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# Teaching intercultural competence in Spanish faculties of medicine: What do medical educators think?

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**Abstract.**

Using anonymous online questionnaires, this exploratory cross-sectional study adopts a descriptive approach to analyse how intercultural competence (IC) is conceptualised, taught, and perceived by 125 medical educators in Spain. The findings indicate that formal IC training is limited and many educators rely on informal or experiential learning, which leads to conceptual ambiguity and raises doubts about whether IC can be systematically developed without clear pedagogical frameworks. Preparedness to teach IC is also uneven, resulting in inconsistent teaching practices and weak curricular integration. Although around half of the participants include IC-related content, it is usually addressed indirectly rather than through dedicated modules. Institutional support is perceived as insufficient, with key barriers including lack of teacher training, curriculum overload, and unclear priorities. Despite its relevance in diverse clinical contexts, collaboration with interpreters and intercultural mediators is rarely included in teaching. In sum, this paper highlights the need for clearer conceptual frameworks, more structured curricula, and stronger institutional commitment to IC in Spanish medical education to ensure culturally responsive and equitable healthcare.

**Keywords:** intercultural competence, medical curricula, migrant patients, healthcare interpreting

**Resumen.**

Mediante cuestionarios anónimos en línea, este estudio exploratorio transversal adopta un enfoque descriptivo para analizar cómo se conceptualiza, enseña y percibe la competencia intercultural (CI) entre 125 docentes de medicina en España. Los resultados indican que la formación reglada en CI es limitada y que muchos docentes recurren al aprendizaje informal o experiencial, lo que genera ambigüedad conceptual y plantea dudas sobre si la CI puede desarrollarse de manera sistemática sin marcos pedagógicos claros. La preparación para enseñar CI también es desigual, lo que da lugar a prácticas docentes inconsistentes y a una integración curricular débil. Aunque aproximadamente la mitad de los participantes incluye contenidos relacionados con la CI, estos no suelen abordarse mediante módulos específicos, sino de forma indirecta. El apoyo institucional se considera insuficiente, señalándose como principales barreras la falta de formación del profesorado, la sobrecarga curricular y la ausencia de prioridades claras. Pese a su relevancia en contextos sanitarios diversos, la colaboración con intérpretes y mediadores interculturales apenas se aborda en la enseñanza. En conjunto, este trabajo subraya la necesidad de marcos conceptuales más claros, diseños curriculares más estructurados y un mayor compromiso institucional con la CI en la formación médica en España, para así garantizar una atención equitativa y adecuada desde un punto de vista cultural.

**Palabras clave:** competencia intercultural, currículum médico, pacientes migrantes, interpretación sanitaria

## 1. Introduction

To say that doctors are trained to practise medicine might seem quite simple at first. However, this idea entails far more than it initially suggests. Beneath this seemingly straightforward principle lies a deep connection between scientific and humanistic disciplines. Among other aspects, future doctors are taught about the human body, its processes and systems, anatomy, physiology, biochemistry and pathology, as well as diagnostic and treatment options. And yet, beyond the strictly biomedical dimension, there is also a human component in every doctor-patient relationship that cannot be overlooked: communication practices, breaking bad news, negotiating treatment, managing difficult decisions and building trust. The growing presence of language-discordant patients further intensifies this complexity. Medical consultations in multilingual and multicultural settings (MMS) bring together culturally and linguistically diverse speech communities, which may hold different understandings of medical practice, health and illness, and differing social and affective norms of communication, politeness conventions, and turn-taking patterns (1).

In this context, there is a clear need to move towards culturally competent healthcare organisations. Such organisations not only respect all cultures but also incorporate practices that facilitate cross-cultural communication and integrate knowledge of diverse cultural backgrounds into their core values, systems, policies, and procedures (2-3). Achieving this, however, requires the effective integration of translators, interpreters, and intercultural mediators within multidisciplinary healthcare teams (4-5), alongside the training of healthcare providers in intercultural competence (IC), which is defined as the ability to interact and communicate effectively across cultural contexts by drawing on appropriate knowledge, skills, and attitudes (6).

Sharing a common framework to provide culturally sensitive services would facilitate interprofessional collaboration between healthcare interpreters and providers, ultimately contributing to quality care in MMS (7). IC is widely recognised as a core component of interpreting practice and is embedded in numerous theoretical models and educational initiatives (8-9). Although medical curricula identify culturally sensitive care as a key objective (10), empirical evidence reveals considerable variation in curricular content, teaching and assessment methods, trainers' expertise in IC, training duration, and the degree of integration with other subjects and modules given greater priority in medical curricula (11). Additionally, medical schools often provide insufficient preparation for working with healthcare interpreters and intercultural mediators (12).

In Spain, previous research on undergraduate medical education for the 2025/2026 academic year revealed that, although IC is formally acknowledged across curricula, its integration remains uneven (13). Related content is often addressed only tangentially within broader modules covering ethics, medical humanities, monolingual patient-provider interactions, healthcare management, tropical medicine and international cooperation, multidisciplinary teams, soft skills development, and foreign language acquisition. Notably, only 1 of 214 subjects explicitly refers to intercultural mediators as professionals with whom doctors collaborate.

Building on this previous research, the present exploratory cross-sectional study aims to gain first-hand insights from medical educators in Spain on how IC is taught and assessed. Adopting a descriptive approach and using online questionnaires, this paper investigates whether and how IC is evaluated, the instructors' knowledge of the subject, the guidance they have received on teaching it, and their pedagogical approaches. The study also explores if instructors address the role of healthcare interpreters and intercultural mediators, the institutional barriers they face, and their views on students' acquisition of IC. In terms of structure, the theoretical background on IC in medicine and healthcare interpreting is included in Annex 1. Section 2 describes the methodological approach, followed by the presentation of the main findings in Section 3. In subsequent steps, Section 4 discusses the implications of these results and Section 5 presents the conclusions.

## 2. Methods

This cross-sectional study was conducted within a descriptive and exploratory framework. It relies on anonymous questionnaires administered online to obtain both qualitative and quantitative data from educators who teach medicine in Spain. Online questionnaires were considered appropriate for our purposes, since they offer a cost-effective way of collecting data in real time and facilitate access to a wide and geographically dispersed population (14).

The questionnaire was designed *ad hoc* based on key themes identified in the literature on IC, medical education and healthcare interpreting (see Annex 1). Although the instrument was not formally validated prior to distribution, it was designed for the exploratory purposes of this study to ensure coverage of the preceding review of these themes and, as such, it aimed at capturing broad tendencies, perceptions, and practices. It was organised in six sections and included a combination of questions (table 1).

**Table 1.** Questionnaire structure.

| Section | Main areas | Question type |
|---|---|---|
| Sociodemographic data | Gender | Closed-ended (with open-ended "Other" option) |
| | Age | Open-ended |
| | Previous education | |
| Professional profile | Employing university | Closed-ended (with open-ended "Other" option) |
| | Professional rank | Open-ended |
| | Subject profile | |
| | Academic year of instruction | |
| Familiarity with IC | Training on IC | Closed-ended (with open-ended "Other" option) |
| | Training on IC teaching | Open-ended |
| IC in course content | Explicit inclusion in syllabus | Closed-ended (with open-ended "Other" option) |
| | Explicit inclusion in modules | Multiple choice |
| | IC-related knowledge | |
| | Methodological and assessment approaches | |
| Interprofessional practice with healthcare interpreters or intercultural mediators | Mentioning healthcare interpreters or intercultural mediators | Closed-ended (with open-ended "Other" option) |
| | Collaborative seminars, activities, and workshops | Open-ended |
| Institutional support | Internal policies concerning IC | Closed-ended (with open-ended "Other" option) |
| | Challenges | Open-ended |
| | Proposals for improvement | Multiple choice |

Following (13), invitations were sent to the instructors of 229 subjects taught in 37 public and 13 private faculties. These subjects were selected based on their potential relationship with IC according to their syllabus characteristics (e.g. ethics, medical humanities, monolingual patient-provider interactions, healthcare management, international cooperation, multidisciplinary teams, soft skills development, and foreign language acquisition). E-mail addresses were obtained from publicly available online sources, particularly course syllabi, faculty webpages, and directories. The initial invitation was sent on 31 January 2026, followed by reminders on 13 and 26 February 2026. To increase response rates, a snowballing technique was also employed, and initial respondents were encouraged to refer other eligible participants within their social and professional networks (15). Additionally, invitations were sent to the general contact e-mail addresses of medical faculties, with a request for distribution among their members. This process resulted in 125 responses that met the

inclusion criteria (2 responses were excluded because participants taught IC in faculties other than medicine).

Regarding data organisation and analysis, closed-ended questions were summarised using frequencies and percentages. In contrast, qualitative data from open-ended questions were organised and interpreted following a thematic analysis approach (16). Questionnaires were consulted repeatedly to identify recurring patterns, common themes, and interdependencies across the dataset, which were noted in an Excel template to facilitate organisation. This process combined inductive and deductive strategies (17), which allowed themes to emerge from the data while also being informed by existing theoretical frameworks. To ensure consistency, responses were coded iteratively, grouped into the proposed categories, and fine-tuned through multiple readings.

Ethical clearance was obtained from the University of Alcalá's Committee of Ethics with the reference number CEIP/2025/6/170.

## 3. Results

### *3.1. Participant characteristics*

As previously mentioned, the study included 125 participants teaching at Spanish faculties of medicine. Of these, 54.4% (n = 68) identified as male, 44.8% as female (n = 56) and 0.8% as non-binary (n = 1). Age distribution was as follows: 20-30 (3.2%, n = 4), 30-40 (12.8%, n = 16), 40-50 (25.6%, n = 32), 50-60 (34.4%, n = 43), and over 60 (24%, n = 30). Regarding their educational level, nearly half of the sample held a PhD (47.2%, n = 59), a similar proportion reported holding a bachelor's degree[1] (48.8%, n = 61), and only one respondent indicated a Master's degree (0.8%, n = 1). A small proportion did not provide specific information (3.2%, n = 4).

With regard to disciplinary area, academic backgrounds were classified as health sciences (e.g., medicine) in 63.2% of cases (n = 79), experimental sciences (e.g., chemistry) in 10.4% (n = 13), humanities in 13.6% (n = 17), interdisciplinary (e.g., medicine, surgery, and Spanish philology combined) in 6.4% (n = 8), or social sciences (e.g., sociology) in 4% (n = 5). A further 2.4% (n = 3) did not specify. Finally, most participants received their academic training in Spain (72.8%, n = 91). Other respondents were trained at institutions abroad (1.6%, n = 2) or reported pathways encompassing both national and international settings (0.8%, n = 1). In some cases, the location of academic training could not be determined due to insufficient information (24.8%, n = 31).

Despite their initial sociodemographic focus, these responses provide a useful context for interpreting the findings presented in the following sections. More precisely, they indicate that the sample is characterised by a strong academic background, primarily within the health sciences, which reveals a predominance of biomedical knowledge and entails that disciplines more closely aligned with IC are less represented (e.g., humanities). Such an imbalance may explain the profile of educators involved in medical programmes, who may be less familiar or sensitised to the teaching of IC. Furthermore, since most participants were trained in Spain and a large proportion are over 40 years of age, our data largely reflect how IC has traditionally been approached within the medical education system in Spain.

### *3.2. Teaching roles and academic setting*

Participants teach in 42 different universities in Spain, 30 of which are public and 12 private institutions. Concerning educational level, 58.4% (n = 73) teach in undergraduate programmes, whilst

1 Due to differences in the Spanish higher education system, for our purposes "bachelor's degree" also includes former *diplomatura* and *licenciatura* qualifications.

2.4% (n = 3) are solely involved in postgraduate itineraries, and 39.2% (n = 49) combine both undergraduate and postgraduate options. According to the academic ranks used in Spain (see 18 for a detailed description), participants hold the following positions[2]: full professor (13.6%, n = 17), associate professor or equivalent (23.2%, n = 29), senior lecturer (7.2%, n = 9), assistant professor (12.8%, n = 16), part-time lecturer (35.2%, n = 44), temporary replacement lecturer (4.8%, n = 6), predoctoral (1.6%, n = 2) and postdoctoral (0.8%, n = 1) researchers, and undetermined (0.8%, n = 1).

To learn more about their academic context, respondents were asked to classify the subject(s) they teach into predefined categories, with the option to include additional categories when necessary. Responses were grouped into ten categories, as shown in figure 1.

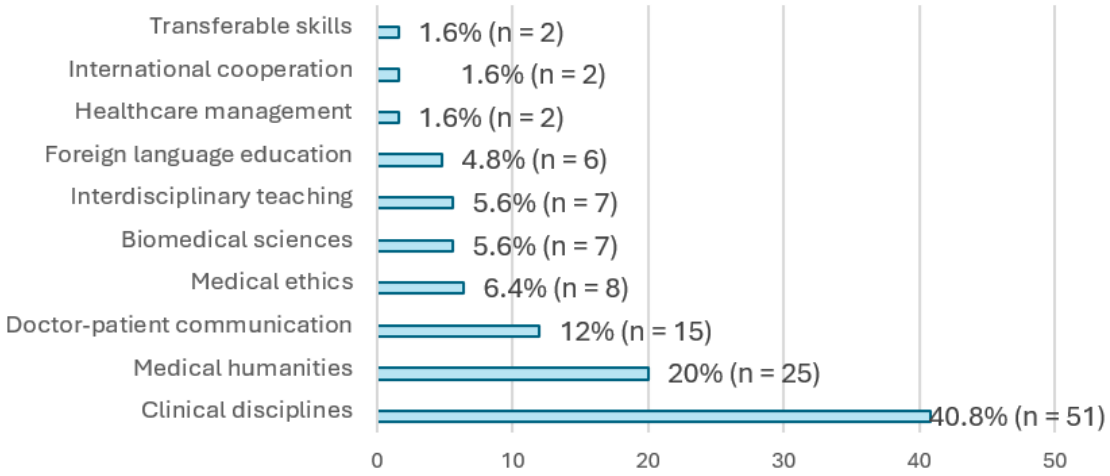


**Figure 1.** Main subject areas taught by medical educators in the sample.

Responses illustrate that clinical disciplines (e.g., family medicine) predominate (40.8%, n = 51), followed by medical humanities (e.g., history, cultural aspects; 20%, n = 25) and clinical communication (12%, n = 15). Smaller proportions include medical ethics (6.4%, n = 8), interdisciplinary teaching (e.g., ethics and clinical communication combined; 5.6%, n = 7), and biomedical sciences (e.g., cell biology; 5.6%, n = 7). The remaining categories are less represented: foreign language education (e.g., English; 4.8%, n = 6), healthcare management (1.6%, n = 2), international cooperation (1.6%, n = 2), and transferable skills (e.g., soft skills; 1.6%, n = 2).

This pattern aligns with the characteristics observed in the previous section. Participants predominantly locate their teaching within clinical disciplines, but medical humanities and doctor-patient communication are also represented. The latter constitute relevant spaces for the integration of IC, as they are related to communication, social context, and the human dimensions of care. However, the extent to which IC is addressed within these subjects may vary depending on their curricular status. Some humanities-based subjects are part of the core curriculum, but more specific

2 In order of appearance, the corresponding Spanish academic ranks are: *catedrático, profesor titular, profesor permanente laboral/contratado doctor, profesor ayudante doctor, profesor asociado, profesor sustituto, investigador predoctoral,* and *investigador posdoctoral*. Given the lack of a one-to-one correspondence between different academic systems, ranks were translated based on career progression and employment stability. Accordingly, *profesor titular* is rendered as associate professor, whereas *profesor permanente laboral/contratado doctor* is classified as senior lecturer, since both are stable, postdoctoral positions below full professorship. For clarity, *profesor asociado* is translated as part-time lecturer, indicating lecturers with accredited professional experience in the field and limited teaching commitments at universities.

subjects are offered as electives, which may limit students' exposure to IC throughout their training. As a result, not all medical students engage with IC-related content to the same extent during their degree, and this may lead to uneven levels of awareness and sensitivity to cultural aspects influencing healthcare delivery.

### *3.3. Training related to IC*

Participants were asked whether they had received any formal training in IC. Most responses were negative (73.6%, n = 92), with a minority reporting having received such training (26.4%, n = 33). It is interesting to note that, when inquiring further into the type of training they had received, a total of 42 participants described having engaged with IC through different routes. This wider sample is explained by the fact that 9 participants who had initially stated that they had not received formal training described other forms of exposure to IC. As Figure 2 shows, 28.57% (n = 12) reported formal education programmes (e.g., university subjects), while an additional 28.57% (n = 12) described informal learning (e.g., self-directed study). A further 23.81% (n = 10) referred to non-formal learning (e.g., workshops or short courses outside formal university programmes), 14.29% (n = 6) reported multiple pathways (e.g., combining on-the-job training with short courses), and 4.76% (n = 2) described experiential learning (e.g., clinical practice or stays abroad).

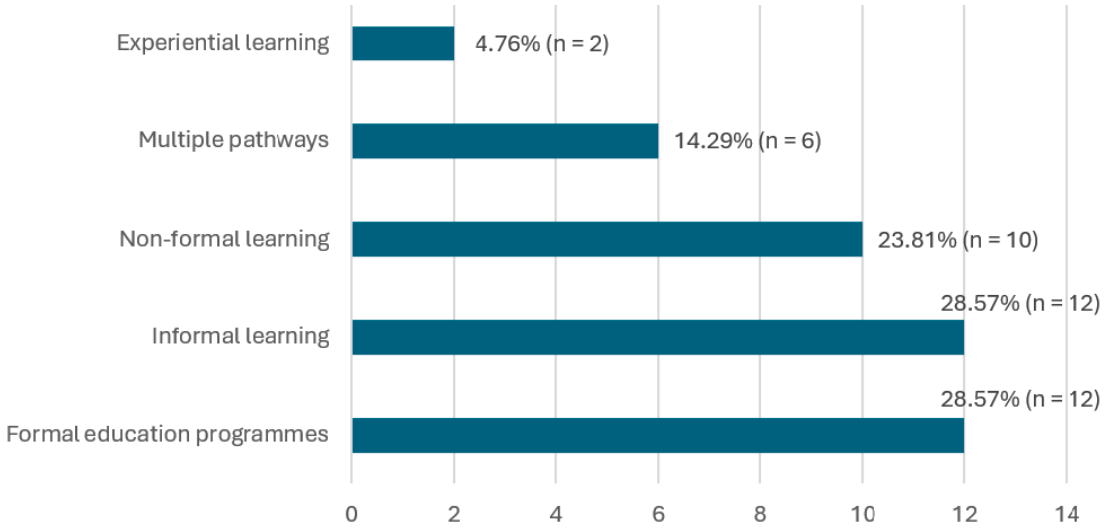


**Figure 2.** Participants' learning pathways in IC.

Following our aims, respondents were also asked to indicate whether they had received any training to teach IC, with only 9.6% (n = 12) responding affirmatively. Despite initially reporting no such training, an examination of the open-ended responses revealed that several participants described learning experiences aligned with these teaching practices. Through the categorisation of these responses, additional forms of preparation were identified. These included formal education, ranging from one-day university courses to specialist diplomas (6.4%, n = 8), self-directed learning (5.6%, n = 7), experiential forms of learning (1.6%, n = 2), including on-the-job learning and professional collaboration with intercultural mediators, and combined pathways, typically involving formal training alongside autonomous learning (4%, n = 5). What emerges from these results is that only 17.6% (n = 22) of the sample had received some degree of preparation for teaching IC, with considerable variation in the nature and duration of these training experiences.

Participants' accounts emphasise the limited prevalence of formal training in IC, which suggests that many educators lack familiarity with IC as both a conceptual and pedagogical construct.

Moreover, the diversity of learning pathways identified in their responses points to a fragmented and unsystematic approach to IC training for educators. Despite not always having studied it formally, engagement with intercultural aspects of care sometimes occurs informally or experientially. This contrasts with more established areas of medical education, where instructors are typically recognised as subject specialists. Together with the reported absence of train-the-trainers opportunities, this lack of IC-specific training among educators may hinder their understanding of the concept and their ability to teach it effectively.

### *3.4. Teaching practices and integration of IC in medical education*

A total of 40.8% (n = 51) of the participants stated that they teach content related to IC as part of their courses. Based on their responses, this content is more commonly addressed in an integrated manner within broader course content rather than as standalone modules or sessions, the latter being reported by only 21 participants. Nevertheless, the findings reveal a remarkable discrepancy between respondents' self-reported lack of engagement with IC and their descriptions of course content, which frequently include elements associated with IC models in 67.2% of cases. To illustrate, the most prevalent trends are identified in Figure 3 (6 items, representing 1.67%, did not form a coherent thematic area and were excluded):

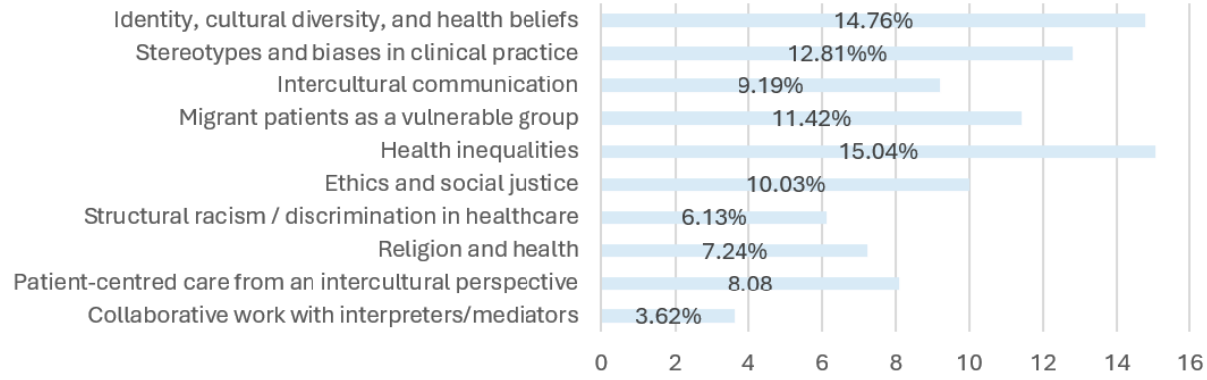


**Figure 3.** Most frequently addressed IC-related contents in the sample.

Notwithstanding this, the explicit curricular integration of IC appears to be rather limited in the sample. Only 13.6% (n = 17) indicated that IC is formally specified in their course syllabi, either as a learning objective or as part of the content. In contrast, 70.4% (n = 88) of respondents reported that IC is not included in their syllabi, and a further 16% (n = 20) were uncertain about whether it is explicitly referenced. These realities are very significant when considering the role of course syllabi as formal frameworks guiding teaching practices. If IC is not explicitly included in these documents, it is unlikely to be formally addressed or assessed, reinforcing its marginal status within the curriculum.

In terms of methodological approaches, theoretical lectures predominated in the sample (30.37%, n = 58), followed by simulations and problem-solving activities, including case studies, roleplays, and problem-based learning (24.61%, n = 47). Guided discussions represented 19.37% (n = 37) of the responses, whereas the use of readings and audiovisual materials accounted for 13.09% (n = 25). Collaborative projects were reported in 10.99% (n = 21) of the cases. Immersive experiences, such as the participation of social and healthcare mediators or training trips, constituted only 1.57% of the findings (n = 3).

Concerning the assessment of IC, the majority of respondents indicated not evaluating it explicitly (75.2%, n = 94). When asked to specify their methods, lecturers who described assessment practices mentioned exams, oral presentations, written or research projects, self-assessment,

practicum work, questions on audiovisual materials, grading students' participation in class discussions, roleplays, case studies, and assessing students' participation during training trips.

Although it can be argued that methodological and assessment approaches may vary across subjects, institutional requirements, educators' preferences or students' needs, this heterogeneity in the case of IC may also reflect a lack of shared understanding or consensus regarding this competence both theoretically and practically. Given that most respondents reported limited or no training in IC, questions arise regarding the consistency and adequacy of the pedagogical approaches used, particularly considering that, in most cases, they have a biomedical background.

Finally, participants were asked whether students acquired sufficient skills to interact with patients from other cultures after finishing the courses they teach. Only 17.6% (n = 22) responded affirmatively. The remaining percentage was divided between the categories of "only partially" (38.4%, n = 48) and "no" (44%, n = 55). In this regard, it is essential to underline the tension between cultural knowledge and interpersonal skills, conceptualised as the distinction between "know-what" and "know-how" (19). In the widespread absence of immersive or practice-based learning opportunities reported in the data (e.g., simulations involving healthcare interpreters or engagement with culturally diverse communities), IC risks being reduced to theoretical knowledge, reinforcing static perspectives on health and illness, rather than fostering adaptive communicative competence in medical settings.

### *3.5. Collaboration with healthcare interpreters and intercultural mediators*

Only 33.6% (n = 42) of participants reported addressing the role of these professionals in their course content. In line with these findings, most respondents stated not covering interprofessional collaboration practices (71.2%, n = 89), whilst the remaining participants stated that they approached these either explicitly (9.6%, n = 12) or only tangentially (19.2%, n = 24).

To obtain further information, participants were asked whether their medical faculties organise joint modules, seminars, or sessions together with translation and interpreting educators or practitioners. A modest 4% (n = 5) responded affirmatively, whereas 32.8% (n = 41) answered "no" and a further 63.2% (n = 79) replied "not sure." Similarly, 90.4% (n = 113) of participants reported not collaborating personally with translation and interpreting lecturers or practitioners in their own subjects. As exceptions to these trends, two respondents indicated that they collaborated with mediators from Muslim, Jewish, and Far Eastern cultural backgrounds, or carried out fieldwork with Roma communities. Another participant, a sworn translator-interpreter, stated that he exposes students to real-life intercultural communication scenarios that they may encounter in their professional careers to foster discussion. The anecdotal nature of these practices suggests that they respond to individual initiatives rather than institutionalised approaches.

Based on our sample, there is a notable lack of interprofessional collaboration between medical education and translation/interpreting disciplines, despite the coexistence of both types of programmes within many Spanish universities. This points to what appear to be missed opportunities for interdisciplinary integration. Additionally, the high proportion of participants who are unaware of such collaboration highlights the extent to which these domains remain institutionally fragmented, instead of being treated as complementary fields advancing migrant patient care.

### *3.6. Institutional strategies, barriers, and recommendations*

The final part of the questionnaire aimed to gather information about institutional strategies and barriers within the participants' faculties, as well as their recommendations for improving IC-oriented training. While 8.8% (n = 11) reported the existence of such a strategy, the findings show that most respondents were unaware of whether their institution had any policy in place to promote IC

education (65.6%, n = 82). Only 5.6% (n = 7) indicated that their faculty includes IC in a clear and structured manner, whereas others perceived its inclusion as limited (20%, n = 25), stated that it does not exist (20.8%, n = 26), or were unsure about its presence (53.6%, n = 67). This lack of awareness may indicate either the absence of institutional strategies for IC or their insufficient visibility and implementation. In both cases, the result is a unstructured landscape in which students are likely to acquire uneven levels of IC, which potentially affects their preparedness for intercultural clinical encounters.

Our results may help explain why 73.6% (n = 92) of participants considered it essential to strengthen IC training. The remaining respondents were divided between those who did not regard such reinforcement as necessary (12%, n = 15) and those who were uncertain (14.4%, n = 18). In any case, participants identified several barriers to implementing IC-related content. The most frequently mentioned were the lack of teacher training (30.23%), followed by insufficient time in the medical curriculum (22.79%), a generalised perception that it is not relevant (20%), a lack of institutional interest (15.35%), and assessment-related difficulties (9.3%). The remaining responses, each representing 0.47%, referred to issues such as an excess of scientism, limited understanding of the function and importance of IC, lack of training in patient care (particularly when they can face discrimination), and structural racism, given that most medical students in Spain are white[3].

To overcome these barriers, participants were asked to propose measures to improve IC training in Spanish medical faculties. A thematic analysis of these responses made it possible to identify eight themes, each comprising more specific subthemes. These are presented in table 2, together with pertinent quotations from the participants' responses. As the questionnaire was originally administered in Spanish, the excerpts have been translated into English by the author. Some participants proposed recommendations that fitted more than one category and were classified accordingly.

**Table 2.** Thematic classification of proposed measures.

| Theme | Subtheme | Quote |
|---|---|---|
| Curricular integration and revision of IC (38.35%, n = 51) | - Compulsory or specific courses | Compulsory subjects on the topic (respondent 1) |
| | - Transversal inclusion in the curriculum | Introducing interculturality across all subject curricula (respondent 2) |
| | - Review and adaptation of existing content | Expanding the credits allocated to the Doctor-Patient Relationship subject (respondent 5) |
| | - Explicit assessment | Including cultural competence as an assessable criterion in clinical placements and OSCEs (Objective Structured Clinical Examinations) (respondent 51) |
| | - Greater presence of humanities and social sciences | Increasing the time and resources devoted to humanities subjects within the curriculum and facilitating interdisciplinary collaboration with medical subjects (respondent 98) |
| Teacher training (22.56%, n = 30) | - Need for specific training | The first and most important step is to improve the intercultural training of teaching staff (respondent 45) |
| | - Raising awareness among lecturers | First and foremost, giving due importance to the issue (respondent 116) |

3 The respondent explicitly used the term 'white' (*blancos*).

| | | |
|---|---|---|
| | - Core requirement in teacher education | Including IC as a teaching competence (respondent 31) |
| Communication skills and clinical interaction (3.76%, n = 5) | - Communication training | There is an excessive emphasis on theoretical knowledge in strictly medical fields, but it is often overlooked (in my humble opinion, far too much) that doctors will be dealing with human beings, and that the primary tool for this interaction will be communication (respondent 17). |
| | - Respect, empathy and patient-centred care | Respect for the patient, regardless of their background (respondent 27) |
| | - Bias and cultural humility | It is essential to implement workshops that require students to confront their own unconscious biases and prejudices, fostering "cultural humility" rather than the mere memorisation of other cultures' customs (respondent 102). |
| Practical exposure and experiential learning (8.27%, n = 11) | - Internships in diverse contexts | Facilitating external internships in culturally diverse settings (respondent 37) |
| | - Experiential activities and simulations | Rather than isolated theoretical lectures, students should participate in clinical simulations with actors portraying linguistic barriers or specific religious beliefs, allowing them to practise treatment negotiation in a safe environment (respondent 102). |
| | - Contact with diverse communities | It should include members of different communities who participate in teaching by sharing their experiences and stories (for example, leaders from Muslim, Jewish, African, or Roma communities, etc.) (respondent 40) |
| | - Contact with healthcare interpreters and intercultural mediators | This should be complemented with practical rotations in community health centres with high levels of migrant diversity, where students can work closely with cultural mediators and professional interpreters, understanding that a patient's health is inseparable from their worldview and social context (respondent 102). |
| Institutionalisation and structural support (8.27%, n = 11) | - Institutional recognition | At our Faculty, this is not considered a teaching objective (respondent 91) |
| | - Policies and formal guidelines | Although IC is included among the degree competencies, it should be ensured that it is explicitly incorporated into the subjects where it is relevant (respondent 16) |
| | - Visibility within the faculty | First, the University and Faculty need to be aware of its importance (respondent 13) |

| | | |
|---|---|---|
| Cultural knowledge, languages and understanding diversity (8.27%, n = 11) | - Cultural knowledge | Discussing anatomical variations and physiological responses according to ethnic background during dissections (respondent 51) |
| | - Languages relevant to medical practice | Medical students have a good level of English, but not of Mandarin or sign language, which can sometimes be important in clinical settings (respondent 22) |
| | - Avoiding a Eurocentric perspective | A less "Western-centred" perspective should be introduced across all areas (respondent 65) |
| Lack of awareness or conceptual uncertainty (7.52%, n = 10) | - Indeterminacy | Developing a plan in which the key items to be addressed and the way to address them are agreed upon (respondent 28) |
| | - Conceptual confusion | I cover it because it is impossible to ignore in my subject, but I was not even aware it existed before this questionnaire (respondent 122) |
| Resistance, rejection and scepticism (3.01%, n = 4) | - Perceived irrelevance | In my opinion, IC is irrelevant in medical training (respondent 15) |
| | - Direct rejection | Time should not be wasted on this type of issue (respondent 121) |
| | - Other priorities | There are other basic needs (respondent 97) |
| | - Lack of a solid opinion | I do not have a formed opinion on this issue or on its potential inclusion in the curriculum as presented in the course syllabus (respondent 82). |

As shown in table 2, curricular integration and revision of IC-related contents emerged as the dominant theme (38.35%, n = 51). Many participants called for the structural integration of IC within the curriculum through compulsory or specific subjects, the explicit assessment of IC, and the adaptation of existing content. This also involved calls for greater allocation of time and resources to humanities and social sciences within medical programmes, which reinforces earlier findings regarding the marginal and uneven integration of IC in course syllabi. Consequently, it appears that participants tend to frame IC as a structural or curricular issue that requires intervention at an institutional level and not as a topic that depends on individual pedagogical responsibility. Relatedly, some suggestions emphasised the need for institutionalisation and structural support (8.27%, n = 11). This includes institutional policies, formal guidelines, and clearly defined teaching objectives.

Teacher training represented the second most frequent theme (22.56%, n = 30). Participants underlined that IC cannot be effectively implemented without adequately trained and highly aware teaching staff. A smaller number of respondents stated that the very nature of IC was unclear to them (7.52%, n = 10), which indicates limited conceptual comprehension. This lack of clarity aligns with the emphasis placed on teacher training previously discussed and highlights the need for a more coherent and shared understanding of IC among educators.

Another group of participants (8.27%, n = 11) equated IC with learning about other cultures, languages, and traditions. Recommendations in this category included avoiding Eurocentric perspectives, learning languages relevant to clinical practice, and engaging with cultural understandings of the body or culturally-influenced practices in specific settings, such as surgery or palliative care. Other respondents focused on communication skills, clinical interaction, empathy, and bias, highlighting the need to address implicit prejudices and enhance social awareness (3.76%, n = 5). Although these conceptions should be complementary, their presentation, almost as if they were opposing poles, reinforces the tension between knowledge-based and skills-based approaches to IC discussed in previous sections. Furthermore, the limited emphasis on communication is extremely revealing, given its central role in every doctor-patient interaction. Here, however, it seems to occupy a secondary position. Communication in healthcare settings involves far more than biomedical proficiency, linguistic skills, and cultural understandings affecting healthcare provision: it requires the ability to translate such knowledge into practice in a way that both respects patients and pursues clinical objectives.

Some participants proposed practical training and experiential learning (8.27%, n = 11). Some proposals in this direction include clinical placements, direct contact with culturally diverse communities, simulations, and interdisciplinary activities involving migrant communities, healthcare interpreters, and intercultural mediators. These strategies address the lack of experiential and immersive approaches reported in the data, suggesting that collaborative activities are not currently being developed to a sufficient extent. Particularly noteworthy is that participants rarely referred to structural inequalities, discrimination, systemic barriers, or language access issues affecting culturally diverse patients, which suggests that IC may still be conceptualised primarily at the interpersonal rather than structural level.

Finally, a small number of respondents (3.01%, n = 4) expressed explicit resistance or scepticism, often arguing that medical students faced more urgent training needs within the limited time available. Although marginal in quantitative terms, resistant discourses reveal underlying tensions concerning curricular priorities, professional identity, and the legitimacy of IC training within medical education. These resistant accounts reveal the prevalence of biomedical knowledge, which is consistent with the professional and educational profiles of participants, as well as the limited time available in medical curricula.

In sum, the data indicate that participants do not tend to perceive IC as an isolated competence. Rather, they see it as a structural educational challenge requiring curricular reform, institutional commitment, pedagogical transformation, collaborative practices with healthcare interpreters and intercultural mediators, and a redefinition of medical professionalism in multilingual, multicultural settings.

## 4. Discussion

### *4.1. Educators' training profiles*

The findings show a scarcity of formal IC training among educators, which is frequently replaced by informal, self-directed, or experiential learning pathways. It can be argued that these experiences foster awareness of intercultural issues to a certain extent, but their heterogeneity contributes to unstructured understandings of IC. A similar pattern emerges concerning preparedness to teach it, with only 17.6% having received pedagogical training that differs greatly in terms of content, format, and duration. This variability translates into inconsistent teaching practices and uneven student learning outcomes, entailing that future doctors may have superficial understandings of IC instead of the abilities required for effective intercultural practice. These results resonate with previous international research, particularly in highlighting insufficient faculty

preparation and limited train-the-trainer opportunities (20-22), a reflection echoed by respondents themselves, who identified the lack of teacher training both as one of the main barriers to IC implementation and as a priority for future development.

The disciplinary background of the sample may partly account for these findings. Participants mainly reported formal training in health sciences, which reflects the broader predominance of clinical fields over areas more closely aligned with IC. In other words, biomedical perspectives dominate medical education and tend to privilege clinical knowledge over sociocultural and communicative dimensions. While biomedical profiles are expected in medical education and should not be understood as problematic, their prevalence contributes to hierarchies in which certain forms of knowledge are marginalised. Offering continuous development sessions for educators at the heart of medical institutions may alleviate IC knowledge gaps and help them develop IC-tailored educational proposals.

### *4.2. Curricular integration and pedagogical practices*

Although 40.8% of participants reported addressing IC-related content in their teaching, this is often done tangentially within broader areas. This means that, even when IC-related topics are present, they are not recognised as a distinct domain of knowledge (11), which points to a broader lack of clarity surrounding IC in medical education (23). At the same time, the gap between its perceived importance and its actual implementation should not be overlooked. In line with previous studies (11, 24), our results demonstrate that IC risks remaining superficial without explicit learning aims, longitudinal integration, and assessment tools.

From this perspective, IC is conceptualised in narrower terms, limiting engagement with approaches that emphasise diversity, cultural understandings of health and illness, engagement with migrant communities, and collaboration with interpreters. This restricted integration may have important implications for both training and practice, particularly in relation to the "know-what" and "know-how" distinction (19). It is undeniable that some degree of cultural knowledge may be transmitted, at least from a theoretical perspective, but the limited use of experiential and practice-based approaches restricts students' ability to apply this knowledge effectively in clinical interactions. One potential solution is to include elective subjects in translation and interpreting departments open to medical students, allowing them to gain immersive, collaborative experiences, or, alternatively, offer translation and interpreting students the possibility to attend medical subjects emphasising doctor-patient communication.

### *4.3. Institutional frameworks and structural barriers*

Although IC is recognised as one of the components of medical programmes, our findings reveal that it is not always effectively integrated at the institutional level and, therefore, we cannot expect educators, students, and practitioners to provide culturally sensitive care if they are not made aware of its importance during the early stages of their education. On a positive note, 73.6% of participants in the sample recognise the need to strengthen IC training, with many indicating that students either fail to acquire sufficient skills to interact in multicultural settings (44%) or do so only partially (38.4%), which, in turn, contributes to broader inequities in healthcare delivery for migrant and linguistically diverse populations. Despite this widespread positive attitude towards IC, institutional support remains weak. The data indicate that such institutionalisation is largely absent or unclear, underlining the need for comprehensive institutional strategies rather than isolated initiatives. Together with this lack of institutional guidance, additional constraints such as time pressure within overcrowded curricula (22.79%) and certain perceptions of limited relevance (20%) or assessability (9.3%) further compromise integration efforts.

*4.4. Interprofessional collaboration in multilingual and multicultural settings*

Only 33.6% of participants referred to healthcare interpreters and intercultural mediators, and typically only in passing. In addition, interdisciplinary training activities involving interpreting educators or students are absent in 90.4% of cases. This supports previous research describing insufficient preparation for working with healthcare interpreters and intercultural mediators in medical schools (12, 25). This external position reflects the fact that linguistic and intercultural expertise is often undervalued despite being essential to equitable care and has implications for healthcare interpreting as a profession, which will continue to struggle for recognition if more established professions do not validate it. Relatedly, some participants discuss the limited linguistic proficiency of medical students in English or other languages such as Mandarin or Arabic, without referring to their collaboration with onsite or remote healthcare interpreters who can help overcome communication and cultural barriers as part of their professional responsibilities.

Furthermore, the absence of collaborative initiatives influences the future practice of both healthcare interpreters and providers aiming to serve migrant populations, as well as patients' well-being. Contemporary models emphasise the need to understand patients holistically, considering cultural background, language, and social context. Not integrating these dimensions may result in miscommunication, reduced adherence to treatment, diagnostic errors, and inefficient use of healthcare resources, and may also perpetuate inequalities in access to care among migrant and linguistically diverse populations (26).

*4.5. Limitations and future lines of research*

This study offers a contextual overview of IC integration in Spanish medical education through a cross-sectional, exploratory approach. As a consequence, future research should expand the sample size and use longitudinal designs to track changes over time. Since most respondents were aged 40 or above (84%, n = 105), it is important to analyse how perceptions of IC evolve as newer groups of educators enter the educational landscape and institutional priorities shift.

In terms of methods, the use of convenience and snowball sampling may have introduced bias, potentially favouring participants already interested in IC. Although this limits generalisability, the involvement of 125 educators from 42 universities supports the descriptive value within the study's exploratory focus. Additionally, the questionnaire was designed *ad hoc* and was not formally validated before use, which may affect reliability. To overcome this, future research would benefit from the design, piloting, and validation of instruments.

## 5. Conclusions

- IC continues to be unevenly integrated into medical education. Its presence in medical curricula is often implicit and dependent on individual educators' initiatives, who typically lack formal training in IC as a conceptual and pedagogical construct, contributing to heterogeneous teaching practices.
- There is a tension between the need to strengthen IC curricular integration and the risk of reducing it to the theoretical transmission of cultural knowledge. Without more experiential approaches, this may lead to reduced IC proficiency, as students may be aware of cultural differences, but lack the necessary skills to manage these in practice.
- Despite their recognised importance in multilingual and multicultural clinical settings, the limited collaboration with healthcare interpreters and intercultural mediators further constrains the development of IC and impacts negatively on their professionalisation.

- Advancing IC in medical education requires clearer conceptual frameworks, stronger institutional support, interprofessional practices, and greater emphasis on the development of adaptive and communicative skills for culturally and linguistically diverse medical settings.

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## Annex 1. Theoretical framework

### Intersection of culture and healthcare: IC and its integration in medical education

The lack of appropriate IC among providers has been identified as one of the main barriers to immigrants' access to healthcare systems (27). Thus, training institutions are now striving to meet several policies, standards, and regulatory requirements that expect providers to work effectively in intercultural environments (see, for example, 28-31).

As a field of inquiry, culturally sensitive care emerged as a strategy to both eradicate ethnic inequalities and include the healthcare needs of disadvantaged cultural communities (32). Since its

introduction, several models have emerged. Some of them focus on 'competence', while others emphasise the construct of 'culture' (33). A review of the literature indicates that early frameworks conceptualise cultural competence[4] as a developmental process, identifying six dynamic stages through which practitioners progress (2). Subsequent models have sought to organise intercultural knowledge into different dimensions, thus framing 'culture' in terms of the interaction between interrelated domains affecting healthcare. For instance, Purnell's model (36) adopts a taxonomic framework, outlining twelve cultural domains (i.e., family roles, death rituals, spirituality), while Leininger (37) identifies seven key components influencing healthcare delivery, including cultural beliefs and religious factors. Parallel to these more structural approaches, other models emphasise interactional and communicative practices, underlining patient-centred communication (38). It can be said that these models reflect differing conceptualisations of this competence, ranging from stage-based developmental processes to domain-based frameworks and interactional, communication-focused approaches.

Despite the proliferation of models, the concept of IC is loosely defined, poorly understood, and used interchangeably with related concepts, such as diversity (39), confusing both educators and students (23). Early perspectives presented static, reductionist conceptualisations of culture, attracting criticisms that providers could learn enough to develop a thorough understanding of other cultural groups different from their own (32). This "check-list" approach (where competence is reduced to the acquisition of separate cultural facts or traits that do not necessarily represent every member of a cultural group) gradually transitioned into alternative proposals framing IC as a dynamic, lifelong process of self-reflection and continuous learning. Within this perspective, an intra- and interpersonal approach encourages healthcare professionals to critically examine their own cultural assumptions, beliefs, and biases, enabling them to learn from each patient as a unique individual to facilitate the provision of care (40-41). This shift justifies the introduction of associated concepts. Among these, some examples include cultural humility, cultural care, cultural safety, cultural sensitivity, critical consciousness, or critical cultural competence (23).

According to Campinha-Bacote (42), being competent in intercultural settings implies the orchestration of cultural awareness, knowledge, skill, desire, encounters, and humility, which enables providers to integrate cultural diversity into services, recognise the influence of one's own cultural background, understand patients' cultures, distinguish variable cultural perceptions from health issues, and apply these elements effectively in clinical interventions (43). This perspective aligns with Betancourt's (44) categorisation of undergraduate cross-cultural education into three interrelated approaches (i.e., knowledge-based, attitudinal, and skills-based), aimed at understanding cultural beliefs, fostering sensitivity, and adapting clinical practice to each patient.

However, the lack of conceptual clarity and consensus regarding what constitutes IC has been identified as a major barrier to faculty development (23). Several authors have highlighted the absence of clear institutional guidance on course duration, assessment, and content (11, 41). These topics are often taught by educators who may themselves have limited IC (20-21). In addition, opportunities for train-the-trainer programmes and resource allocation for IC initiatives are scarce across institutions (22). Although regulatory bodies require intercultural proficiency, most medical curricula tend to address this through ad hoc or symbolic approaches, lacking structured,

4 Although *cultural competence* is widely used in the literature and often interchangeably with *intercultural competence* (34), the latter is used in this paper as an umbrella term to reduce terminological heterogeneity and emphasise the contact between different cultural groups and the providers' knowledge, attitudes, skills, and behaviours to interact and communicate effectively with patients from diverse cultural backgrounds (35). Accordingly, cultural competence is only retained when referring to models or studies that explicitly adopt this terminological choice.

longitudinal integration (11), and educational compartmentalisation persists: IC is treated as an add-on instead of a core clinical skill, lacking both vertical (i.e. across all years of the degree) and horizontal integration (i.e. across all subjects) (24).

Curricular heterogeneity is also evident in pedagogical and assessment practices, contributing to different outcomes across universities. Some authors (44) highlight that common teaching methodologies include group discussions, case studies, lectures (both face-to-face and online), reflective exercises, and active approaches, such as simulations or roleplay. Additional strategies include clinical or research projects, videos, workshops (20) and immersive experiences through clinical rotations, presentations, posters, and preparatory readings (45). In terms of assessment, a variety of methods are used, including essays, reports, questionnaires, multiple-choice questions, and reflective portfolios (46). These variations further suggest that IC may be formally endorsed at the level of curriculum discourse, yet its implementation often depends largely on individual teachers' initiatives and ideas (47).

In any case, pedagogical and assessment approaches should be designed to avoid reinforcing stereotypes or the misconception that IC relies solely on memorising information, when it is more about applying knowledge effectively in practice (46). Instead, healthcare providers should not only know how to deliver culturally appropriate services, but also how to communicate interculturally. This goes beyond the "know-what," understood as concrete knowledge of different cultures, toward a reflective "know-how" that enables providers to recognise, coordinate, and adapt communication patterns and emotional cues according to the cultural perspectives of participants and the context of the interaction (19).

Widely explored in second language acquisition and teaching (49-51), intercultural communicative competence (ICC) entails that individuals understand differing norms and conventions of communication, and use them effectively to engage with people from different cultural backgrounds (52). Even so, given the diverse profiles of patients, who may speak different languages, lack a shared language with providers, and belong to multiple cultural systems, healthcare interpreting and intercultural mediation emerge as complementary activities essential to ensuring high-quality care in MMS. Although training on working with medical interpreters has been shown to improve students' communication skills and their ability to serve linguistically diverse populations (53), the reality is that formal integration of such training within undergraduate medical curricula remains very limited (25).

**Intersection of culture, language and health: healthcare interpreting**

Mishler (54) distinguishes between the voice of the lifeworld and the voice of medicine, which represent two distinct and often conflicting frameworks in which the patient's personal experience of illness and the provider's scientific and technical focus coexist. Within this space, the link between culture, language, and health becomes apparent. As documented in the literature, health and language are culturally bound, and culture is, in turn, shaped by the collective meanings attributed to health and the linguistic frameworks through which they are expressed. To illustrate, the use of metaphors in medical consultations varies across languages and cultures (55), and heterogeneous understandings of health and illness imply that patients and providers conceptualise differently aspects such as family roles, high-risk behaviours, nutrition, pregnancy, death rituals, spirituality, mental health, traditional practices, hospital use, adherence to medication, and interactions with healthcare practitioners (7, 56). These differences entail that patients and providers may not share the same lens through which they approach health-related issues. However, cultural differences do not fully account for the challenge, as these often have to be addressed without a shared language.

In this context, healthcare interpreting lies at the heart of MMS. As a common form of dialogue interpreting, it involves triadic exchanges between providers, patients, and interpreters, conducted either onsite or remotely across diverse healthcare settings (57). For successful practice, healthcare interpreters must demonstrate communicative and textual, cultural and intercultural, thematic, professional instrumental, psychophysiological, interpersonal and strategic sub-competences (7). The orchestration of these, combined with an adequate integration of healthcare interpreting, leads to increased patient satisfaction, comprehension and adherence to treatment, as well as better access to healthcare and fewer communication errors (26), and even promote patient-centred care (58). Consequently, providing culturally sensitive care and ensuring culturally competent healthcare organisations include the provision of professional interpreters and intercultural mediators as part of multidisciplinary healthcare teams (4-5).

Despite this evidence, ad hoc practices remain common, and, when available, interpreting services are often provided intermittently (59). In countries such as Spain, healthcare interpreting remains underprofessionalised, which has important practical implications for the definition and scope of interpreters' work. Interpreters are frequently expected to perform tasks beyond interpretation, resulting in a blurred definition of professional responsibilities and a complex understanding of their roles, which are yet to be fully defined (60-61). Some stakeholders continue to view interpreters as confined to word-for-word rendering (62), but in practice they often exercise agency, adopting active roles to bridge differences in knowledge, beliefs, social norms, and cultural backgrounds between patients and providers (63). This dual function further complicates the distinction between healthcare interpreting and intercultural mediation. Whereas some authors emphasise their separation and treat them as distinct activities, others advocate for a unified professional profile capable of performing both interpretation and intercultural mediation (56).

The situation becomes even more complex within the medical field itself. Research has revealed a gap in providers' understanding of the professional boundaries and communicative complexity of healthcare interpreting. Interpreters emphasise intercultural mediation, knowledge of healthcare systems, and empathetic communication as integral components of care delivery, but clinicians frequently conceptualise interpreters primarily as conduits for the literal transmission of information (64), often unaware of the broader clinical, therapeutic, metalinguistic, and empowerment functions they fulfil (65). Such reductionist assumptions may lead providers to treat interpreters merely as instruments for advancing their own agendas. This can constrain interpreters' practice and generate tension in the medical encounter whenever a word-for-word interpretation is believed not to have occurred (66). However, a fundamental incongruity is observed: while providers formally demand mechanical literalness (i.e., limiting themselves to what providers and patients say), they also rely on interpreters' cultural and situational expertise, particularly when misunderstandings occur, and expect a more active performance subconsciously (67).

As a result, this situation reveals a lack of knowledge on the part of providers about interpreter roles and competences, which partly explains the widespread adoption of ad hoc practices instead of professional services (68). For healthcare interpreting to consolidate itself as a professional activity, healthcare providers must first understand its value and familiarise themselves with the tasks and roles of interpreters (69). Without this recognition, it is unlikely that formal education proposals highlighting IC and teamwork with healthcare interpreters will come to the fore. If communication in MMS is not recognised as problematic, it will not be established as a core competence in medical curricula.

In response to this gap, the field of translation and interpreting (T&I) has already recognised this need and made advances in healthcare interpreting education. Nowadays, several training initiatives have been implemented in the shape of formal university programmes, NGO proposals, onboarding

sessions, and even MOOCs (60). This is not yet happening in medical undergraduate programmes. Although some proposals have been described in the literature, they appear to be largely anecdotal (25). This calls for greater attention to IC on the part of practitioners, an objective pursued by the research project Intercomsalud, which, amongst its aims, seeks to provide training to active healthcare practitioners (70). However, this awareness must be present from early educational socialisation processes rather than emerging only during professional socialisation in the workplace. These reflections justify the development of the present study, which focuses on faculty training and the perceptions of educators themselves.