

Building intercultural competency: student perceptions of diversity education within an undergraduate medical curriculum

Adele Schiff · Oliver Mercer · Noreen Ryan · Ana Baptista

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Abstract

Background Providing interculturally competent care is essential for clinicians. Intercultural competency (ICC) focuses on having the ability to navigate and adapt care to each individual and being aware of one's own assumptions rather than just having the knowledge of specific cultures [1–4]. ICC encourages reflection and constant dynamic learning to collaborate and communicate with patients. The General Medical Council (GMC) states that medical schools ‘*should provide students with an understanding of how to provide effective treatment to a diverse, twenty-first century population*’ [5]. Currently at Imperial College School of Medicine (ICSM), teaching focused on ICC is delivered from the first year using various teaching strategies such as tutorials and guided online learning sessions. Our aim is to understand early undergraduate students’ perceptions of their learning of interculturally competent care.

Methods This qualitative study utilised semi-structured focus group discussions with Year 1 and 2 medical students from ICSM. A total of 13 students took part. The questions focused on students’ perceptions of the content of teaching, preferred teaching methods, and students’ motivation for developing ICC. The transcribed anonymised focus group discussions then underwent thematic analysis.

Results Analysis revealed two key themes in teaching ICC: the teaching content and making teaching authentic. Students recognised that they have learned about the needs of patients from diverse backgrounds in topics such as dermatology and LGBTQ+ healthcare. However, if epidemiological data is used, it must be contextualised to avoid generalisation. The learning methods preferred include small group teaching and hearing patient voices throughout teaching. Clinical placements were noted to be the setting in which students learned most about the impact of interculturally competent care. Students would also appreciate teaching on understanding unconscious biases and advocating for patients in their position. The motivation for developing ICC stems from its relevance to clinical practice, through examples and the potential for assessment on the subject.

Conclusion Overall, students felt that ICC teaching should be embedded throughout the core curriculum and that the clinical relevance should be highlighted. Additionally, current learning and assessment material should be reviewed, and ICC teaching should be facilitated by specifically trained tutors. This study reinforces the importance of introducing ICC teaching early in medical training and provides suggestions for improvement to further refine ICC-focused learning resources for undergraduate students.

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Abbreviations

ICC	Intercultural Competence
GMC	General Medical Council
ICSM	Imperial College School of Medicine
LGBTQ+	Lesbian, Gay, Bisexual, Transgender and Queer+
MSC	Medical Schools Council
AS	Adele Schiff
OM	Oliver Mercer
AB	Ana Baptista
NR	Noreen Ryan
OSCE	Objective Structured Clinical Examination
MLA	Medical Licensing Assessment

Introduction

Throughout medical school, students are taught to provide person-centred care. Therefore, medical students should be equipped with the skills to provide inclusive care tailored to patients from across society. The way these topics are taught and learnt by students is paramount in determining institutions' success in promoting the development of compassionate and interculturally competent doctors.

Person-centred care focuses on addressing individual needs and values whilst providing respectful and responsive care with a multidisciplinary approach [6, 7]. Within person-centred care, the focus has shifted from addressing only patients' healthcare needs and their disease to also considering and addressing their emotional and physical needs [8]. This encourages shared decision-making regarding interventions and management with healthcare professionals, with the ultimate aim of improving healthcare outcomes. This approach also aids communication and counters historical medical paternalism [9]. Intercultural competency (ICC) is an important part of person-centred care. The Purnell Model views cultural competence as a multifaceted entity which is more than just acknowledging individuals' characteristics of diversity such as race, ethnicity, age, gender, sexuality, spirituality, physical abilities, education, and socio-economic status. At the centre of the model is the person surrounded by their family, community, and global society. There are numerous cultural domains which provide a viewpoint to understand and assess an individual's cultural identity and needs [10]. More recently, the language has shifted towards providing interculturally competent care. Although they are similar concepts, ICC focuses on the ability to navigate and adapt care to each individual and to be aware of one's own assumptions rather than just having the knowledge of specific cultures. ICC encourages reflection and constant dynamic learning to collaborate and communicate with patients [1–4]. The General Medical Council (GMC) advises that UK medical schools '*should provide students with an understanding of how to provide effective treatment to a diverse, twenty-first century population*' [5]. Imperial College School of Medicine (ICSM) is based in London, one of the most multicultural cities in the world, and as a result, students encounter patients from a broad range of backgrounds whose understanding and experiences of health and illness may differ from their own.

The Equality Act 2010 defines protected characteristics as: age, gender reassignment, being married or in a civil partnership, being pregnant or on maternity leave, disability, race including colour, nationality, ethnic or national origin, religion or belief, sex and sexual orientation [11]. Students are not expected to be experts in the experiences of every patient, nor be experts in how these experiences may influence how a patient engages with healthcare and perceives disease. However, it is imperative that these future clinicians develop their skills in ICC to be able to provide inclusive care for every patient. The GMC guidance focuses on discouraging discrimination and promoting equality within the curriculum [5]. However, individual medical schools are left to implement this themselves [12]. The Medical Schools Council (MSC) advises a diverse curriculum at undergraduate level

and suggests that this could be achieved by partnering with a range of students as co-creators, having a dedicated diversity lead for the curriculum and to embed this teaching across the curriculum, not just in a single module [13]. Medical student awareness, knowledge, skills, and attitude towards providing inclusive and person-centred care can be a challenging topic to assess, however, it is paramount, as learning good practices does not only impact patient outcomes, but also on burnout among doctors [14].

Context

ICSM runs a six-year medical degree that includes an intercalated Bachelor of Science degree in the fourth year. Most students join the programme directly or shortly after completing secondary school. In Year 1, students have several sessions based in primary care and a 2-week hospital placement, where they learn in a hospital with clinical teams. In Year 2, students similarly have several GP sessions and two 2-week hospital placements. Most clinical training takes place during Years 3, 5, and 6 through placements. In Years 1 and 2, the curriculum focuses on integrating science, clinical knowledge, and skills, whilst building the foundation for the values and behaviours required of doctors.

This study was conducted following two of the authors creating an interactive, guided online learning session within the Professional Values and Behaviours domain of the Year 2 medical curriculum. The session, co-designed with students, aimed to prepare medical students to be able to appreciate the lived experiences of patients from diverse backgrounds and to foster an understanding and respect for diversity in all aspects of professional practice. The session specifically addressed key dimensions of identity, including sex and gender, age, sexual orientation, disability, race, and ethnicity. Each section explored the forms of discrimination these groups may face, both as patients and within the healthcare workforce. It provided guidance, resources, and further reading on how to support and advocate for these groups and encouraged students to reflect on the stories shared and their own experiences and thoughts in this area.

Whilst this session was being developed, the authors discussed whether exploring how ICC was taught and perceived at ICSM would be useful to investigate. As a result, this study involving focus groups was created. The focus groups were conducted after the online learning was available to Year 2 students; however, not all students had completed it. The Year 1 participants had not had this specific guided online learning but would have had teaching and learning designed to promote interculturally competent care throughout their course. Year 1 and Year 2 were chosen as a cohort, as the interculturally competent care teaching is organised throughout these two years in the Professional Values and Behaviours course, when teaching is mainly delivered in the classroom. This cohort was also selected, as student teaching is mainly placement based in the later years.

Aim

We aimed to evaluate how early year undergraduate medical students currently perceive their learning of intercultural competence and how this could be improved moving forward in its design and delivery throughout the course.

Methods

Phenomenology aims to explore the lived experience of those having experienced the phenomena; current medical students have greater ‘lived experience’ of learning about this topic at medical school at this moment in time. In line with a constructivist approach, we used focus groups of students from Years 1 and 2 to elicit shared and common knowledge [15]. This cohort was chosen as it is at this point within the curriculum where the centralised learning activities described above were delivered. In addition, Faculty wished to ensure these concepts were introduced to students early as a foundation for their future clinical placements and medical practice.

Ethical approval

Ethical approval was granted by Imperial College London's Education Ethics Committee (EERP2324-023a).

Clinical trial number: not applicable.

For the qualitative component, the Consolidated Criteria for Reporting Qualitative Research (COREQ) 32-item checklist was followed (Appendix 1).

Recruitment

All Year 1 and Year 2 medical students at ICSM were invited to participate in this research study from February 2024 to May 2024. There were no other inclusion or exclusion criteria. Participation was voluntary, and recruitment took place on a first-come, first-served basis. Participants were recruited through lecture shout-outs and displayed posters. Students who registered their interest were sent a Participant Information Sheet and had the opportunity to ask questions. Informed consent to participate was required for all participants, and all completed a written consent form prior to the focus group.

Positionality

AS was a female medical student at ICSM at the time of this study. She co-developed the online learning activity for Year 2 with OM. OM is a resident doctor and an associate clinical teacher at ICSM. He has previously been involved in teaching and assessment in this curriculum domain. AB is an experienced medical education researcher, particularly using a wide range of qualitative methodologies. She is not involved in course organisation or assessment. NR is Domain Lead for Quality Healthcare, which forms part of the Professional Values and Behaviours Domain at ICSM.

Focus groups

Focus groups were conducted using a semi-structured topic guide to maintain consistency across sessions. The guide was developed by AB and AS (Appendix 2). AS was a medical student at ICSM, which helped ensure that the study design, topic guide, and discussions were relevant and appropriate to the student experience. Each session lasted 60–90 min and was hosted online using Microsoft Teams to ensure all participants could access the focus groups, and Microsoft Teams offered a secure store to record the discussion. At the start of each session, the aims of the session and goals of the research were explained to the participants. To prevent perceived coercion, students were explicitly reassured that participation was entirely voluntary and would have no bearing on their academic standing, course progression, or relationships with faculty. Only the participants and researchers were present, and there were no repeat focus groups. The sessions included probing questions about diversity related teaching within their medical training. Facilitated by AS, the focus groups fostered a peer-led, open environment that encouraged participants to share their perspectives freely, helping to minimise power dynamics and create a safe space for discussion [16, 17]. The focus group transcripts were recorded and transcribed, then anonymised.

Data analysis

An inductive approach to thematic analysis was followed using Braun and Clarke's six stages of thematic analysis [18]. Two researchers (AS and AB) familiarised themselves with the anonymised verbatim transcripts, formulating codes and organising them into themes derived from the data, which were iteratively described and reviewed. AS and AB refined the themes and subthemes prompted by a careful analysis of the dataset together. This process stimulated reflexive conversations and matured the interpretation that will be presented in the next section. As a medical student, AS brought insight into the student experience, which informed the interpretation of the focus

group findings. AB contributed an experienced qualitative research perspective to the development and refinement of the thematic analysis and interpretation of the results. Throughout the research process and discussions, AS engaged in a reflexive practice throughout, and all themes and assumptions were thoroughly discussed to minimise any personal influence AS, as a medical student, may have had in the analysis.

Due to the nature of their respective roles – AS as a student and AB as a qualitative educational researcher, iterative and critical discussions regarding the themes, descriptions, and evidence were held. This allowed for a clear organisation of the dataset and interpretation. Finally, data saturation was reached when participant responses supported each other, becoming somewhat repetitive, with no new concepts, insights or experiences introduced by the end of the focus groups presented in this study.

As teaching faculty, OM and NR were not involved in the data collection or iterative analysis. However, they added their external views to the thematic analysis process by validating the coding process, specifically in relation to the themes and subthemes explored below.

Results

Four focus groups were held with a total of 13 students. Three Year 1 students (S7, S8, S13) and ten Year 2 students took part in the discussions. Analysis identified two major themes of teaching content and assessment, and making teaching authentic.

Teaching content and assessment

Participants were asked when teaching surrounding protected characteristics was included in their medical school education so far. Most students expressed that throughout the course, they were taught about how certain ethnic groups, genders and patient populations had higher disease prevalence. Although they also noted how focusing on this can lead to generalisations or stereotyping; *'assumptions are dangerous, and I don't think as much emphasis should be put on these epidemiological statistics'* (S10). Students voiced that if epidemiological data is used it should be explicitly highlighted that this is not a guaranteed aspect, or a *'hard and fast rule'* (S10).

The teaching of dermatology was commonly referenced. All participants noted that it was positive that a wide range of skin photo-types were shown in teaching resources. However, participants reflected that this should be the standard; *'It's a bit sad that it's almost praised,[it] should be a given from the get-go... that's just the bare minimum.'* (S10).

It was also suggested that this could be improved by providing comparisons between skin phototypes for the same condition: *'there's no comparison between the same type of rash or the same type of condition between different skin colours.'* (S4). Additionally, students in one focus group brought up that *'a lot of the literature surrounding dermatology in med school or in general, it's mainly tailored to certain demographics, like mainly white skin...'* (S7). Students felt they needed further context to this rather than just photographs to highlight potential clinical implications. This was powerfully highlighted: *'I said...how would that [glass test for meningitis] work on a black child whose skin doesn't blanch... They said we don't know. And to me... that's a problem.'* (S12).

Students recalled that transgender healthcare had been mentioned within endocrinology teaching: *'one of them [the lectures] right at the end, like the last slide, had loads of definitions..like cisgender'* (S9). This was met with mixed opinions by participants. For example, one student voiced *'I think that was really nice that they included that at the end, because I feel it tied into what we were learning as well, so, it felt relevant that they included that'* (S10). However, some felt this was tokenistic: *'So not having it be 2 slides at the end of a lecture about different gender identities. I feel if it's going to be brought up, it has to be treated as if it's important to get us to remember, but right now, sometimes it just feels like a side thought'* (S4).

Students proposed that it could be more embedded in teaching: *'I think it should be integrated a bit more into our curriculum rather than here are two slides'* (S12). Additionally, students suggested the importance of

acknowledging that sex and gender are different, exemplified through the use of inclusive language: *'instead of saying pregnant women, we can say pregnant people because there's an awareness that some people who don't identify as women can also be pregnant'* (S3).

Students also noted that, in other parts of the curriculum such as in simulated patient interviews, the patient had a same sex partner, however this was not the focus of the case, thus normalising Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ+) patients; *'it's come up a few times that I can remember in communication skills and just not assuming that the person you're talking to is in a heterosexual relationship like using partner instead of boyfriend, girlfriend, wife'* (S4).

Another area recalled by the students was teaching on how different religions approach life after death. This was praised by all focus groups. As well as the taught session, additional reading materials were provided; however, some students voiced, *'it's hard to know what you need to know'* (S1). Students reflected, *'there's only so much you can learn within one year'* (S11).

All focus groups discussed that in some dedicated teaching sessions on intercultural competency, there was poor attendance and engagement. They stated this was because sometimes students were unable to see the importance of this teaching, and to increase attendance, ***'it needs to be embedded into assessable things'*** (S12). Moreover, students felt that the current assessment methods for their professional values and behaviour sessions did not require engaging with the teaching; *'the [exam] questions that they asked were just common knowledge and you could have answered them without going to any of the sessions'* (S10).

Students had a variety of ideas regarding how best to be assessed for topics relating to intercultural competent care. Some suggested adding another assessment examining ethical situations and fact recall, such as definitions, so that there is *'examinable content about it'* and *'even if it's a short exam, has to be something else to pass'* (S13). Others suggested a more interview-style examination, potentially within OSCEs, as you can *'show [your] emotions and the interviewer can actually see you [are] caring as opposed to just regurgitating some sort of set answers'* (S1). Simpler changes, such as normalising that patients having certain protected characteristics in question stems was suggested as a simple yet efficient change.

Making teaching authentic

Authentic examples and experiences from clinical placements emerged as two key subthemes.

Authenticity

Participants spoke about a particular session in which the importance of language was highlighted to them. The session involved service users, including patients, families, and carers, speaking to students about the importance of language in the care of patients with diabetes. It highlighted the importance of person first language; *'I think lived experiences are much more valuable to me than hearing it from someone who hasn't experienced that'* (S12). This session also helped students retain knowledge; *'I feel when you have someone come in and actually speak to you about it, it has more of a lasting impact than if you were to just passively read it, like on the end of a slide for example'* (S10).

Using real examples and case-based learning was also thought to be an effective way to teach person-centred care. Students voiced that having case-based teaching on how dismissal or biases because of gender or any protected characteristics could affect patient care was paramount: *'if we had a case where we can see how biases in medicine can lead to actual delays in patient care and worse quality of care, and we had an actual discussion around that'* (S3).

Moreover, students emphasised the importance of ensuring that teaching was meaningful and relevant, rather than perceived as *'virtue signalling'* (S12) or tokenistic. They suggested that for students to engage more in teaching, they needed to know the clinical relevance and its impact on their later lives as clinicians; *'Nicer if more understanding of this is important because this actually impacts different people'* (S3).

Students emphasised how some of their peers were not aware of the impact of discrimination in healthcare. There is a *'lack of exposure'* (S9), maybe because they have never experienced it, and so using examples showing the detrimental impact discrimination can have on patient care is crucial; *'showing its importance rather than telling us it's important'* (S9).

Small group teaching that facilitated discussions surrounding these topics was unanimously preferred to lectures or learning from written text; In *'tutorials you feel more inclined to come to it because you feel your work is part of a team'* (S7). Especially having a tutor present to encourage discussion and creating a safe and constructive space was particularly relevant; *'Having that kind of [open] environment where we can have these discussions'* (S3).

Experiences on clinical placements

At this stage of the curriculum, participants had minimal clinical experience, yet all commented that it was placements that provided the best opportunity to see the importance of respecting patients' beliefs and identities. As one student said, *'When you see it on the wards, and you see the clinical relevance and why it's important to our future job. It is so much easier to retain because you don't feel you're learning it because you have to, you're learning it because you want to provide the best care'* (S2).

However, not all their experiences were felt to be good practice. One student reflected on the care of a trans woman who was being cared for on a male ward, and the clinical team were not using the patient's preferred pronouns. The student could see that the patient felt uncomfortable. However, the student felt unable to intervene due to the hierarchy within the clinical team: *'the fact that you feel that there's sort of a hierarchy that you'd have to sort of fall under, and you can't always point out everything'* (S8). Following this discussion, and sharing of similar experiences in other focus groups, students often commented that they wanted more teaching about acting as an advocate for patients.

Discussion

In this study, key themes within the topics and teaching towards building intercultural competency in early year medical students were demonstrated. These were explored and contextualised throughout the discussions and analysed using reflexive practices.

This study reinforces that ICC is not developed solely through the transmission of knowledge; rather, it develops through interactions with peers, educators, patients, and the wider sociocultural environment. Revisiting our approach from a constructivist perspective, students actively constructed their understanding of culturally responsive practice by reflecting on these experiences, drawing on their prior beliefs, values, and identities. A phenomenological orientation complements this perspective by focusing on students' lived experiences and the meanings they attribute to encounters that shape their ICC learning. This approach acknowledges that there is no single objective account of how intercultural competence is learned or applied; instead, multiple realities exist, each influenced by individual experiences and contexts. By exploring these diverse perspectives through qualitative inquiry, this study generated insights that can inform curriculum development.

Despite the introduction of the national Medical Licensing Assessment (MLA), there is no set list of topics medical schools must cover to help students develop their skills in intercultural competency or person-centred care [19]. However, legally, through the Equality Act 2010 and Public Sector Quality Duty, medical schools are required to work towards eliminating discrimination, advancing equality of opportunity, and fostering good relations between people with protected characteristics [13, 20].

The most prominent themes regarding teaching content centred on dermatology across different skin phototypes and LGBTQ+ health. Students stressed that, for dermatology teaching, it should be a requirement that all educators use a range of skin phototypes and compare and highlight the impact of misdiagnoses. There has been

a move to emphasise the importance of dermatology teaching within the undergraduate curriculum across the UK through the GMC and new MLA examinations [21]. Additionally, learning outcomes suggested by the British Association of Dermatologists Undergraduate Curriculum Update of 2021 explicitly included the expectation of graduates to recognise skin disease in different skin types than their own [22]. This is a pertinent issue, especially as people of colour with malignant melanoma are more likely to be diagnosed later, with advanced disease, which leads to poorer outcomes [23]. Dedicated teaching sessions, the inclusion of diverse clinical images within lectures, and online image banks for independent review have all been suggested by medical students in the literature [24, 25]. These recommendations were echoed by the experiences and perspectives shared by participants in our focus groups.

LGBTQ+ people have disproportionately worse health outcomes and experiences of healthcare. The 2017 National LGBTQ+ survey found that 16% of respondents had a negative experience because of their sexual orientation and 38% due to their gender identity [26]. Nationally, there is significant variability in the teaching medical schools provide on these issues, with a lack of space within the curriculum as a universally reported barrier to the implementation of LGBTQ+ teaching [27]. A 2022 survey found that 36% of medical students reported no dedicated teaching on LGBTQ+ health issues and 88% reported no dedicated LGBTQ+ communication training [28]. Students in our study appreciated the inclusion of LGBTQ+ patients within their communication skills training; however, they would appreciate more integration and highlighting of gender terms, as well as health issues facing these patients, to create a more interculturally competent cohort.

The importance of diversity in teaching extends beyond supporting interculturally competent care, but a lack of diversity can also lead to students feeling excluded and not represented in their own educational experience [29]. A proposed step towards normalising diversity is by embedding it into cases, or question stems, without it being the focus [30]. The impact of ICC on patient care and safety was also brought up by students talking about their experience, namely noticing rashes on a range of skin types. Students were not directly asked about the impact on patient safety within the focus groups; however, this could be explored further in future studies. Nonetheless, the experiences shared resonated with the other focus group attendees and authors, highlighting how much more impactful using real, clinically relevant examples is in the teaching of ICC.

The literature highlights that dedicated teaching sessions addressing topics such as implicit bias, health disparities, advocacy, and the needs of diverse populations have been widely explored. A range of teaching and learning methods—such as simulation, small group discussions, lectures, reflective exercises, case-based learning, assigned readings, and multimedia resources—have been employed. Most studies report that the use of varied, mixed teaching strategies enhances learner engagement and provides a richer educational experience [31]. Students within the focus groups expressed a clear preference for small group sessions with a focus on communication skills in dedicated teaching sessions. Additionally, they particularly value learning activities that incorporate patient perspectives and voice, which align with GMC recommendations [5].

When teaching on cultural diversity is woven throughout the curriculum, medical students' knowledge, and preparedness to provide care to culturally diverse patients improve progressively over the years of the curriculum [32, 33]. However, achieving more seamless and integrated teaching often depends on course leaders' expertise in the subject [34]. Moreover, as highlighted in the focus groups, meaningful engagement with these sessions often depends on students recognising the relevance to future clinical practice or understanding that the content may be assessed.

It was clear that students felt they learnt a great deal through their clinical placements, beyond the learning provided by dedicated, centralised teaching sessions. However, the literature recognises barriers to discussing diversity related issues in clinical settings, such as the hierarchical relationship between student and teacher, which was also highlighted in the focus groups, alongside the need to use inclusive language [29]. Interestingly, the stories shared about patient experiences highlighted a desire among medical students for more practical training on how to effectively advocate for patients during their clinical education. Teaching surrounding unconscious biases and challenging potential prejudices on placement was also felt to be needed and is supported by previous studies [32, 35]. Students can find this challenging, as bias-awareness teaching as well as active bystander teaching is easier

in the protected setting of their centralised teaching sessions compared to clinical settings. These can improve knowledge, but behaviours may not be impacted [36]. This can be due to the hierarchical positions, contradictory examples in the hidden curriculum, and lack of longevity and practice scenarios in this teaching [37–39]. In the absence of dedicated teaching sessions, students' learning may become largely experiential, relying on chance exposure [40]. The Medical Schools Council recommends that assessors receive specific equality, diversity, and inclusion training and that staff involved in the educational supervision of medical students during placement are equipped to support students who experience or witness discrimination [13].

This study contributes to the growing body of evidence suggesting that experiential learning, through patient interaction and diverse teaching modalities, is preferred by students over traditional didactic methods such as large-group lectures. Notably, this cohort consisted of students at the start of their medical training and future clinical careers and already had nuanced and complex views of intercultural competence and its impact. Throughout the discussion, students were able to be active interpreters of their own experiences and explore these in more depth. Thus, these focus group findings reinforce the importance of introducing intercultural competency early in medical training, even before extensive clinical exposure. Intercultural competence can be nurtured longitudinally, beginning with focused teaching on cultural awareness and communication skills in the first year, and becoming increasingly integrated into clinical practice as students advance [33].

Limitations

Given the self-selected, voluntary participation in this study, participants may have been more interested or motivated in learning about intercultural competence and thus engaged in teaching materials more than other students. It would be valuable to gain insights from a wider cohort of students and to explore the barriers to engagement.

Additionally, there was paid participation in this study. This was used to help increase recruitment among a student population who would be giving up their otherwise free time. As a result, the population of participants may have been those more motivated by compensation than reflection; however, based on previous studies asking students to participate, this was deemed the most efficient way to recruit.

All the participants were also from a single institution and in only two year groups. This meant students could only comment on the teaching received from a particular medical school, and views expressed were all from a shared contextual experience. As is the nature of qualitative research, this reduces applicability to other institutions, and future work could be conducted to explore this across institutions. Moreover, further research asking the same cohort of students at the end of their medical school journey would demonstrate whether there was further teaching on these topics later in the curriculum and whether that was appropriately adapted to when students have more clinical experience.

Additionally, demographic data of the participants was not collected due to ethical approval. The absence of demographic data does limit the transferability and context of the data reported. Moreover, the ability to explore within-group variation and exploring how personal experiences relate to views on teaching content would have been interesting to stratify.

However, participants also knew their demographic data was not collected, which could have helped foster a greater sense of privacy and trust. Students may have been more honest and open within their discussion as they had anonymity. Additionally, where discussions focused on personal experiences, belonging, and identity, participants did not feel like they would be speaking on behalf of others or categorised based on personal characteristics.

Take-home messages

- **Teaching Content:** It was clear that students felt that interculturally competent teaching should be embedded within their core curriculum, ensuring that its clinical importance was explained. When epidemiological data is used, it should be explained within the social context and emphasised that it should not be used to completely

rule out diagnoses. Current learning material should also be reviewed to avoid overgeneralisation and simplification and to ensure the use of inclusive language. As educators, we need to consider how to assess the topic of intercultural competence, so it is meaningful and promotes student learning.

- **Students as advocates:** Provide teaching for medical students on advocating for patients while working within the constraints of the student role. Identify and systematically update clear directions and instructions for students on whom to raise issues with. Sessions have also been introduced that discuss practical strategies with students on how they might deal with challenging conversations where they face bias or discrimination.
- **Educator training:** Provide training for tutors and clinical staff in intercultural competence and inclusive practice to foster a safe learning environment and enable effective support for students during clinical placements.
- **Patient Voice:** Students value sessions involving patient voice, either in the form of case-based discussions, communication skills sessions, or sessions with expert patients and service users to develop their skills in providing person-centred care. In addition, use patient voices in teaching and developing learning materials.

Conclusion

Early year medical students are inundated with teaching, from foundational sciences to communication skills, and early clinical placements. Finding the time and space in the curriculum to effectively teach and engage students in learning about ICC can be challenging. However, ICC is a vital part of the curriculum and plays an important role in helping future doctors develop into compassionate and safe clinicians.

This study has identified how early year medical students with limited clinical experience are currently developing their ICC, as well as providing suggestions for improvement. In line with a constructivist approach, the results show the complexity of teaching ICC, and the findings are a co-construction of perspectives of students and researchers and their contextual interpretation. This study provides a more detailed exploration of student perceptions rather than categorisation. However, future research could focus on gaining data throughout medical school years; different medical schools and a longitudinal study approach could be used to assess particular interventions. Nevertheless, these findings contribute to the growing body of work towards developing and refining interculturally competent-focused learning resources for undergraduate early year medical students.

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Data availability The data generated and/or analysed during the current study are available from the corresponding author on reasonable request.

Declarations

Ethics approval and consent to participate Ethical approval was granted by Imperial College London's Faculty of Medicine Medical Education Ethics Committee (EERP2324-023a).

Informed consent to participate was obtained for all participants in the study. This study adhered to the Declaration of Helsinki.

Consent for publication As part of the informed consent process, all participants agreed to the publication of anonymised responses.

Competing interests The authors declare no competing interests.

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Authors and Affiliations

Adele Schiff¹ · Oliver Mercer^{1,2} · Noreen Ryan¹ · Ana Baptista¹

✉ Oliver Mercer
o.mercer@imperial.ac.uk

¹ Faculty of Medicine, Imperial College London, London, UK

² Barts Health NHS Trust, London, UK