SPECIAL THEME RESEARCH REPORT

Teaching Social and Cultural Awareness to Medical Students: "It's All Very Nice to Talk about It in Theory, But Ultimately It Makes No Difference"

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ABSTRACT

Purpose. To investigate the effect of exposure to a new course addressing social and cultural issues in medicine on third-year medical students' awareness and understanding of how these issues affect their lives as students, the lives of patients, the work of physicians, and patient-physician interaction. The course, Physicians, Patients & Society (PPS) was introduced at the time the school was moving to a PBL curriculum.

Method. In the late 1990s, a questionnaire was administered to third-year medical students at one Canadian medical school, prior to the curriculum change (Time 1). In-depth interviews were held with 25 of these students. A few years later, the same methods were repeated (Time 2) with a third-year class that had experienced the PPS course.

Results. The response rate for Time 1 was 59% ($n = 72$), for Time 2, 51% ($n = 61$). Students in Time 2 did not demonstrate increased awareness of social and cultural issues. Most failed to recognize, or even denied, the effects of race, class, gender, culture, and sexual orientation. Those who acknowledged the effect of social differences tended to deny social inequality, or at best recognized disadvantages experienced by Others, but not the accompanying privileges enjoyed by their own social group.

Conclusions. In general, students concluded that learning about social and cultural issues made little or no difference when they did their clinical rotations. For a medical school to produce physicians who are sensitive to and competent working with diverse communities requires a balance between attention to "difference," attention to self, and attention to power relations.

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In recent years there have been calls for greater social responsiveness in medical education in Canada, the United States, and the United Kingdom.[1–3] Educators have stressed the need for thorough training in the social determinants of health, as well as emphasis on student attitudes appropriate to "future responsibilities to patients, colleagues and society in general."[4,p.S54] Medical schools enter into an implicit social contract with policymakers, patients, and the general public through their receipt of public funding.[5–7] They have an obligation to produce physicians who are capable of meeting public interests and of addressing broad social issues relating to health and well-being.

Ayers and colleagues[5] argued the social responsibilities of medical schools include improvements in the quality, equity, relevance, and cost–effectiveness of health care and health status. Improving equity in health care and health status has often been interpreted as meaning some degree of community involvement by the school, its faculty, and its students through research, outreach clinics, rural placement programs, and community development programs.[4,7,8] Yet it has been argued that simply placing students in community settings is not sufficient and does not necessarily build social accountability.[9] There must be accompanying efforts in the curriculum to help students learn to listen deeply, to examine their own beliefs and biases honestly, to practice skills for critical self-awareness, to develop understanding of the ways their own values and attitudes affect their care of patients, and to take into

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account social and cultural differences without judgement.[10]

This paper assesses the efforts of one Canadian medical school to produce more socially responsive physicians. In the late 1990s, I conducted research with third-year medical students, exploring their experiences of medical school, professional identity formation, social values, and attitudes in the context of a socially and culturally diverse student body.* Shortly after that study was completed, the school introduced a new curriculum; part of the rationale was to produce medical practitioners who would be more responsive to the needs of community and society. One new course, "Physicians, Patients & Society" (a pseudonym), was expressly intended to "develop physicians who are competent and sensitive to the ethnic, cultural and gender diversity of the community."[11,p.2] Among its goals were developing student skills, abilities, and attitudes to address critical issues in the doctor–patient relationship, including cross-cultural health care, and meeting the needs of diverse patient populations.

"Physicians, Patients & Society" (PPS) was a longitudinal course during the first and second years of the undergraduate curriculum. Students met in groups of eight with a tutor one afternoon each week. Sometimes all groups met together in large plenary sessions for a lecture, or guest speakers, then went to tutorials for discussion; occasionally, content experts joined the tutorial groups. The course covered anthropology and sociology of medicine (five weeks), sexual medicine (five weeks), complementary and alternative medicine (three to five weeks), population health and health promotion (six to nine weeks), domestic violence (two weeks), mental health (two weeks), addiction medicine (five to eight weeks), health care and epidemiology (15–17 weeks), and health policy, health care ethics, and law (12–13 weeks). The total numbers of weeks for individual themes were still changing during the first few years of the curriculum. Each theme was coordinated by an expert from that field. Regular tutors included family physicians, clinical faculty members, basic science faculty members, nurses, sociologists, anthropologists, and others. Students were evaluated on attendance and participation, exam scores (OSCE and triple-jump), and written assignments and presentations that required them to engage with health care and health concerns outside hospitals and private practice settings—in child care centers, schools, needle exchanges, addiction treatment centers, sexual health clinics, and so on.

I repeated the research I had conducted earlier with one of the first classes to go through the new curriculum, assessing students' social values, attitudes, and awareness. The new study sought to investigate the effect of exposure to a course addressing social issues in medicine on students' awareness and understanding of the ways cultural difference, socioeconomic status, gender, sexual orientation, racialization, and other social differences affect their lives as students, the lives of patients, the work of physicians, and the patient–physician interaction. (I use the term racialization to stress that "race" is not a biological reality but rather a social process of ascribing meaning—usually inferiority and superiority—to physical differences.) Although the research was not hypothesis-testing, I brought to the research an assumption that, compared with previous students, students under the new curriculum would be better able to see how social factors affected them as students, as future physicians, and as people.

METHOD

Before the curriculum change (Time 1), I administered a questionnaire to an entire third-year class and held in-depth interviews with 25 of those students. Three years later, I repeated the same methods with a third-year class that had experienced the new PPS course (Time 2). The two questionnaires were almost the same; at Time 2, I dropped a few questions, and added a few specifically about the new curriculum. Both questionnaires had open-ended and closed-ended questions assessing the extent to which students felt they fit in at medical school, the extent to which they identified as future physicians, perceived conflicts between their emergent professional identity and other aspects of self, what they had "put on hold" during medical school, and the extent to which they believed social group membership affected the experiences of medical students, the practice of physicians, and the experiences of patients. The questionnaire was administered through student mailboxes with a follow-up notice, a second questionnaire package, and a final reminder.

Interview participants were recruited through a request in the questionnaire as well as through snowball sampling, where participants were asked to suggest classmates whose views might be very unlike their own; participants who agreed to be interviewed returned a postcard separately from their completed questionnaires. Interviews occurred as students were finishing their third year. Most were held in students' homes, a few in hospital cafeterias, parks, or coffee shops. They took 60–90 minutes, following a semistructured interview guide focused on students' experiences of medical school; how they had come to feel they belonged in medical school; how they thought

*I am carefully not identifying the school where the research took place; this was a condition of access to conduct the study. Similarly, if I state the exact years of the research, Canadian readers will know precisely which institution is being examined.

their experiences were shaped by race, class, gender, and so on; and, at Time 2, their views about the curriculum and the PPS course. The interviews were tape-recorded with the students' consent, transcribed verbatim, and coded inductively. The research was approved by the university Behavioural Sciences Research Ethics Board.

In this paper, I report questionnaire results using descriptive statistics. Patterns and trends in the data are described mainly to set a context within which to understand the qualitative data. Comparisons between results of the first questionnaire at Time 1 and the second questionnaire at Time 2 are presented as chi-square and *t*-test results. The chi-square results indicated whether distribution on a particular variable was affected by the year of the questionnaire (thus, by exposure to the PPS course); *t*-test results indicated whether any difference in means between Time 1 and Time 2 was significant. The qualitative data allowed me to gain insight from the experiences of the medical students as described in their own words.

RESULTS

Participants

The response rate for Time 1 was 59% ($n = 72$); for Time 2, 51% ($n = 61$). In both Time 1 and Time 2, participants were highly heterogeneous, reflecting the overall student population (see Table 1). Since the 1980s, approximately half of the students at this medical school have been female, and about 30% have been from "visible minority" groups.

Perceptions of Social Neutrality

Time 1 concluded that medical training under the previous curriculum taught students to see medical practitioners as neutral in terms of their social characteristics.[12] Students and faculty members believed it was desirable to be color-blind, gender-blind, class-blind, and so on. Interviewees argued that it did not and should not matter whether the physician was male or female, or what his or her cultural background, sexual orientation, or social class background was. On the questionnaire, students indicated that they believed social factors had little or no effect on their experiences as medical students, nor on the ways physicians practice medicine. While they were slightly more cognizant that the social characteristics of *patients* could affect doctor–

Table 1

Characteristics of Third-year Medical Students Who Did Not Participate in the Course "Physicians, Patients & Society" (Time 1) and Characteristics of Those Who did Participate (Time 2), One Canadian Medical School

Characteristic	Time 1 Questionnaire Participants ($n = 72$)	Time 2 Questionnaire Participants ($n = 61$)	Time 1 Interview Participants ($n = 25$)	Time 2 Interview Participants ($n = 25$)
Gender				
Female	36 (50%)	32 (53%)	14 (56%)	14 (56%)
Male	36 (50%)	29 (47%)	11 (44%)	11 (44%)
Age				
Mean	27 years	28 years	28 years	27 years
Range	24–40 years	25–39 years	23–40 years	23–38 years
Race/ethnicity*				
Euro-Canadian	38 (53%)	37 (61%)	18 (72%)	17 (68%)
Asian	15 (21%)	14 (23%)	6 (24%)	6 (24%)
South Asian	6 (8%)	4 (6%)	0	1 (4%)
Jewish	2 (3%)	1 (2%)	1 (4%)	0
Aboriginal	1 (1%)	0	0	0
African/Caribbean	0	1 (2%)	0	1 (4%)
Not given	10 (14%)	4 (6%)	0	0
Self-reported social class background				
Upper-/upper-middle	36 (50%)	33 (54%)	14 (56%)	14 (56%)
Lower-middle	23 (32%)	17 (28%)	6 (24%)	8 (32%)
Working/poor	11 (15%)	10 (16%)	5 (20%)	3 (12%)
Other	2 (3%)	1 (2%)	0	0

*Euro-Canadian includes "Canadian," British, Scottish, Irish, American, German, Scandinavian, Polish, Italian, Portuguese, and Oceanic. Asian includes Chinese, Japanese, Korean, Taiwanese, Indonesian, Malaysian. South Asian includes Indian, Punjabi, Pakistani.

patient encounters, the overwhelming message was that medical students and physicians are socially and culturally neutral, largely unaffected by their sex, age, race, class, sexual orientation, and religion. They do their daily work unaffected by their social location.

It might be expected that this belief in social neutrality would be challenged by the PPS course, reducing students' tendencies to say social factors make little or no difference. This expectation was not borne out. Table 2 shows the percentage of students in each survey who saw their own various individual and social factors as having little or no effect on their experiences in medical school. Even among the students who had experienced the PPS course, 43–95% believed social factors (class, parental status, race, culture, religion, gender, and sexual orientation) had had no effect on them. In fact, students at Time 2 were slightly *more* likely to say religion made no difference. The students were more affected by their own social group membership than by exposure to the PPS course. Students who were from racialized or cultural minority groups tended to be more likely to indicate that race or culture had an effect (χ^2 p = .000, t-test p = .484); students who identified as working-class or poor were more likely to say class had an effect (χ^2 p = .05, t-test p = .04); students who said they had a religious affiliation were more likely to say religion makes a difference (χ^2 p = .112, t-test p = .002).

Students' perceptions of the effect on practice of a physician's own social factors were also unaffected by the PPS course (see Table 3). Again, a third or more of the students indicated that social factors make no difference. For more than half of these variables, the proportion saying "no difference" actually *increased* slightly at Time 2, though not significantly. Again religion stands out: For some reason, the students at Time 2 were more likely to say religion has no effect in medical school but were less likely to say a physician's religion makes no difference to how he or she practices. And again, students' social group membership made a bigger difference than did exposure to the PPS course. Students from racialized or cultural minority groups, and students who claimed a religious affiliation, were more likely to say race and culture, or religion, make a difference to a physician's practice (χ^2 p = .015; .028; t-test p = .002; .004).

Finally, students at Time 2 were *less* likely than the previous cohort to think *patients'* social characteristics affect their treatment (see Table 4). Fully 40–85% of these students thought patients' class, race, gender, culture, sexual orientation, religion, and relationship/marital status make no difference to patient care. In all of these categories, the proportion of students indicating "no difference" *increased*, though the difference was significant only for sexual orientation. Again, students' own social group memberships were a better predictor of their beliefs in the effect of social variables than was exposure to PPS.

Qualitative Results

While similar patterns emerged in the analysis of qualitative interviews at Time 1 and Time 2, it is not particularly effective to use the interview data as a measure of change. To say one group was more aware or less aware of

Table 2

Perceptions of Third-year Medical Students of the Effects of Their Own Social and Cultural Factors on Their Medical School Experiences, One Canadian Medical School

Factor	% Who Perceived Effect to be "Neutral" Time 1†	Time 2‡	Item Mean* Time 1	Time 2	Significant Difference Time 1:Time 2
Academic abilities	8.5%	11.5%	5.2	5.1	
Personality	8.7	8.2	5.3	5.4	
Interpersonal skills	9.9	8.2	5.7	5.7	
Skills, talents	18.3	19.7	5.2	4.9	
Social class	52.1	44.3	4.4	4.4	
Parental status	53.5	43.3	4.8	4.3	
Race, culture	74.6	72.1	4.2	4.2	
Religion	71.8	83.6	4.5	4.0	χ^2 p =.03; t-test p =.001
Gender	80.3	59.0	4.2	4.3	
Sexual orientation	94.4	95.0	4.0	4.0	

*1= negative effect, 4 = neutral, 7 = positive effect.

†Time 1 = students who did not participate in the course "Physicians, Patients & Society."

‡Time 2 = students who did participate in the course "Physicians, Patients & Society."

Table 3

Extents to Which Third-year Medical Students Thought Physicians' Social and Cultural Factors Affect Practice, One Canadian Medical School

Factor	% Who Thought "Not At All"		Item Mean*		Significant Difference
	Time 1†	Time 2‡	Time 1	Time 2	Time 1:Time 2
Interpersonal skills	0.0	0.0	4.9	4.8	
Personality	1.4	0.0	4.7	4.6	
Clinical skills	0.0	0.0	4.6	4.4	
Talents, abilities	8.6	14.8	4.0	3.7	
Age	21.1	24.6	3.2	3.2	
Parental status	36.6	40.0	3.0	2.9	
Gender	35.2	32.8	2.9	3.0	
Race, culture	34.3	41.0	2.9	2.9	
Relationship status	50.7	52.5	2.6	2.5	
Social class background	46.5	37.7	2.6	2.9	
Religion or lack of religion	58.5	41.0	2.4	2.8	χ^2 $p = .05$; t-test $p = .02$
Sexual orientation	68.1	75.4	2.0	1.9	

*1= makes no difference at all, 5= makes a great deal of difference.

†Time 1 = students who did not participate in the course "Physicians, Patients & Society."

‡Time 2 = students who did participate in the course "Physicians, Patients & Society."

social issues, based on the content of their interviews, would be misleading. These data cannot assess the extent of social sensitivity, or differences between groups. They can, however, indicate the ways students thought and spoke about social and cultural issues. Here I present analyses of interview data from Time 2 students to illustrate the ways those exposed to the PPS course understood social and cultural diversity.

It's just not an issue. The overwhelming theme in the interviews was that diversity is not an issue in medical school. Gender, race, sexual orientation, culture, and class were all perceived by students as making little or no difference. They suggested these are generational issues or problems restricted to "redneck" places and/or

Table 4

Extents to Which Third-year Medical Students Thought Various Characteristics of Patients Affect Their Treatment, One Canadian Medical School

Characteristic	% Who Thought "Not At All"		Item Mean*		Significant Difference
	Time 1†	Time 2‡	Time 1	Time 2	Time 1:Time 2
Level of compliance	4.2	6.6	4.1	4.0	
Severity of illness	5.6	4.9	4.3	4.3	
Personality	5.6	9.8	4.1	4.0	
Age	12.7	24.6	3.5	3.3	
English ability	27.1	13.3	3.3	3.6	
Appearance	28.2	37.7	3.1	3.0	
Social class background	33.8	39.3	3.0	2.8	
Race	46.5	55.7	2.6	2.3	
Gender	52.1	55.7	2.5	2.3	
Culture	44.3	59.0	2.7	2.3	
Sexual orientation	62.0	82.0	2.2	1.8	χ^2 $p = .13$; t-test $p = .03$
Religion or lack of religion	70.0	85.2	2.0	1.8	
Relationship status	84.5	85.2	1.6	1.6	

*1 = makes no difference at all; 5 = makes a great deal of difference.

†Time 1 = students who did not participate in the course "Physicians, Patients & Society."

‡Time 2 = students who did participate in the course "Physicians, Patients & Society."

the uneducated. The students argued that because the third-year class was racially diverse and gender-balanced, racism and sexism must not be problems. They insisted it would a comfortable place for gay and lesbian students to be "out of the closet," though most believed there were no gay or lesbian students in their class. Similarly, most students were convinced they had no classmates from working class or impoverished family backgrounds, although about 15% of their class self-identified as coming from those backgrounds.

More than simply ignorant of racism or sexism, and oblivious to the diversity in their own class, some students reported that their classmates denied racism when faced with it. One student of African heritage described several experiences she thought were racist. After describing one of the most blatant, which drew on multiple pejorative stereotypes, she noted that many of her classmates didn't "get" it: "I've told some other people and they've been sort of like, 'So, why does that bother you?' And it's like, well, I can't *make* you understand why that feels bad . . . why I found that offensive."

Seeing "difference" without power relations. When students did recognize difference, they tended to talk about it in terms of individual personalities. They saw individual differences—in assertiveness, in comfort with authority, in career preferences—as far more salient than group differences. When they did discuss difference in terms of social groups, they denied structural power relations of dominance and subordination. For example, several students commented that some of the Asian students in their class tended to "segregate themselves," hanging out only with other Asian students. The students described this as a choice by the Asian students, never questioning whether the segregation could be a protective response to racism or marginalization. Similarly, the only African Canadian student experienced denial of the power relations of racism when she named her membership in a subordinated group. When she expressed affinity with a student of African descent in the class entering two years below her, her white friends were very puzzled:

> I was like, "There's a black girl! I'm going to have to meet her and talk to her!" . . .It's not that I don't like white people or that I'd like her automatically because she's black, but it was just a sense of, I don't know, a weird sense of community. . .Hey, let's talk about being in medicine and sharing a similar experience.

In both cases, students from racialized minority groups may have felt connections with other members of their social groups because of their shared experience of subordination relative to the dominant social group. While students were sometimes willing to recognize group differences, they were less willing to recognize social relations of dominance/subordination: power relations.

Similarly, the overwhelming consensus among the students interviewed was that sexual orientation is not an issue because no one need know if you are gay, lesbian, or bisexual. As one student said, "It is nobody else's business." Students suggested gays and lesbians need not "flaunt" their sexuality, any more than heterosexual students do. They showed very little awareness about how often heterosexuals unintentionally and unknowingly publicly express their sexual orientation through rings, casual conversation about evenings or weekends, or who's dating whom. Again, what is being denied here is social power relations.

Culture was also described as an issue of difference, rather than of social relations of power. Virtually all of the students focused on the advantage held by Asian and Indo-Canadian students who speak a second language: "Sometimes I think it's advantageous to be Asian and to speak another language- . . .If you speak Cantonese or Mandarin, you're a hot commodity." The denial of gender as a structured relation of social inequality was evident in the emphasis on family roles as the major gender distinction, as well as in reactions to an annual event called "Women in Medicine Night." Every autumn, the first-year women are invited to an evening where they will hear from alumni talking about being female in a demanding profession. Except the female alumni are actually second-year male students in drag, who eventually strip during their speeches, turning an apparently serious evening into a night of hilarity. The third-year students interviewed could not see how this was in any way offensive or demeaning to women, calling such responses "extremist."

Seeing only disadvantage—"Othering." To the extent that students did see difference as a matter of power relations, they were much more likely to see disadvantage than privilege. Most of the students who spoke about gender differences referred to discrimination faced by male students in obstetrics–gynecology rotations. There was also agreement that women faced unfair treatment, including "heckling" and uncomfortable joking, in surgery and some surgical subspecialties, described as "old boys' clubs." A few students thought their school would not be a safe place for gay or lesbian students to be "out," arguing that while medical school may not be any more homophobic than any other part of society, being "out" on the wards, around senior clinicians, or in residency applications could have serious disadvantages for gay or lesbian students. Gay and lesbian students were seen as disadvantaged.

Similarly, social class differences were understood in terms of disadvantages, as people living in poverty were perceived by some to be treated less well in health care settings. Class dif-

ferences among students were spoken of in terms of disadvantage to students who did not come from wealthy families—not having fancy cars, condominiums near the hospitals, or expensive vacations; facing massive student loan debts; spending their free time during the school year working to earn tuition. Finally, several students pointed out the ways cultural difference systematically disadvantaged students from non-Western backgrounds within their own class. They described Asian students, especially women, being less successful in a problem-based learning curriculum due to their shyness and quietness—ways of being that may be culturally-derived. As one female Asian student said

> We don't show the confidence that they want from us and we don't constantly try to prove ourselves and talk all the time. I guess it is probably to do with background. In the Asian culture...it is okay not to say things if you are an Asian female.

One result of treating difference only as disadvantage may be the construction of a "deficit identity"[13] for those groups depicted as Other, as different from the norm. Some students suggested that even as the PPS course tried to help students see beyond their own circumstances, it sometimes engaged in a process of "Othering," urging students to see "those people" as having problems rather than learning to see themselves as equally affected by their own class, culture, and social background. As one student said

> As for learning other individuals' problems...to some degree it did do that. As for doing kind of introspection and having people define their own [values], I don't know that it really did that. It was more a looking in on other individuals....If they were trying to get us to evaluate our own biases, I don't know that would really have been achieved in that format. It was more a format to look at *others*. Here is the IV drug user in the community. Here is the–

Indeed, several students used the language of "exposure" when talking about the PPS course; they were "exposed" to people who live on the streets, to people with addictions, to people from other cultures, to sex trade workers, and to gay/lesbian/bisexual/transgendered people.

Seeing and not seeing privilege. Very few students were able to identify the advantages, or privileges, enjoyed by students from dominant social groups. The 17 students of European heritage struggled to name the effect of whiteness on their experiences. Most of them agreed, in one way or another, with one student's comments: "It is so easy when you are not the minority to not notice things. So I am not sure." One white male commented on his way being eased by being "kind of what patients expect to see," while another said: "If I already look like a doctor then I might be easing into it and I don't even know it. It might be easy for them to accept me or like me or something." Two students suggested they might find it easier to identify with their residents and attending physicians, the majority of whom were European Canadian.

While most students saw class as purely an issue of money, some did see the less tangible privileges class status can confer, recognizing that class can also affect expectations, aspirations, supports, role models, values, social networks, and so on. A few students recognized these more subtle signs and symbols of class, noting small advantages held by people from upper- or upper-middle-class backgrounds. Two referred to fitting in better at receptions and formal social gatherings. Three talked about being more skilled at chatting up the right people, making connections with people who may help your career later. Some mentioned the importance of being able to chat about golf in the operating room, of bonding with classmates through class activities such as ski trips. Some simply spoke of feeling comfortable around wealth, and around doctors, as the following quote from a female student illustrates

> I think a lot of the people in my class come from wealthy homes, upper middle class. And just in so doing you get used to a lot of social things, like what is socially acceptable. So you can go out to a fancy restaurant with your attending and know what fork to use....You don't know how to interact with people, you're like, "Gosh you're a *doctor*," instead of like all your friends' parents have been doctors...I think it would probably be more uncomfortable.

Inequalities as everyday practices. Some students, on some issues, were able to see social and cultural differences not only as disadvantage, not only as privilege, but as social relations of inequality built into the very norms, values, and everyday practices of the world around them in medicine. A few students discussed social class as a feature of the school itself, arguing that the school and its curriculum may marginalize students from working class or impoverished backgrounds. As one male student noted

> The class that the classroom operates in is upper-middle class. And so behaviors or just attitudes and things that happen to people of lower classes aren't as easily, aren't as comfortable anyway....I can imagine that if someone from one of these other groups came into our classroom that they would really be shocked at certain things.

Two students mentioned a derogatory term widely used by students and faculty members to refer to patients from the "skid-row" area of the city, imagining the discomfort that could cause classmates who came from impoverished families.

Four students discussed gender as a feature of the medical school, a culture or climate in which everyday practices systematically enforce and recreate gender inequalities. They argued that women in medicine are given subtle messages about not quite belonging. One female student described an emergency room where the one female physician was "despised" by all the nurses when she acted just the same as the 19 male physicians: "People really didn't respect her authority." Two women referred to a kind of camaraderie shared among the male clinicians and students that was just missing for female students. One of the women said

> The more subtle things I am not even sure they recognize they are doing it.... They would just be more likely to take the guy aside in surgery and show him something...tell him that he is great. Or they are on call with him and they take him out to dinner, whereas we don't even really talk.... That is just the best way I can describe it. Or subtle comments about their women patients even, I mean I am a woman too. The obvious and blatant ones are easy. The orthopaedic surgeons telling really crass jokes in the OR I think are inappropriate, but those are kind of obvious to pick up. Or the comments that women aren't going to work full time so they are not real doctors—I have had that one probably 20 times. But the subtle things, maybe they are just not comfortable around the women students and so they are more likely to be like that.

This student went on to say, "You sound like you have a chip on your shoulder when you notice it."

"Ultimately it makes no difference." Perhaps most disturbingly, to whatever extent students had or developed awareness of social and cultural issues in medicine, they found there was simply no room for this awareness on the wards. They suggested that although it was interesting and enlightening to learn about other social groups, other cultures, this had little if anything to do with real clinical practice. The pace of practice, the expectations faced by students, did not leave room for such issues. As one student said

> It's all very nice to talk about it in theory, but ultimately it makes no difference when you get to third year because you know, PPS kind of went out the window....You go into Emerg at like 3 AM and you want to get back to sleep, you whip through,...get all the pertinent positives, all the pertinent negatives, do my physical and get out....At three in the morning, my culture, my class, my background, doesn't really make a difference.

The result is that even though students have been exposed to issues of social and cultural difference, the standard of clinical practice is to treat everyone neutrally, objectively, as if they were cultureless, classless, raceless, genderless. In the words of one student, "Most patients, I tend to treat them the same."

Students said repeatedly that there was no time or space for practicing socially and culturally sensitive medicine on the wards; they found the things they learned in PPS irrelevant when faced with the pragmatic considerations of "the real world." They talked about wishing the PPS course could somehow happen in third and fourth years, when they are facing actual situations on the wards, when they are dealing with real clashes in cultural values and class backgrounds with patients, when they have some real life experiences. Learning about social issues in the abstract, before they work much with real people, made the learning less compelling and ultimately less useful than it might have been.

Discussion

Under the old curriculum, students tended to learn that the proper stance of a physician is one of social neutrality—classless, raceless, genderless, cultureless, as well as class-blind, color-blind and so on.[12] The new PPS course was intended to teach students sensitivity to gender differences, cultural diversity, differences in social backgrounds, and how such factors affect well-being, health-seeking behaviors, and physician–patient interactions. The intent was to help students see and understand not only the "Other"—how the lives of people unlike themselves make sense in their own terms—but also how students *too* are affected by assumptions, expectations, experiences, and biases rooted in their cultures and social backgrounds.

In this regard, the PPS course does not appear to have been entirely successful. The questionnaire results show that students who were exposed to this course for two years were not significantly more likely to say social characteristics have an effect on students, physicians, or patients. The questionnaire results can only be suggestive. With a cross-sectional design, there is no way to know whether the two cohorts of students were equivalent when they entered medical school. Although students at Time 2 may have appeared no more socially aware than the earlier cohort, they could have begun medical school with far less awareness. Demographically the two groups were similar. In addition, the questionnaire had not been validated as a measure of change in attitudes or awareness. Nonetheless, the results suggest that an express focus on producing more socially responsive medical school graduates through a two-year longitudinal course did not result in students with significantly different attitudes than those who came before.

The qualitative results are also suggestive rather than definitive. In general, students failed to recognize, or even denied, the effects of race, class, gender, culture, and sexual orientation. In some instances, students recognized

difference but denied power relations, denied social inequality. In other instances, students saw inequality, but only one-sidedly, recognizing disadvantages experienced by Others, but not the accompanying privileges enjoyed by their own social group. A very few students saw how social inequalities and privileges were woven into the everyday practices of daily life.

Some of the PPS course's lack of effect may have had to do with details of the course itself. It seems likely that the course content was not appropriate to developing physicians "competent and sensitive to the ethnic, cultural and gender diversity of the community." During its evolution, the PPS course became a kind of dumping ground for pre-existing courses displaced by curricular change. It became an amalgam of unrelated course material lacking sustained attention to crucial themes of power and powerlessness. The PPS course was not widely respected and supported in all departments; in response, developers tended toward content that would be seen as academically rigorous, rather than anything that might be perceived as subjective or "touchy-feely." Finally, while regular tutors for PPS initially included a wide range of disciplines, eventually only a handful of non-physicians remained. It was cheaper to have faculty members already on salary at the medical school as tutors than to bring in members of other disciplines and professions.

It is impossible to know from my research what details of the course itself could be altered to improve its effectiveness—perhaps more contact hours, more or different reading, different assignments or different exercises in tutorials, perhaps more lectures, or fewer lectures. What does come through clearly is that there is a disjuncture between what students learn in PPS in the preclinical years and what they learn on the wards in the final two clinical years.

The PPS course was not wasted effort, however, even if it was not wholly successful. Some students found safe space for self-reflection. Some learned from exposure to people and issues unfamiliar to them. One described his first encounter with a patient who had been abused by her husband; the skills he drew on to talk with her had come from his PPS tutorial. On a larger scale, the existence of the course legitimized concerns with social and cultural issues. There was tremendous resistance to the course—because it was not "real science" or "real medicine," it competed with anatomy, physiology, pharmacology and was seen as "peripheral"—yet it did provide a space for debate about and engagement with social issues.

Nevertheless, the course did not accomplish everything it intended. It is possible the focus of PPS was too diffuse. One student suggested it was trying to accomplish too many things: cover content and structure; teach concepts, theory and applications; as well as teach students to recognize and work with their own feelings, biases, and assumptions. He suggested both students and tutors tended to focus on "the head stuff," avoiding dealing with attitudes, avoiding reflexivity in favor of safer topics. "Doctors," he claimed, "already do enough head stuff"; what would help them be better physicians is getting in touch with their own biases and finding effective ways to deal with complex emotions.

Dennis Novack and his colleagues argued that healing, the work of helping patients become whole again, requires of the physician humanistic qualities of active listening and genuine communication, facilitated by the physician's own self-awareness: "When they are not brought to the level of consciousness, physicians' personal attitudes, biases, fears, emotional reflexes, psychological defenses, and moods can interfere with their abilities to arrive at an accurate diagnosis, prescribe appropriate treatment, and promote healing."[10,p.517] Medical ideology stresses objectivity, the belief that one's own opinions, feelings, biases, and reactions can and should be put aside; this ideology places the medical practitioner outside the actual encounter with a patient.[14] It leaves students or new graduates without guidance when they find they *do* have feelings, reactions, biases, when they find they are very much situated in the clinical encounter. Curricula intending to help students become more socially aware must also help them become "situated practitioners,"[14] critically aware of their own social location, their own emotions, their own impacts on the situation.

The tendency of students and tutors in the PPS course to focus on content rather than self-awareness may have enhanced a tendency toward "Othering." While students read case studies that depicted how social factors affect patients, they did not examine how social characteristics affect physicians and medical students themselves. A few students noted that while the course was valuable in bringing up important social and cultural issues, it did so in a way that encouraged them to see "Others" as having special issues that must be taken into account, as deviant. When learning across cultures or groups, it is easy to begin to see only the immigrants and ethnic minority groups as having a culture, only those of Asian, African, or Indian heritage as having a race, only women as having a gender, only gays and lesbians as having a sexual orientation, only the working class and impoverished as having a social class. Everyone else is neutral, normal. In this context the experience of learning about "Others" can become one of voyeurism, stereotyping, exoticization, identifying the "deviant" features of "those people's" lives. It can heighten the boundaries of Us versus Them, rather than lowering those boundaries. As Kai and colleagues argued, the "difference perspective" that predominates in medical education

about cross-cultural health risks falling into a "recipe approach" to learning, "with an emphasis upon passive acquisition of knowledge about how a behaviour or disease might be different in a particular group" rather than encouraging self-reflexivity and self-awareness.[15,p.255] Such an approach can reinforce stereotyping.

Let me be very clear: A course intended to produce physicians able to work effectively across differences of race, culture, gender, sexual orientation, religion, and so on must explicitly address power relations. It must be about racism, not just cultural difference; it must be about homophobia and heterosexism, not just differences in sexuality; it must be about sexism and classism, not just gender differences and the health issues faced by "the poor." Most importantly, such a course must be focused on helping students develop ways to recognize and challenge their own biases, their own sources of power and privilege.

For a medical school to produce socially accountable practitioners, physicians sensitive to and competent working with the diversity of their communities, requires a careful balancing between attention to "difference" and attention to self. To avoid reinforcing stereotypes, to avoid "Othering," curricula should balance exposure to diversity with accompanying efforts to promote reflection upon attitudes, beliefs, and biases; to develop skills for critical self-awareness; and to develop understanding of power and privilege.[16] Moreover, such training must be continued throughout the undergraduate and graduate training, to ensure that students see socially responsive, socially accountable practices among the residents and attending clinicians with whom they study. The ability of medicine as clinical education to incorporate greater social awareness and responsiveness is cast into doubt by the relationship between the learning students did in the PPS course and the learning they did in their clinical experiences on the wards. In teaching cross-cultural health care, it is essential that students see what they are being taught actually being practiced by their clinical teachers.[15] When students do not see clinicians modelling practices that attend to the cultural and social diversity of patients and practitioners, they begin to see socially responsive medicine as, "all very nice to talk about in theory, but ultimately it makes no difference."

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