2 were male. Thirdly, due to COVID-19, some of the interviews were conducted as Zoom or hybrid meetings, which required more structure and

control from the interviewer to ensure that all were heard. This may have hampered the discussion since it could not be as fluent as in a face-to-face meeting. Furthermore, COVID-19 affected all aspects of our everyday life, including teaching and studying, and this research project itself. Being away from the traditional setting and teaching of the University could have caused recall bias of the MSs and CLs. On the other hand, the periods of the COVID-19 lockdown were limited, and since the teaching continued online, it is unlikely that recall biased affected informants to a high degree. Fourthly, even if our findings do reflect the general status of the medical program at the UCPH (as also indicated by the previous curriculum content review and the survey on competence needs among teaching staff<sup>44</sup>), they may not represent the situation in all other medical training institutions in Denmark and internationally, with different traditions, student and teacher compositions and possibly longer histories of ethnically diverse populations. Some universities have moved faster to ensure more elements of DC training, such as the University of Amsterdam.<sup>46,47</sup> However, the findings are well in accordance with previous international studies and very recent recommendations and guidelines by international organizations pointing at challenges and ways forward regarding organizational support and curriculum content.<sup>26</sup>

## Conclusion

Our findings illustrate insights from a European university realizing the need—but still on its way to make the changes necessary—to meet the challenges of a more diverse society. The study results could thereby serve as valuable input for the further process of medical curriculum development at UCPH as well as inspire and support other medical schools and health educational programs (eg, dental, nursing) in implementing more diversity-sensitive curricula by using UCPH as a case study.

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## Data availability

The data that support the findings of this study are available from the corresponding author, upon reasonable request.

## Ethics approval and consent to participate

All participants involved in the study were informed and consented verbally to participate which concurs with the Danish data practices on obtaining consent (35). The individual participant's oral consent was recorded by the moderator responsible for the technical part of the FGDs. According to the Danish

Act on the Biomedical Ethics Committee System and the Processing of Biomedical Research Projects, the study was not notifiable to the Danish Research Ethics Committee System, as it did not include biological material. Link to relevant legislation (in Danish only): <https://www.retsinformation.dk/eli/fta/2011/593>. The study was conducted in accordance with general ethical codes within the field of research, cf the Declaration of Helsinki. Data was handled in full accordance with the requirements defined by the Danish Data Protection Agency.

## Supplemental material

Supplemental material for this article is available online.

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