

Cultural Competency

in Medical Education:

A Guidebook for Schools



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How to Use This Guidebook

Inside, you'll find:

- An explanation of why culturally competent medical education is important;
- A suggested curriculum outline for cultural competency that can be tailored to any school;
- A blueprint for making cultural competency an integrated part of an institution, including strategies for selling the new curriculum to the entire school;
- Tips for preparing medical school faculty to teach cultural competency through integration;
- Detailed methods for student instruction in cultural competency, based on existing curriculum type; and
- A look at ways to evaluate the efficacy of a culturally competent medical education and student/faculty performance within it.

A Blueprint for Change

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For a country rich in resources, the United States' health-care system is often impoverished when it comes to combining quality medicine with cultural awareness in an era of burgeoning diversity. The problem is simple: When physicians face substantial cultural and language differences, they are far less likely to adequately address a patient's health concerns. The consequences of not meeting that need can be severe, leading to even greater health problems.

Although culture can be defined in many different ways, it is important to note that any patient's encounter with a physician can be considered cross-cultural. The physician has different beliefs, values and practices about medicine and health care that can be different from what any patient may believe, value or practice concerning his own illness. However, it has become more important in today's society to formally educate medical students about the tools needed to understand patients whose cultural background is different from their own. No physician should leave medical school today without the knowledge about the role culture plays in health care and the tools to understand patients whose backgrounds are different from their own. Those tools—called cultural competency—are lacking from current curricula. And change only comes with action.

In 1998, the U.S. Department of Health and Human Services (DHHS), Health Resources and Services Administration (HRSA), and Bureau of Health Professions' (BHP) Division of Medicine and Dentistry (DUD) developed PRIME—Promoting, Reinforcing, and Improving Medical Education.

Among PRIME's aims was to create a cultural competency curriculum that could be used in medical schools nationwide and test it in seven schools selected for the pilot program: Wake Forest University School of Medicine (WFU), the University of Kansas School of Medicine (KUMC), Medical University of South Carolina (MUSC), the University of Massachusetts Medical School (UMass), Mercer University School of Medicine (MU), Pennsylvania State University School of Medicine (PSU) and Saint Louis University School of Medicine (SLU).

What follows on these pages are the results of the lessons the pilot schools learned about the most effective way to make cultural competency in medical education a reality—the result of not only believing that medicine can be changed for the better but of helping others believe it, too.

Toward Understanding:

The argument for a culturally competent medical education

Many people agree that doctors should be trained in understanding how culture plays a role in health and health-care delivery. Cultural competency is a standard recognized by the Liaison Committee on Medical Education (LCME) as critical to a medical school's mission. The standard states:

“Faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, disease and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health-care delivery, while first considering the health of their patients.”

Sometimes, however, believing in the benefits of change and implementing them are two different concepts. Few studies have systematically documented or explained how this “understanding” is translated into a practical application. Researchers and authors have written that cultural competency can be taught in a course, class or series of classes, taking the form of lectures and interactive sessions;¹ workshops;² student clerkships;³ electives;⁴ immersion programs;⁵ month-long rotations;⁶ cultural teaching OSCEs⁷ (objective-structured clinical examinations); and language training.²

The problem with these approaches is that they have an ending—cultural competency is confined to something that happens within a context, not as an ongoing mode of thinking and acting that pervades all practices in a medical school. Simply adding content to the medical school curriculum does not fully address the goal of creating culturally competent health-care providers.

A look at how medical schools address cultural competency standards found whole pieces of a medical school’s makeup—the institutional culture, the people, the processes and practices—were left out of the plan. This short-sighted view might yield students a glimpse of cultural competency in the form of an elective whose lessons are quickly forgotten in the stresses of clinical training, but it won’t do much to create what is really required to forge change: culturally competent medical education.⁸

It is only with the whole picture that one can be effective. When cultural competency isn’t a thread that runs seamlessly through all levels of a medical school philosophy and curriculum, its importance is underestimated and underexposed—those who need training the most remain the farthest from the experience. The following are some lessons shared by schools that have worked on cultural competency training:

Faculty recruitment and time constraints

One of the initial challenges in implementing a new course or curricular activities is securing the faculty’s commitment. Some faculty members do not see the relationship between culture and what they are currently teaching. Even when faculty members are committed to introducing the concepts of culture and diversity as they relate to health-care delivery, the work of preparing for an extra course is burdensome—and often not reimbursed.

Administrative support

It is essential to institutionalize cultural competency into the educational system, not just the curriculum; but to do this, support from the school administration is crucial. Cultural competency training should be made an integral part of strategic planning at all levels. Sustainable support funding for all involved, including staff training and other activities related to an initiative, should be provided. And collaboration from all aspects of the medical school is necessary to integrate the importance of teaching culture in the curriculum.

Student motivation and time constraints

Some students choose to take elective courses because of personal interest and others because of educational requirements. Unfortunately, when culture and diversity courses are offered as an elective, there is no real educational need created for the students to enroll. Often, students who participate in cultural competency elective courses have previously shown an interest in culture and diversity, having spent time in other countries or underserved communities in the United States or they are members of ethnic minority groups.

And even when interest is high, many students are anxious about taking on extra coursework during their second year, before boards, and student enrollment or dropout levels can be disappointing as a result.

But a culturally competent medical education could help change all this. It’s an approach for transforming medical education based on literature from multicultural education, transcultural nursing and medical anthropology^{9, 10, 11, 12} that critiques the shortcomings and failures of current medical education and addresses the importance of culture as a component to the practice of medicine, as well as part of patient care across race, class, gender, age, etc. Culturally competent medical education also addresses potential discriminatory practices of the medical school and

makes changes accordingly.⁸

The underlying goal of culturally competent medical education is to foster in both faculty and students an understanding of the negative outcomes that can occur when culture and diversity are overlooked in the doctor-patient relationship. This involves not only a transformation of the schools but a transformation of the self.

Schools are social systems in which all of their major components are closely interrelated. For culturally competent medical education to be a success, formulating and initiating change strategies that reform the entire school is essential, as changing the whole school means changing the environment—which in turn means changing the assumptions of biomedicine.

Five Factors of Understanding

Creating plans for culturally competent medical education means understanding five key factors at play at any medical school.

1. Medical schools are a culture in and of themselves. They have their own language, values, beliefs and traditions that produce a body of knowledge and standardized practices.
2. Medical schools must understand that they are products of culture, where all of the cultural elements are understood as major contributory factors to the teaching and practicing of medicine.
3. An institution must be willing and able to examine and review the cultural knowledge, values, beliefs and practices it is promoting.
4. Medical schools must offer opportunities to students, faculty and administrators to question these assumptions of biomedicine by offering alternative views of health and illness.
5. Medical schools must offer learning activities that foster self-awareness of how students view others—and how that view affects the way health care is delivered.

The PRIME Cultural Competency Curriculum

The PRIME curriculum gave the participating schools the flexibility to address the major core competencies in ways that worked within their own curricula and teaching structures. Different types of learning and specific resources that could be used were suggested. The main curriculum was as follows:

A.) Definition of Culture and Cultural Competency

The content explores working definitions of culture for use throughout the curriculum. Students analyze the definition of culture and how it may relate to health and health care coupled with an exploration of useful frameworks in order to gain an understanding of what is meant by competency.⁹ Language and communication methods (verbal, gesture, written) are examples of elements that form and shape a culture. This section also looks at culture and its relationship to worldview and related issues of self-concept. Cultural competency is examined in terms of one's ability to navigate through other cultures—to understand, appreciate, make comparisons, get beyond stereotypes and be sensitive to cultural elements of others.

Core Competencies: Students should be able to:

- Have an understanding of the scope of the definition of culture.
- Have an understanding of the elements that form and define culture.

B.) Definition of Diversity and Diverse Populations

This is a discussion of diversity and its relationship to culture. Populations can contain both visible and invisible diversity characteristics; recognizing this is essential to avoiding biases and understanding proper health-care delivery. In exploring diversity and diverse populations, these characteristics are addressed:

- Race and ethnicity
- Gender and gender identity
- Sexual orientation
- Ability/disability status
- Religion and spirituality
- Age
- Education
- Socioeconomic status
- Language/communication modality
- Individual experiential background
- Lifestyle (interests, hobbies, activities, affiliations)
- Family dynamics

Core Competencies: Students should be able to:

- Have an understanding of the visible and invisible aspects of culture, including but not limited to the above characteristics.
- Recognize intracultural diversity.
- Recognize personal and professional tendencies toward bias and stereotyping.

C.) Issues in Health Care: The Impact of Diversity

The content looks at the impact of culture on the field of medicine as a whole, both historically and in present day. This session will also study the effect of an increasingly diverse U.S. population on this relationship.

Core Competencies: Students should be able to:

- Understand the theory of cultural competence from a historical perspective, especially as it relates and responds to progress in traditional allopathic and osteopathic medicine.
- Understand the public health implications of cultural competence in health care.
- Appreciate the interaction between characteristics of diverse populations and health care.

D.) Cultural Models of Health, Disease and Illness

This section investigates how cultures view different aspects of health and illness in a variety of ways. For example, the cause of illness may be attributed to organ failure for one culture, spiritual imbalance for another, or presence of bad spirits in a third. Failure to examine patient actions in the context of their cultural model of health and disease not only serves to deteriorate the physician-patient relationship but can also lead to misdiagnoses.

Core Competencies: Students should be able to:

- Recognize cultural models of health, disease and illness.
- Know the common cultural models of health and illness in their own community.
- Become familiar with basic religious and folk beliefs that affect patients' beliefs or understanding of the etiology of their illness or the efficacy of their treatment.

E.) Cultural/Traditional Health-Care Practices

Students learn how cultural health-care practices impact the patients' decisions. For example, issues such as a patient's knowledge of his illness, the role of family and members in decision-making, trust of health-care providers of different cultures, the perceived role of physicians and the hospital setting and the role of cultural faith healers vary greatly among diverse populations.

Core Competencies: Students should be able to:

- Recognize cultural and traditional health-care practices.
- Be aware of the impact of other nonallopathic and nonosteopathic health-care practices in the managed-care setting.
- Assess other health-care resources and methods patients use or used during traditional allopathic and osteopathic care (e.g., home remedies, traditional healers).

F.) Negotiating Cultural Conflicts in the Doctor-Patient Relationship

The subject focuses on the practical skills necessary to effectively address situations when physicians and patients encounter conflicts in their cultural approach to health care and treatment options.

Core Competencies: Students should be able to:

- Recognize cultural conflicts regarding cultural beliefs of health and illness, traditional health-care practices, etc.
- Assist the health-care team in developing a mutually acceptable, culturally responsive plan for patients facing illness.

G.) Effective Communicating and Interviewing

Studying appropriate forms of communication, especially for use in patient interviews, is the most important part of delivering culturally competent care. This topic will instruct students to listen and ascertain the important features of the patient and his situation, ranging from family dynamics to his cultural model of health and illness to his feelings and concerns about health care.

Core Competencies: Students should be able to:

- Demonstrate the ability to present concerns from another's perspective.
- Demonstrate an interviewing style that elicits another's perspective.
- Recognize behaviors that cause others to become defensive.
- Identify and attempt recovery from mistakes in communication.

H.) Using Interpreters

Students should recognize situations in which an interpreter would eliminate or minimize any communication and cultural barriers between the health-care team and the patient and his family. The effective use of interpreters (e.g., facing the patient, not the interpreter) also is addressed in this session.

Core Competencies: Students should be able to:

- Assess the need for interpreters in the clinical setting.
- Be familiar with the appropriate, effective use of interpreters.
- Be familiar with the Americans With Disabilities Act and what this means with respect to sign language interpreters in the clinical setting.
- Be familiar with the process of obtaining interpreter services in one's local hospital or clinic.

I.) Taking a Patient's Cultural Profile/History

Students need a basic framework to help them identify elements of culture and assess the characteristics of different cultures. Some examples include: (1) communication—through language or interpreters; (2) cultural value knowledge—knowing what is acceptable or unacceptable within a certain culture; and (3) the ability to look for and recognize different family dynamics within a culture.

Core Competencies: Students should be able to:

- Learn the elements of the cultural profile and history.
- Learn to elicit elements of the cultural profile and history and be able to record it in the medical written record.
- Learn the use of the cultural profile and history with individual patients and in assessing needs in the larger community.

Overall Lessons Learned

In the pages that follow, many of the lessons that the PRIME schools learned about cultural competency in medical education are shared in detail. Among those are:

- The importance of an integrated, institutional approach to cultural competency in medical education, with a focus on the whole climate—not just an elective or two;
- Faculty on the clinical side must be especially educated on the importance of cultural awareness in a medical setting;
- Change can take place within an existing curriculum structure, rather than through a total overhaul;
- Learning must match not just the varying methods of student comprehension but also the curriculum and the situation;
- Evaluation efforts must be considered from the outset of a curriculum change, not just after the fact, and they must complement the evaluated situation. Work with key players to develop a system of review.

Notes:

- ¹ Gonzalez-Lee, T.; Simon, H. (1997). Spanish and cross-cultural sensitivity to medical students. *Western Journal of Medicine*, 146: 502-504.
- ² Godkin, M.; Weinreb, L. (2001). A pathway on serving multicultural and underserved populations. *Academic Medicine*, 76: 513-514.
- ³ Rodgers, K.D.; Coulehan, J.L. (1984). A community medicine clerkship on the Navajo Indian reservation. *Journal of Medical Education*, 63: 624-628.
- ⁴ Esfandiari, A.; Drew, C.R.; Wilkerson, L.; Gill, G. (2001). An international health/tropical medicine elective. *Academic Medicine*, 76: 516.
- ⁵ Rubenstein, H.L.; O'Connor, B.B.; Nieman, L.Z.; Gracely, E.J. (1992). Introducing students to the role of folk and popular health belief systems in patient care. *Academic Medicine*, 67: 566-568.
- ⁶ Takayama, J.I.; Chandran, C.; Pear, D.B. (2001). A one-month cultural competency rotation for pediatrics residents. *Academic Medicine*, 76: 514-515.
- ⁷ Altshuler, L.; Kachur, E. (2001). A culture OSCE: teaching residents to bridge cultural worlds. *Academic Medicine*, 76: 514.
- ⁸ Bloom, S. (In print). Cultural competency in medical schools: a case study of change. Unpublished doctoral dissertation. Temple University, Philadelphia, Pa.
- ⁹ Banks, J.A.; Banks, C.A. (2001). *Multicultural Education: Issues and Perspectives*. New York, N.Y.: John Wiley & Sons.
- ¹⁰ Gorski, P. (1996). Multicultural Supersite: Multicultural philosophy series. Retrieved January 21, 2003, from Multicultural Supersite Web site: <http://www.mhhe.com/socscience/education/multi/philosophy/3critical.html>.
- ¹¹ Campina-Bacote, J. (1998). *Inventory for Assessing the Process of Cultural Competence Among Health Care Professionals*. Cincinnati, Ohio: Transcultural C.A.R.E. Associates.
- ¹² Kleinman, A.; Eisenberg, L.; Good, B. (1978). Culture, illness and care. *Annals of Internal Medicine*, 88: 251-258.
- ¹³ Cross, T.; Bazron, B.; Dennis, K.W.; Isaacs, M.R. (1989). *Towards a Culturally Competent System of Care*, Volume 1. Washington, D.C.: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Top to Bottom: Making Cultural Competency Institutional

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Learning Objectives

Following the completion of this chapter, the reader should be able to:

1. Assess the impact of external, organizational and internal influences of the institutional climate in relationship to cultural competency.
2. Determine steps in planning for effective organizational change.
3. Determine the critical components for managing institutional change.

Checking the Climate

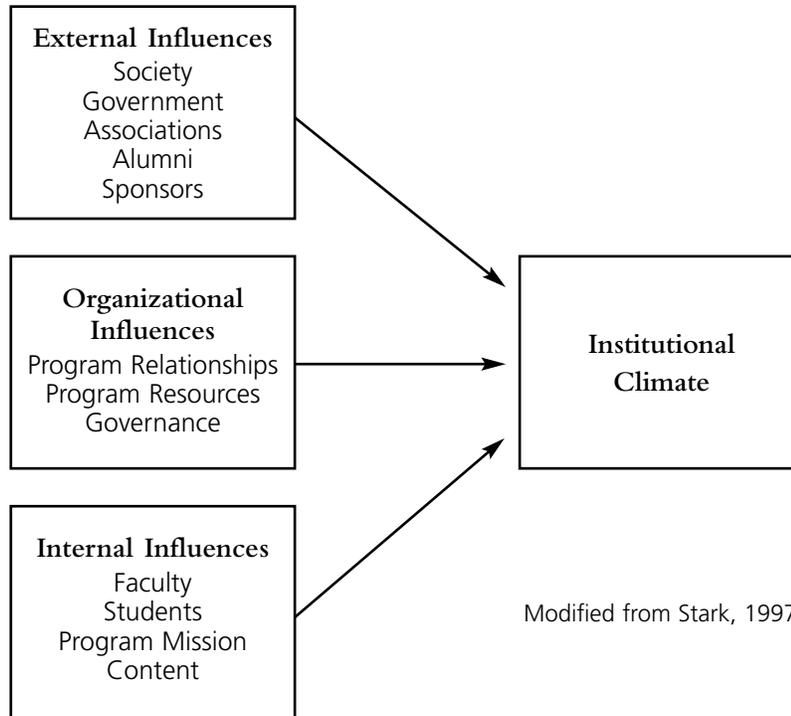
It's impossible to improve how an institution addresses cultural competency without first taking an honest look at what currently it's doing right—and wrong. In the end, a school might simply need to enhance its existing efforts; on the other hand, it may need to create an entirely new program.

The best place to start is by understanding the ways in which external, internal and organizational influences impact cultural competency at medical schools.¹

External Influences: If you can't be in control, be aware

Of course, the most obvious external influence is that cultural competency is now mandated by the LCME.² The LCME's standard on cultural competence (Section II, ED 21, ED 22) for the accreditation of American and Canadian M.D. programs is a guiding principle for medical schools as they go forward. The task is to decide the nuances of how that standard is met, to have a full picture of the demographics of the various cultures medical students will serve—from understanding different cultures' views on what constitutes illness to who has medical decision-making authority in a family.

Figure 2-1: Institutional Climate



Other outside factors that affect institutional climate include influences by sponsors, funding sources and such organizations as alumni associations that can affect the content of the medical curriculum.

Don't underestimate the impact available literature in medical and other disciplines can have on an institution's commitment to cultural competency, both in terms of content issues and curriculum planning issues. An extensive review of what's available—the prevailing trends—can provide valuable insight about the state of an institution. So can looking at peers.

Some experts also advocate environmental scanning—a technique that looks at such broader media as magazines, television, movies and the Internet to gain a feel for regional or national influences that might impact the way a school does business.

Organizational Influences: How the pieces come together

How do cultural competency programs at an institution fit into other aspects of undergraduate medical education? In many schools, for example, cultural competency is a small component of a larger course—global courses often intended to cover material not presented in other core courses. Schools may also mix cultural competency into clinical clerkships or electives.

An additional factor is determining the resources given to the cultural competency program. Is specific funding in place for faculty time, educational materials and guest speakers? Is funding available for someone to direct the cultural competency curriculum for the entire undergraduate experience? Are resources available to train faculty to become proficient in teaching cultural competency?

All of these issues of governance are important to the cultural competency training effort, indicating commitment levels and providing a sense of the structure of leadership. In some cases, leadership takes the form of a single director or office, such as a course director or a multicultural affairs office. But leadership can also come from a collaborative committee of course, clerkship, instructional development and multicultural affairs directors, as well as the dean's office.

Internal Influences: Knowing the players and how they play

Faculty play an enormous role in putting together a successful cultural competency program. Identifying faculty who have a specific interest in cultural competency also means finding potential

“The institutional leadership in undergraduate medical education must commit time and money to developing the teaching materials, environments and partnerships that are necessary to make the study of culture in medical education a reality.”

—Melanie Tervalon, M.D., *Academic Medicine*, June 2003

allies and change agents who can assist with altering the curriculum. They'll be needed to work with the other faculty who should be identified: those who are resistant to change, whether from a lack of knowledge or understanding, a competition for resources (time or money) or from bias or prejudice.

In most medical schools, the cultural competency opinion leaders are likely to be those whose primary roles are in other areas—administrative, clinical or biomedical science. What sets them apart is their specific interest and expertise in the area of culture and health. Their network of influence may be departmental or may have a larger range depending on their accessibility. Not only can they exert a positive influence for acceptance and adoption, but they also add expertise to the process.³

But those working on reform measures for cultural training should be diligent about making sure interested faculty members also possess the skills necessary to help reshape an entire program. Don't assume expertise in cultural competency; discern it.

Students' roles

Similarly, students can be a font of information for devising a cultural competency curriculum; after all, it's their medical school. Some digging may be required, because most student influences come in the form of evaluation feedback following a program or event. But looking at how students have been involved in previous planning and decision-making can help predict how involved they will be in cultural curriculum changes. Including students in these stages may increase acceptance and relevancy of the training programs among your target audience.

SLU for example, planned its curriculum with both its Cultural Competency Committee and interested students. The SLU committee had broad representation, including members of the Multicultural Affairs and Curricular Affairs offices and faculty from many clinical departments. The faculty and staff provided a variety of expertise, but all had a strong interest in cultural competency.

Because cultural competency programs are often new and allocate only a small amount of dedicated instruction time, the content is often limited as well. Analyzing both how and what is taught is important, including surveying all courses and clerkships to look for the hidden curriculum—that collection of unintended knowledge, attitudes and skills conveyed in any medical school course or rotation.⁴

Assessing the institutional climate provides not only the starting point to developing a culturally competent medical education but also information that can provide insight into potential barriers and benefits in the innovation process. The next step is to take the information gathered and build a plan.

Institutional Climate Checklist

External Influences

- Examine societal, government and association mandates.
- If relevant, explore alumni interest in or advice about programs.
- Be conscious of funding or sponsors for existing or new cultural competency programs.

Checklist continued

Organizational Influences

- ✓ Examine how current cultural competency education is related to other courses.
- ✓ Explore current resources in terms of time and money allocated to cultural competency training.
- ✓ Examine the leadership structure guiding the current cultural competency education.

Internal Influences

- ✓ Assess faculty for interest, expertise and resistance regarding cultural competency.
- ✓ Assess students for interest, experience and resistance regarding cultural competency.
- ✓ Examine any current content for cultural competency, including basic sciences and clinical courses. Be conscious of a “hidden curriculum,” which can be a barrier to cultural competency education.

Planning for Change

Mission Control

Creating a mission statement for the overall cultural competency program is the best way to begin planning an institution’s change. Such existing statements as the LCME standard, university-wide statements or educational goals can be used or incorporated into a specific mission statement for the cultural competency initiative. The information gathered from a climate checklist will help guide the content and conviction of a mission statement.

Mission Statement: Mission statements are typically short and provide a broad guide for the initiative based on purpose, core values and ethical standards.⁵ For example:

The cultural competency program will provide a link to assure that education about diversity, culture and health will be a thread throughout the 4 years of undergraduate medical education.

As with any other undertaking, the mission statement for a culturally competent curriculum could be considered a kind of ideological roadmap for change.

Goals: Goals are built on the foundation of the mission statement; they translate the mission into specific units or educational experiences and are written in terms of what will be provided to the student. Goals describe a specific course or educational activity, such as one of the sessions developed at SLU:

The session on how to obtain a culturally appropriate medical history will teach students the principles of eliciting the patient’s health beliefs and how they impact the delivery of appropriate health care.

Objectives: Just as the mission drives the development of the goals, goals provide the foundation for developing objectives. Objectives break down a goal to illustrate how it will be achieved by a student in more specific terms. An objective describes what the student is expected to accomplish—an act that should be both achievable and measurable—rather than what the course or educational activity will provide the student.⁶

Think of the objective as the intrinsic result for the student. For example, one objective for eliciting a culturally appropriate history from a patient might be:

After completing the workshop, the medical student will be able to ask five of the eight Kleinman questions⁷ (see Figure 2-2) during a simulated interview with a standardized patient.

Figure 2-2:

Arthur Kleinman's Eight Questions for Eliciting the Patient's Explanatory Model of Her Illness

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?

Kleinman, Eisenberg and Good, 1978

The Kleinman questions, developed out of medical anthropology research, are designed to elicit the patient's health beliefs and expectations or concerns about the disorder and the treatment. This objective would let the student know what to study (the Kleinman questions); how to study (memorizing questions and practicing their use in an interview); and that use of the questions will be measured using a simulated interview.

Make a Wish List

Once a cultural competency training mission is clarified, make a list of people who will be valuable to the new initiative and use it to recruit them for the cause. Start with the key opinion leaders—those individuals who have both influence over a large network of people and interest in the task. Form a committee, formal or informal, to spread good public relations, share ideas and infiltrate different school programs with a positive message.

Also, identify and contact "change agents." Change agents are usually people and groups outside the institution, although in large organizations they may be someone outside the area undergoing change but still a part of the school or university. Change agents typically are experts in the area who are recruited to aid in adoption or acceptance of changes.³ In diversity education, change agents are used in the needs assessment, planning, implementation and evaluation phases.

Diversity on Their Minds

In a sense, the Mercer University School of Medicine (MU) was born to be culturally competent. It was founded in 1982 to fill the urgent need for physicians in Georgia—especially primary care physicians in underserved areas. MU's admissions policy even selectively admits students from medically underserved areas.

So when Georgia officials discovered the State was facing an expected 300 percent increase in its Hispanic population, coupled with an already high number of migrant workers, MU educators felt the school had a mandate to prepare culturally competent physicians.

Instead of jumping into a new curriculum—indeed, into a new way of thinking and instructing—MU began slowly. It asked consultants from the National Center for Cultural Competency in Washington, D.C., to help the school facilitate change.

continued

Consultants planned a day of cultural competency workshops for MU faculty, administrators and students, making it easy for everyone to participate by holding repeat sessions so individuals could plan their work around a choice of times.

The sessions, which incorporated teaching presentations with question-and-answer periods and a visioning process, covered three main themes: the rationale for cultural and linguistic competence in health care; the conceptual framework for a cultural competency model; and the characteristics of culturally competent systems and organizations. The consultants stressed that culture goes beyond just race and ethnicity, and achieving competency is an ongoing process that requires continuous learning—not just an "add-on" to the curriculum. They also said cultural competency is about valuing diversity, managing the dynamics of difference and cultural self-assessment.

That last element showed when the consultants posed the question, "In 5 years, what do you envision happening to make this work?" The participants at MU suggested many opportunities they felt were key, including:

- language courses,
- diversity recruitment strategies,
- immersion in foreign culture, and
- collaboration among faculty members.

Later in the workshop, participants were asked to determine some effective strategies for infusing cultural competency into the MU atmosphere. One faculty member said he finally understood what cultural competency was about; he just needed some time to digest the information before he could put it into practice. Other faculty members were still dubious about the role of cultural competency in medical education, questioning whether it actually works and if there is ever time to make it happen. The consultants, pointing to data that shows how successful diversity education can be, reminded all MU participants that successful cultural competency shouldn't be thought of as taking more time to do; rather, it's about changing how a school meets its responsibilities.

At Mercer University, for example, cultural competency curriculum organizers sought a buy-in from all the parties a curriculum change would affect by funding a day of workshops led by consultants from the National Center for Cultural Competence (NCCC) at Georgetown University (see "Diversity on Their Minds," page 11). The consultants focused on achieving cultural competency and its implications. Although the NCCC and change agents like it can't ultimately tell an institution what the components of its cultural competency curriculum should be, they can guide a school toward its vision.

Keep Selling the Need

Having an articulated mission and a roster of people willing to help make change happen does not ensure success. For that, schools need an ongoing commitment to helping the medical school community understand and welcome the new initiative—and not every school will have the ability to hire consultants. Salesmanship helps in this endeavor. The following ideas should increase the likelihood that an initiative is accepted.³

Increase knowledge: Promote the advantages of cultural competency training by selling the message of how well it serves students by adding to their skill sets. Focus on how the change will be an improvement and will result in better-qualified, more responsive physicians.

Link values: The mission statement should reflect either institutional or association mandates; when selling cultural competency training to the educational community, point out how the training serves to fulfill the values, philosophy and mission of the institution as a whole. This will raise

the perceptions of a student’s medical school education, and hence, his or her career potential after graduating. Cultural competency becomes essential, rather than just another option.

Think incrementally: Change is harder to swallow when it happens all at once. Instead, practice patience. Introduce a plan to an institution’s players with the idea that it will be tested for effectiveness, rather than accepted without analysis. The medical school community will feel it has a better opportunity to evaluate the changes on its own, without being force-fed someone else’s vision.

Be visible: Don’t bury outcomes. Make sure the results of the initiative are publicized to members of the institution. These factors affect not only the chance of successful institutional change but also the rate of the change.

Manage With Care

Educators react to change very differently than most professionals. Understanding the change process and its impact on individuals, organizations and cultures is crucial. As Fullan and Stiegelbauer stated, “The greatest problem faced by schools is not resistance to innovations but the fragmentation, overload and incoherence resulting from the uncritical acceptance of too many different innovations.”⁸

Fully implementing change requires a skillful leader who is not only aware of the various components of an institution and what its respective sensitivities are, but who is also exceedingly patient. Knoster introduced a *Managing Complex Change* model (see Figure 2-3) that had several components: vision, consensus, skills, incentives, resources and action plan.⁹ He suggested that if any one of the components was missing, the change process may be inhibited or abandoned altogether. But, when all the components are present in the system, change is successful.

This model offers a remedy by identifying the symptom and then re-establishing the missing link. Quite often, an educator is able to sense what is wrong but does not understand how to resolve or determine the root of the problem. As cultural competency initiatives are launched and problems are introduced, referring to the following table to identify the symptom that corresponds with the missing link might prove helpful.

Figure 2-3: Managing Complex Change

Vision +	Consensus +	Skills +	Incentives +	Resources +	Action Plan	= Change
	Consensus +	Skills +	Incentives +	Resources +	Action Plan	= Confusion
Vision +		Skills +	Incentives +	Resources +	Action Plan	= Sabotage
Vision +	Consensus +		Incentives +	Resources +	Action Plan	= Anxiety
Vision +	Consensus +	Skills +		Resources +	Action Plan	= Resistance
Vision +	Consensus +	Skills +	Incentives +		Action Plan	= Frustration
Vision +	Consensus +	Skills +	Incentives +	Resources +		= Treadmill

Knoster, 1991

Planning for Change Checklist

- Develop a mission statement with clear goals and objectives.
- Identify and recruit key opinion leaders and change agents.
- Promote the advantages of cultural competency training and the expected outcomes for students.
- Link the values and mission of the initiative with institutional or association mandates.
- Plan for small, easily understood changes that can be introduced on a trial basis or field-tested.
- Promote the initiative and real or expected outcomes of the initiative.
- Provide solid leadership to manage conflicts as they arise.

Improving schools involves change. Change, however, is not an isolated process. Cultural competency changes in medical schools are invariably linked to the personality of an institution itself. In order to change the structure, one has to consider the effects of change on all parts of the school. Examining these parts and considering their influence on the change is important for leaders or change agents.

Innovations in schools are big business, politically and economically. The temptation to latch on to quick fixes, to go along with trends, to react uncritically to endorse innovations as they come and go, is a critical problem. Remember, failure to institutionalize an innovation is one of the biggest reasons that change fails. But if you bring in the institution at large, involve, inform and lead all the individuals affected, a winning cultural competency initiative will result.

Notes:

- ¹ Stark, J.S. (1997). *Shaping the College Curriculum: Academic Plans in Action*. Needham Heights, Mass.: Allyn and Bacon.
- ² Liaison Committee on Medical Education (2000). Standards for accreditation of medical education programs leading to the M.D. degree. *Functions and Structure of a Medical School*. Washington, D.C.: LCME.
- ³ Rogers, E.M. (1995). *Diffusion of Innovations, 4th Ed.* New York, N.Y.: The Free Press.
- ⁴ Turbes, S.; Krebs, E.; Axtell, S. (2002, June). The hidden curriculum in multicultural medical education: the role of case examples. *Academic Medicine, 77*(3): 209-218.
- ⁵ Bryson, J.M. (1995). *Strategic Planning for Public and Nonprofit Organizations: A Guide to Strengthening and Sustaining Organizational Achievement*. San Francisco, Calif.: Jossey-Bass.
- ⁶ Kern, D.E.; Thomas, P.A.; Howard, D.M.; Bass, E.B. (1998). *Curriculum Development for Medical Education*. Baltimore, Md.: The Johns Hopkins University Press.
- ⁷ Kleinman, A.; Eisenberg, L.; Good, B. (1978). Culture, illness and care: clinical lessons from anthropological and cross-cultural research. *Annals of Internal Medicine, 88*: 251-258.
- ⁸ Fullan, M.; Stiegelbauer, S. (1991). *The New Meaning of Educational Change*. New York, N.Y.: Teachers College Press.
- ⁹ Knoster, T. (1991). Presentation in TASH Conference. Washington, D.C.

Training Faculty for Cultural Teaching

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Learning Objectives

Following the completion of this chapter, the reader should be able to:

1. Describe several potential rationales for faculty development in cultural competency.
2. Understand a model for ascertaining levels of student knowledge, skills and attitudes regarding cultural competency.
3. Plan a one-on-one teaching encounter on cultural competency using three distinct teaching methods.
4. Consider other teaching methodologies such as video vignettes, small group facilitation, role play and community immersion for cultural competency training.
5. Understand the elements of formative feedback that may be particularly relevant to this work.

Why Is Faculty Development Necessary?

In the previous chapters, the case—and urgent need—for cultural competency training in medical schools throughout the United States and Canada has been well documented. But integrating cultural competency training into medical education means doing more than just writing new curricula. A well-written plan for training is useless if its teachers don't believe in it. Faculty must be educated, too.

While students may be exposed to well-developed cultural competency classes in their preclinical years, particularly in their "Introduction to Clinical Medicine" course, that curriculum may not be reinforced as students are later involved in clinical teaching settings where there is time to apply the theory and skills learned. Students continue to report that cultural competency is not a part of their clinical training. This is a crucial oversight, because the clinical years are a time when students have greater contact with clinical and social science faculty who will influence the way they go on to practice medicine.

Several researchers¹ have described a hidden curriculum that permeates clinical medical education and undermines the overt lessons taught in the early years of medical education. In these situations, faculty may be reluctant to comment on insensitive or overtly biased comments of students. In worst-case scenarios, the gallows humor and survival instincts pervasive in the culture of residency manifests the very unprofessional and disrespectful treatment of patients that reinforces the need for cultural competency training in medicine.²

To minimize the impact of the hidden curriculum, the entire faculty should be provided training, like that created in 1999 by the UMass Community Faculty Development Center. The program,

now in its fifth year, integrates cultural competency into clinical training³ and is a useful way to instruct faculty as well as students. Some of its ideas are presented here.

Foundations for Educational Planning

Previously, the UMass faculty development curriculum for teaching community-based physicians largely focused on principles of teaching and learning rather than on specific topics. Very little literature existed to guide UMass in developing the cultural competency curriculum. But the principles UMass used to steer curriculum choices, presented below, can be integrated into most existing faculty development programs as they make room for cultural competency.

Follow principals of adult-learning theory. Adult-learning theory, or andragogy, emphasizes the importance of experiential learning. Adults learn best when the material is connected to the experience of the learner and is delivered in several different, short components rather than long lectures. Cultural competency training usually begins with a focus on self-awareness of stereotyping and bias, using reflection and collaborative learning strategies, which fit into this model⁴ (see “Adult-Learning Theory,” below).

Adult-Learning Theory

In the 1980s, Malcolm Knowles pioneered a theory of adult learning, which he called “andragogy”—to distinguish it from pedagogy, which literally translated means the art and science of educating children. The theory, which states that adults learn best when the material is connected to their own experiences, includes the following characteristics of the adult learner:

- self-directed,
- possesses a foundation of life experiences,
- goal-oriented,
- relevancy-oriented and
- needs practical application for new knowledge.

The theory states that when designing learning experiences, the instructor should take into account the following needs of adult learners:

- to know the relevance of what they are learning;
- to learn experientially;
- to approach learning through problem solving; and
- to see the immediate practical application to what they are learning.

Knowles, M. (1984). Andragogy in Action. San Francisco: Jossey-Bass

Get a buy-in from faculty. Making sure faculty members understand why this curricular content is important and how they will benefit from it has become a critical part of the success of the UMass course. The UMass faculty development instructors discuss with primary care providers ways that they can develop strong relationships with patients and deliver patient-centered care, pointing out examples of how the best care requires an understanding of the patient’s culture. Reminding faculty that medicine has its own culture and that the practice of medicine requires physicians to step beyond that insular culture into the population it serves is also helpful.

With other types of participant groups, emphasizing the growing diversity of the population, and the increase in the number of studies that show how underrepresented minorities and other patients who come from lower socioeconomic classes have less favorable outcomes in health care helps. The growing number of studies on relationship and communication disparities experienced by such groups is a powerful argument for battling unintended bias by the medical profession⁵ and ultimately improving patient compliance and health outcomes.

Complete a needs assessment. Teaching to the needs of the faculty is perhaps one of the most challenging objectives in faculty development. Faculty come from a collection of diverse backgrounds, both personally and professionally, and while some faculty are well-versed in the concepts of cultural competency and are highly effective in providing culturally competent care, others are new to the subject. For the former group, instructors need to emphasize effective methods of teaching cultural competency to medical students, rather than rehashing the basic concepts of cultural awareness that these faculty members already know. With the latter group, it's the opposite: There's a focus on some of the content of cultural competency with less emphasis on teaching. Knowing the background of participants as well as their personal goals and expectations can help significantly with participant needs assessment.

Reinforce existing training concepts. There's no reason to reinvent the wheel when looking for methods to deliver cultural competency training to faculty. The goal is simply to make the wheel stronger. For example, UMass' general curriculum describes the educational planning process with the mnemonic GNOME, which stands for Goals, Needs Assessment, Objectives, Methods and Evaluation.⁶ During the school's first faculty development conference, which emphasizes assessing learners' needs, considerable time is spent discussing cultural needs evaluation. In the second conference on methodologies of teaching, student observation techniques and how to teach communication skills that reinforce cultural competency are covered. Finally, for the third conference, which focuses on evaluation, the cultural competency curriculum provides instruction on how to deliver feedback to students about cultural issues in clinical care. Each of these three ideas is discussed in detail in the workshop section that follows.

Cultural Competency: A Workshop in Three Parts

Part I: What a Student Needs

The backbone of the UMass faculty development curriculum is the student needs assessment. UMass modified an already established cultural sensitivity skill model,⁷ which emphasizes cultural sensitivity as a dynamic rather than a static process. The modified model uses three larger conceptual stages instead of the original seven (see Figure 3-1) and suggests that the reactions of medical students to cultural difference will depend heavily on their own personal experiences in this regard.

At the lower end of the scale, students approach issues of culture from a learner-centered or egocentric position, in which students may react to cultural difference in a clinical encounter from perspectives that reflect their own beliefs. Moreover, the student may respond to poor medical outcomes by blaming the patient. Students in this stage may fear or deny difference, may react to difference with superiority or may overgeneralize and stereotype patients based on cultural dimensions such as race, ethnicity, gender, socioeconomic status or sexual orientation.

In the middle stages of the cultural sensitivity scale, students may enter patient encounters with the assumption that a universal approach to issues of respect, doctor-patient communication, and medical knowledge and beliefs is generic to all cultures. In this stage, the student believes that "if I treat everyone like I'd want my mother to be treated, everything will be just fine." Minimization of worldviews is dangerous, because what constitutes respect may vary by culture and person, and may lead to unintentional offense. Students then may react defensively, from an egocentric position, leading to stereotype and superiority (e.g., labeling the patient as difficult).

In the latter stages of the cultural sensitivity scale, students approach culture from a patient-centered perspective, fully aware of the power differential in the relationship and the dynamics of difference. They resist assumption, demonstrate empathy and reflect on difference and their own behaviors on a regular basis.

Faculty need to use a variety of techniques to develop an understanding of the student's stage along the cultural continuum in the context of different clinical encounters. Using facilitative questioning, observing student-patient interactions, encouraging self-reflection and drawing on best hunches from one's experience with medical students are all valid in assessing student needs. However, it is important that faculty be careful to avoid that the patient assumption that observed behaviors, student frustration with challenging encounters or poor relationship and communica-

tion outcomes are the result of egocentric attitudinal needs. Often, these outcomes stem from a lack of skill rather than overt bias. Assuming “there’s an attitude problem” only serves to model stereotyping and may lead to defensive posturing by students. The faculty’s goals are to move medical students along this cultural sensitivity scale and to try to prevent them from slipping back to more defensive postures when they err in their work with patients.

Part II: Techniques for Teaching

Most of the participants in UMass’ faculty development program come from community-based practices. Thus, much of their teaching is in the context of providing primary care. To counter the hidden curriculum previously described, instructors emphasize using a variety of teaching styles, encouraging facilitative and collaborative techniques in addition to more traditional didactic methods. The school also discusses the use of reflection, modeling and giving feedback. These techniques are ideal for one-on-one teaching in an office setting.

Match teaching style to objective. In addition to the specific teaching methods that follow in this section, the faculty development course spends much time focusing on the variety of teaching styles that may be useful in specific scenarios. Participants learn to use these styles for a particular situation, depending on student need. For example, facilitative or nondirective teaching styles may be useful for eliciting students’ feelings and attitudes toward patients in a less overt way (e.g., self-reflection), while collaborative and suggestive styles may be more suitable for teaching the skills of cross-cultural interviewing. Finally, the course teaches the appropriate use of the directive teaching style for particular scenarios involving knowledge content.

Collaborate with the community and colleagues. Regardless of any faculty member’s particular skill level in cultural competency, resources are available within their practices from which to learn. A practice’s community, for example, can serve as a teacher. Faculty can encourage students to work with office staff and community members from local cultures to discover more about patients’ verbal and nonverbal needs and communication patterns, and to develop a heightened level of empathy and respect for both the problems and the strengths of a particular patient population.

Using a multidisciplinary team of health-care professionals also facilitates student learning from various perspectives that exist within the health-care system. The culture of medicine has been described as a nonculture, in which medicine is taught as the truth, rather than as a point of view.⁸ But learning to understand the views of other health-care disciplines may help to facilitate an appreciation for the uncertainties in medicine.

Practice self-reflection. Reflection, and in particular, self-reflection, is an essential tool for becoming more culturally competent. It provides an effective technique for teachers themselves to become more culturally competent as practitioners. Passing this method on to students sends a strong message that cultural competency training is more than a course or a certification; it is a life-long process.

Western medicine is inherently a reductionistic arena that encourages deeming various characteristics of people as “problems.”⁹ Physicians are likely to make mistakes by judging people or considering them from their own particular worldviews, boiling down cultural characteristics into potential problems or risk factors. These inevitable mistakes are not intentional; nonetheless, they may have significant impact on relationships with patients and, more importantly, on outcomes of care.

That’s why it is faculty members’ reactions to these mistakes that send the most important messages to their patients and their students. Faculty should learn to contemplate reactions that show a depth of cultural understanding. These mistake scenarios are an opportunity for growth, heightened sensitivity and achievement of a higher level of skill as a physician—and as a student. A reaction to such an event is perhaps the most powerful opportunity for promoting growth through shared reflection with students—a way of moving them along the cultural sensitivity scale.

Make modeling purposeful. Although modeling may seem like a passive process on the surface, in reality, it can be a powerful and active teaching technique. In modeling, the instructor previews what students will see, asking them to actively observe for particular skills or concepts and then asking them to discuss or report back what they see. Modeling encourages participants in faculty development training to make their use of modeling more purposeful in the office classroom, building and deepening the idea of self-reflection.

For example, a faculty member might say to a student, "I'd like to reflect upon our visit with the last patient. I was embarrassed that I assumed that she is heterosexual, only to find later that she is a lesbian. I really want all of my patients to feel welcome here, and I sent her a strong negative signal. With the next patient, I'm going to try to be more purposeful and mindful of my assumptions. Watch how I interview her regarding the issue of relationships and report back to me what you see."

Here, the faculty member has reflected on a mistake and demonstrated to the student that he is able to recover from that and move forward to a more disciplined and mindful interviewing technique. But the faculty member did not stop there. He also asked the student to perform an active step of observation, learning to improve interviewing techniques and to report back on this after the visit. This, in turn, helps the faculty member discern a student's progress on the cultural sensitivity scale, just as with the reflection technique.

Explain cross-cultural communication barriers. The faculty development training program also teaches a specific cross-cultural communication technique that modifies elements of the LEARN model, developed by Berlin and Fowkes,¹⁰ and combines them with elements of the patient-centered interviewing technique of Carrillo, et al.¹¹ and Arthur Kleinman questions¹² for eliciting the patient's health beliefs (see "Culturally Effective Communication: The LEARN Model Revised," this page). Faculty who are unfamiliar with this communication tool learn to use it and, then, to incorporate it into their teaching practices. Faculty are asked to observe students during interviewing and make behavior-specific observations based on the model. These observations form the basis of feedback that should lead to improved communication for students of cultural competency.

Culturally Effective Communication: The LEARN Model Revised

LISTEN

Identify and greet family or friends of the patient.

Ask patients with English as a second language if they would like an interpreter.

Start with open-ended questions and avoid interruption for the first 30 seconds that a patient speaks.

- "Could you please tell me your reason for the visit today?"
- "How can I help you today?"

ELICIT the patient's health beliefs as they relate to the reason for the visit as well as his health behaviors. The following questions may help in this process:

- "What worries you the most?"
- "Are you afraid that you may have something serious?"
- "What do you think has caused this problem, and what do you think started it?"
- "Have you started any treatment on your own or gotten advice about your problem from someone else?"
- "How can I be of most help to you?"

ASSESS potential attributes and problems in a person's life that may have an impact on his health and health behaviors. Medicine in this country may be totally foreign to someone. Also, in some cultures, families make decisions together as a unit, or individuals may turn to an elder for health advice. Lastly, people may be too shy to discuss their needs out of respect for the physician.

continued

- "I'd like to get to know you more today. Could you tell me about yourself? With whom you live? Where you work?"
- "What brought you here to this country? How does medical care differ here?"
- "Do you have family and friends who help you with decisions or who give you advice?"
- "Do you have coverage for your medications?"
- "Are there times that are bad for you for appointments? Is transportation a problem for you?"
- "Do you have any trouble reading medicine bottles or appointment cards?"

RECOMMEND a plan of action with an explanation of your rationale using language that the patient is able to understand. Physicians underestimate the amount of information that patients want and often provide the information using medical jargon that is unintelligible to the patient. Patients are often too embarrassed to admit this. You can check how well you taught the patient.

- "To make sure that we understand one another, can you tell me what it is that I just told you?"
- "Is there any part that you don't understand?"

NEGOTIATE a plan of action with your patient after you have made your recommendations.

- "Now that we understand each other, let's come up with a plan that works for you."
- "What do you think should be the next steps?"

Adapted from Berlin and Fowkes, 1983; Carrillo, Green and Betancourt, 1999; and Kleinman, Eisenberg and Good, 1978

Part III: Methods of Providing Feedback

Although it sounds simple enough, giving students feedback involves as much technique as teaching the lessons of cultural competency—and formative feedback can offer as much reinforcement of cultural sensitivity as the lessons themselves. The UMass faculty development model places particular emphasis on practicing feedback in small groups, with an overall goal toward moving students forward on the cultural sensitivity scale while having them maintain self-respect. Three methods are particularly useful for delivering formative feedback.

Student self-assessment as feedback. By encouraging learner self-assessment, faculty are also able to perform a needs assessment of a student and take the opportunity to understand the student's knowledge, skills and attitudes.

Behavior-specific feedback. To assume the student holds a particular attitude toward a patient or a cultural group without explicit discussion risks stereotyping. For example, if a learner appears blunt and cold during an interview, a faculty member cannot be sure if this is due to a lack of communication skills or a lack of cultural sensitivity. When providing feedback, then, faculty should address how to improve behaviors rather than chastise in a broad sense about attitudes.

Action-based feedback. Faculty should provide students an opportunity to move forward by explaining how they can improve, rather than merely explaining what was incorrect about an action. Again, involving the learner in this plan of action is particularly important, because students—like faculty—must grasp the relevance of cultural competency training to believe in its value and practice it wisely.

Teaching the Teacher: Techniques Used in Faculty Development Training

Of course, just as there are preferred ways of instructing medical students about cultural sensitivity, there are particularly effective methods of training faculty to pass cultural sensitivity prac-

tices on to their students. In order to make this content appear seamless and integrative with the rest of the faculty development curriculum, UMass follows a format it uses throughout the training program, including the use of video interaction, small group discussions, role playing and community immersion.

Video vignettes. UMass engages the faculty in large group discussions through interactive lectures. In some cases, this may involve audience discussion of video vignettes from popular films or television shows. For example, such films as “Philadelphia”—which portray assumptions regarding race and sexual orientation as well as egocentric reactions when these assumptions come into question—are particularly useful for discussing the egocentric stages of the cultural sensitivity scale. In other cases, UMass faculty development instructors use preceptor-student vignettes that are produced as trigger tapes. Videotaped situations in which students interview patients with interpreters or attempt to use the LEARN communication tool are effective for large group discussion, particularly when it comes to learning how to use the observation checklist with students and debrief them on their progress.

Small group work and role play. Participants rate small group work highly as a faculty teaching method. During the 18-month period that faculty go through the faculty development training process, UMass establishes a “culture group,” for small-group discussion and role play. Small group work is case based, with role play of teaching scenarios emphasized. With this method, trust and familiarity build over time, and participants feel more comfortable with each other when the content turns sensitive. In small group work, faculty development instructors never ask participants to portray a person of a different cultural background. Instead, discussion focuses on self-reflection of cross-cultural encounters that were either videotaped or happened “off-stage.” Role play is also used in large group encounters and can be an entertaining and engaging teaching method for participants—as well as help prepare faculty participants for small group work.

Cultural immersion. Finally, UMass teaches to knowledge-based objectives by talking about the differences between generalization and stereotyping. While the patient remains the best source for learning about culture, immersion into the community and learning about particular habits or cultural norms of a local culture group can be useful for faculty and their students. That idea, however, is presented with an asterisk: Knowledge of such cultural norms cannot be viewed as fact, lest a student or faculty member risk stereotyping. This opportunity allows us to speak to the diversity of cultural beliefs experienced by individuals in a particular culture group depending on their age, socioeconomic and educational background, comfort with English as a second language, and length of time in this country. The degree of cultural assimilation to the United States is discussed as a dynamic process, which precludes assumption and highlights the risk of stereotyping.

Assessing a Faculty Development Training Program

Evaluating faculty development program outcomes is particularly difficult, because the faculty often disperse into a variety of courses and teaching situations. One way is by comparing the coursework’s pre- and post-acceptability ratings and later modifying the training based on qualitative feedback by course participants.

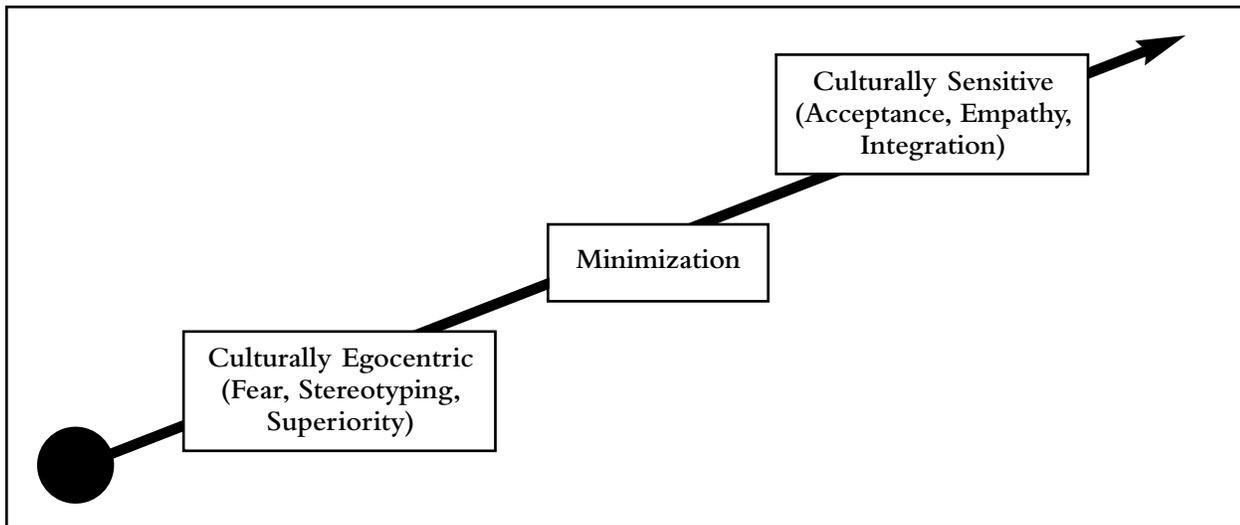
Additionally, intention-to-change data, which measures participants’ motivation to improve cultural competency in clinical care and teaching, can be helpful in determining how behavior or attitude might have been modified as a result of the training program, especially when compared with follow-up reports of behavior change. One study in particular found that intention-to-change evaluation is a valid methodology for measuring outcomes of training,¹³ although this study involved drug prescribing habits, rather than complex interactions with patients and learners.

Another option is to collect evaluation feedback during the course, rather than at the beginning or end of the training program. One way is to collect faculty reaction to video vignettes before and after the particular course session to assess teacher awareness of the “hidden curriculum” of cultural competency.

More Work to Do

Introduction of culture and diversity training in the preclinical years needs to be reinforced by clinical faculty of all levels through modeling, reflection, observation and feedback—something that can't be done without first training faculty members. Schools embarking on a cultural competency curriculum in their medical schools need to consider the needs of all faculty early in this process.

Figure 3-1: The Cultural Sensitivity Scale



Notes:

- ¹ Jackson, P. (1968). *Life in Classrooms*. New York, N.Y.: Holt, Rinehart and Winston.
- ² Mizrahi, T. (1986). *Getting Rid of Patients: Contradictions in the Socialization of Physicians*. New Brunswick, N.J.: Rutgers State University of New Jersey.
- ³ Ferguson, W.; Keller, D.; Haley, H.L.; Quirk, M. (2003). Creating culturally competent faculty: a model curriculum. *Academic Medicine*, 78: 1221-1228.
- ⁴ Quirk, M. (1994). *How to Learn and Teach in Medical School*. Springfield, Ill.: Charles C. Thomas.
- ⁵ Ferguson, W.; Candib, L. (2002). Culture, language and the doctor-patient relationship. *Family Medicine*, 34(5): 353-361.
- ⁶ Quirk, M. (2002). Teaching Strategies, Parts 1-3. *Healthcare Collaborator*, 2: 1-3.
- ⁷ Borkan, J.M.; Neher, J.O. (1991) A developmental model of ethnosensitivity in family practice training. *Family Medicine*, 23: 212-217.
- ⁸ Taylor, J.S. (2003) Confronting "culture" in medicine's "culture of no culture." *Academic Medicine*, 78: 555-559.
- ⁹ Van Ryn, J.B. (2000). The effect of patient race and socioeconomic status on physicians' perceptions of patients. *Social Science and Medicine*, 50: 813-828.
- ¹⁰ Berlin, E.A.; Fowkes, W.C. (1983). A teaching framework for cross-cultural health care: application in family practice. *Western Journal of Medicine*, 139(6): 934-938.
- ¹¹ Carrillo, J.E.; Green, A.R.; Betancourt, J.R. (1999). Cross-cultural primary care: a patient-based approach [see comments]. *Annals of Internal Medicine*, 130(10): 829-834.
- ¹² Kleinman, A.; Eisenberg, L.; Good, B. (1978). Culture, illness and care: clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine*, 88: 251-258.
- ¹³ Curry, L.; Purkis, I.E. (1986). Validity of self-reports of behavior changes by participants after a CME course. *Journal of Medical Education*, 61: 579-584.

Seamless Learning: Incorporating Cultural Competency Into the Curriculum

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Learning Objectives

Following the completion of this chapter, the reader should be able to:

1. Describe the similarities and differences among traditional, problem-based learning and hybrid medical education programs.
2. Develop strategies for implementing cultural competency curriculum in each model.
3. Define the following learning domains as related to cultural competency: knowledge, skills and attitudes.
4. Structure learning objectives for the knowledge, skills and attitudes domains.
5. Design learning activities for objectives in each domain.

The Building Blocks for Learning

Marrying Culture With Curriculum

Andragogy, or adult-learning theory¹ (see Chapter 3, page 16), indicates that the optimal method for teaching cultural competency is to integrate it into the present curriculum. Adult learners perform best when material is relevant to a situation they're studying, and the integration of culture into existing curricula may be the best way to provide students with a culturally competent medical education.

Integrating the information within already structured courses isn't a notion of convenience: It also sends the message that providing good patient care is not separate from basic or clinical sciences courses. It is not an elective. Cultural competency should be a curriculum thread, such as ethics, which is revisited throughout a medical education program and flows seamlessly into existing course materials, so that the ideas are continuously expanded and reinforced.

It's important to keep in mind that, regardless of the curriculum used, all models require a "champion" to support the idea of integrating these important topics in order to address the usual bureaucratic frustrations associated with changing medical education curricula. The LCME requirement for cultural competency training provides the basis for garnering support for the integration of such materials.²

Although all accredited medical education programs prepare students to practice medicine, all

schools are unique in their organization, format and presentation of curricular topics. This chapter opens with descriptions of the three common curriculum models: traditional, problem-based and hybrid—and strategies for integrating cultural competency within their boundaries.

Traditional curriculum

How it works: The traditional model's four-year curriculum is separated into basic sciences education and clinical sciences education. Typically, the first two years are devoted to the study of the biomedical sciences, including anatomy, biochemistry, pharmacology, pathology, physiology and microbiology, with each department in charge of the individual courses, topics and teaching methodology. An "introduction to the patient" course is usually offered, covering approaches to the patient, including physical examinations, history-taking and the behavioral sciences. The primary method of teaching in the basic sciences education is the lecture, with written examinations used to evaluate student performance. The remaining two years are devoted to clinical rotations in outpatient or inpatient settings.

Challenges: The traditional model has come under criticism from the LCME for separating the basic and clinical sciences. Clinicians are answering the complaint by becoming involved in basic sciences education, and some schools require courses in the third or fourth year that revisit basic sciences issues, such as a pharmacology update. Overreliance on lecture as the major source of teaching leads to criticism that students are passive learners—although lecture has been shown to be an efficient way of teaching a great deal of information to a large group.³ Another criticism by the LCME is the lack of institutional oversight and a focus instead on individual departments for curriculum decisions.⁴ The structure of the traditional curriculum can lend itself to territorial disputes about time allotted to the department's subject. Many schools address this concern by appointing or electing a group, such as a curriculum committee, to provide oversight.

Strategies for integration: Integrating a cultural competency curriculum into a traditional model requires departmental allies willing to donate time during their courses for the associated topics in an integrated fashion. Stand-alone information may be lost in the students' desire to master the basic sciences, which is a common problem when cultural competency is taught in a separate, elective course or as a small portion of a basic course. If cultural competency is presented as a segregated course, in a way that has no practical relevance for students, that course runs the risk of competing with the "hard sciences." Too many students view behavioral sciences as common-sense information that is not important because the United States Medical Licensing Examination (USMLE) does not require them to master it. But this can be avoided if the cultural competency information is presented as integrated with the basic sciences information.

Problem-based learning curriculum

How it works: Problem-based learning (PBL) curricula use clinical problems as the focal points for teaching the basic sciences and integrating clinical aspects of medicine into the preclinical years. The intent is to improve understanding and retain medical knowledge. Students meet in small group sessions several times per week with a tutor, either a basic or clinical scientist. In this student-centered environment, tutors maintain group dynamics and ensure that discussion is relevant and at an appropriate depth. Learning objectives and guides to resources are provided. Outside of tutorial sessions, students use the time to seek and consult appropriate resources and study independently. Most PBL programs organize their tutorial sessions into phases designed around organ systems, such as cardiac, pulmonary and musculoskeletal. Phases integrate knowledge from the basic sciences so that students learn the physiology, anatomy, pharmacology, biochemistry and histology of the particular organ system. Other curriculum concentrations such as ethics, professionalism, humanities, epidemiology and clinical skills may be integrated into the small group sessions or offered independently of the biosciences. A central office, often in collaboration with a curriculum committee, provides institutional oversight, removing curriculum governance from departmental control and administration.

Challenges: Although supporters of PBL believe that the problem-solving format prepares students for the clinical reasoning process, no studies exist that show students from PBL programs

perform any better than students from a traditional curriculum after graduation. PBL requires vastly more resources to implement, including adequate numbers of small group classrooms, laboratories and teaching faculty to facilitate the small groups. Many students and faculty who come from traditional backgrounds have trouble with the perceived inefficiency of the PBL process and can become quite frustrated with problem solving in a small group. In addition, the need for PBL sessions to cover a substantial amount of basic sciences information produces a pressure that makes it difficult for some case writers to incorporate the rich and complex issues surrounding cultural competence. Some PBL programs provide separate sessions to address clinical skills, bioethics and population health.

Strategies for integration: One approach to integrating cultural competency topics into a PBL curriculum is to work with the case-writing faculty. Working with cases already in use can be an efficient process, since faculty members may already be familiar with the basic sciences learning objectives. But changing the patients portrayed in “paper cases” or standardized patient cases to reflect a culturally diverse patient population is only the first step. The faculty must also receive support for learning how to engage students in the small group setting in discussions about cultural competency. Faculty development, like that described in Chapter 3, must coincide with case writing and producing guides for facilitators to use in the small group discussions. Cultural competency curricula can also be integrated into ethics, population health or other curriculum topics.

Hybrid: two worlds combine

Harvard Medical School was the first to publish information on implementing a hybrid curriculum.⁵ Recognizing that medical students require different learning approaches, Harvard blended the PBL approach with the traditional lecture-based approach, organizing the curriculum in blocks or organ-based courses. Basic sciences content is blended with the clinical sciences content from the beginning. The hybrid model allows students who learn best in small groups to do so, while acknowledging that a lecture format conveys best some kinds of information, addressing the needs of the traditional learner. The hybrid model can be governed from a central office, providing institutional, rather than departmental, oversight. Integrating cultural competency into a hybrid curriculum requires some of the same strategies as the traditional or PBL models.

Diversity in Learning

Several learning theories postulate that individuals learn in different ways.⁶ An understanding of the different learning styles of students may enhance teaching; but teachers should not change their style to suit the learner. Instead, they should try various strategies in an effort to reach all the learners. Learners are not a homogenous group with the same experiences and levels of interest, just as medical school curricula differ widely. Keeping this in mind, curriculum design should provide diverse activities to fit the varied backgrounds of students, offering options for assignment formats, such as papers, Web sites and oral reports, and the presentation of information through lecture, independent reading and videotapes, for example.

Mastering Domains of Learning

Three basic domains of learning drive cultural competency education⁷ and are used with various teaching strategies to develop a fully culturally competent student.

Knowledge: In the knowledge domain, also called the multicultural/categorical approach, the focus is on increasing the knowledge of the learner regarding cultural topics. The range may include rationale for cultural competency in the medical school curriculum; definitions about culture and related concepts; specific facts about cultural groups; and topics related to theories of cultural competency. This domain may also include knowledge related to assessing the community of concern including predominant groups within the population; identifying prevailing health beliefs, practices and values; identifying social, economic and behavioral determinants of health;

disease incidence and prevalence; evidence-based information related to health disparities; and the impact of the health delivery system.

Skills: The skills domain, or cross-cultural approach, focuses on advancing the skills and tools of the practitioner and identifying the expectations of the learner. The curricula in this domain include strategies for eliciting information from patients through communication and interviewing techniques and incorporating this information into an appropriate treatment plan that displays sensitivity with a focus on interactions and communication skills. Students learn a number of interviewing models to elicit information from the patient regarding these topics. This domain may also include information related to strategies used for physician-patient negotiation in treatment decisions. Learning skills related to ethnographic approaches, assessment of the population and transfer of this knowledge into treatment plans are also part of this domain.

Attitude: The attitude domain, or cultural sensitivity/awareness approach, seeks to increase the learner's sensitivity, respect, humility and awareness of the influence of cultural factors on the patient's values, beliefs and attitudes. The strategies for achieving this include self-reflection and understanding of one's own culture, which helps to identify the learner's awareness of stereotyping, personal biases and beliefs, and how they affect the provider-patient encounter.

Strategies for a Culturally Competent Medical Education

The choice of learning objectives and educational methods to achieve competencies is as dynamic a collection as the students who benefit from them. It's driven by a number of factors, including the current curriculum, the makeup of the learners and the domains of learning used, as introduced in this chapter. It should also take into account the needs assessment of the student's developmental stage, as discussed in chapter 3, and a student's anticipated community of practice.⁸

The types of educational activities used can vary from traditional lectures to more innovative game playing; some methods and techniques are presented below. A number of other resources for instructional activities and cultural competency are available.^{9,10,11} Schools should encourage faculty members to experiment with innovative approaches to work within the curriculum structure in place at their institutions.

Simulations

Simulations allow students to participate in experiences that closely mimic "real life" experiences they will have to master. The closer the simulation comes to mirroring reality, the more successful it will be. The use of simulations is not a new idea; flight schools have used flight simulators for years. More recently, medical mannequins have been developed to allow students and faculty opportunities to treat critically ill "patients" in mock ICU, OR and ER settings. Using simulations in cultural competency training allows students to work on clinical skills in a nonthreatening environment, while receiving feedback about their performances that support their growth. Some simulation methods appear below.

Standardized patients: Standardized patients (SPs) are laypersons trained to portray a patient in a realistic and reproducible way. These are not "role plays" but persons coached during training sessions to know and portray the facts of a patient's case. SPs don't replace work with actual patients, but they do have a number of advantages over patients. The range of conditions and physical symptoms they can portray is extensive, as are the cultural nuances they can mimic of an actual patient. SPs can be scheduled around course times and requirements. Several SPs can portray the same case, to make the use of "live" patients during multiple small groups possible. Students are able to practice an approach to a patient without compromising the patient's safety or comfort. Recruiting and training SPs from various cultural and religious groups expands the ability of faculty members to integrate cultural competency topics into the cases.

SPs can be used to teach and to evaluate students. In a teaching setting, an SP can present to a group of students with a facilitator and allow each student, in turn, to practice clinical skills—such as history-taking—while receiving feedback from the facilitator and peers. SPs can model patients

in difficult situations (e.g., breaking bad news) to provide practice for the students before experience with a real patient in a similar situation. In a lecture setting, an SP illustrates points made in the lecture, with the faculty member interviewing the SP in front of the class. With a “time in/time out” method, SPs can be taught to go into “suspended animation,” seemingly unaware of the discussion among the students.

As a tool for evaluation, SPs can be used to assess clinical skills such as history taking, using the Kleinman questions (see chapter 2, figure 2-2, page 11) and physical examination skills that cannot be evaluated with a traditional paper-and-pencil, multiple-choice exam. Unlike a “real” patient who may become fatigued or change his story, a well-trained SP stays in role and sticks to the script, providing an unchanging, objective measure of student ability. The Medical Council of Canada and the Educational Commission have used SPs to assess clinical skills of foreign medical graduates for several years for licensure examinations. The USMLE has also begun to use SPs for licensure.

SPs can be used for making students aware of cultural conflicts, learning how to negotiate conflict, practicing and demonstrating effective communication in interviewing, taking a cultural profile/history and becoming familiar with the proper way to use interpreters.

Role play: Role play allows a student to assume a prescribed role for a brief period, usually in a small group setting. Typically, one student plays the patient role, while another one takes on the role of the physician. The rest of the group serves as observers, taking notes and providing feedback to the participants. Faculty members also can play the patient’s role while the students take turns in the role of the physician.

The chief criticism of the role-play exercise is that it’s artificial and unrealistic. But, if this criticism is discussed prior to the experience—stressing the importance of practicing in a nonthreatening and nonclinical setting—students can be persuaded to see the value in the experience.

Role plays should not be allowed to drag on. The facilitator’s job is to stop the interaction before too much time elapses—typically, five minutes. Each role should be scripted in a format that allows the students to quickly grasp the point, amounting to no more than a single page. The role play provides the stimulus for group discussion. In addition, it forces students who otherwise would theorize about problems to actually demonstrate what techniques work and don’t work. Role plays can be used for practicing effective communication and interviewing, taking a cultural profile/history and negotiating cultural conflicts.

Paper cases: Think of these as “hard copies” of standardized patients. Written much like a case study, the “patient” is followed longitudinally via the instructor, who continues to distribute more paper that contains additional information about the patient’s case. Although lacking the lure of interviewing an actual patient, paper cases can serve as an excellent stimulus for discussion. They are inexpensive to prepare and distribute and can be used in large or small groups.

Games and simulations: These are a more elaborate rendering of role playing. A popular simulation for cultural competency is the BaFa BaFa game. Originally planned as a behavioral technique to select uniformed service members for overseas assignments, the game consists of dividing a group of individuals into two “tribes.” Participants spend a short time learning the “culture” of their new tribe, including language and ways to interact. Then, participants spend time “visiting” the other culture, trying to learn about it. The game is devised so that the cultures are almost diametrically opposed, creating conflict. The most important part of the game comes at the end, during debriefing, when the lessons of the game are applied to everyday life.

Another successfully used simulation is “Welcome to the State of Poverty.” Participants are divided into families of different sizes, parental structure, ethnicity and resources, though all families have limited resources. The simulation exposes the participants to the socioeconomic stressors that affect the daily lives of those with limited resources as the head of the household struggles to house and feed the family, keep the children in school and provide for the basic necessities. The simulation assists health providers by illustrating the realities and obstacles faced by families in poverty.

Such games as BaFa BaFa and such simulations as “Welcome to the State of Poverty” are excellent for learners who enjoy hands-on, active forms of learning. Games and simulations can be used

to help students recognize personal tendencies toward bias and stereotyping, understanding the visible and invisible aspects of culture and appreciating the interaction between and among diverse populations.

Lectures

Other than assigned readings, lectures remain the most efficient and economical way to convey large amounts of information quickly to large groups of people. Like the biblical tongue, the best way to teach is a well-delivered lecture, and the worst way to teach is a poorly delivered lecture. Lectures are helpful for conveying information about health-care disparities, theoretical frameworks about culture, and cultural models of health, disease and illness. Many references are available on the topic of effective lecturing, including presentation style and use of audiovisual materials. The chief criticism of lecture is that it can be a passive form of learning in which the students can't directly participate.

Self-awareness and self-reflection

Debriefing periods following experiential activities, writing assignments on topics and journaling require that the student reflects on his experiences. This is an important strategy to use to help a student identify his own beliefs and attitudes, exposing him to different ways of thinking and continually asking him to consider the process of adapting and incorporating a new way of thinking and acting. This type of educational method can be incorporated into other strategies as a way of debriefing from activities, or it can be more involved, such as keeping journals or records of experiences. An opportunity for self-reflection is central to structuring experiential learning. A critical piece of self-reflective exercises is to structure the debriefing questions and the journaling to ensure the student focuses on and personalizes the desired lessons and has adequate time to include these activities in the learning environment.

Clerkship activities

Extending the cultural diversity and competency curriculum into the clinical years from the pre-clinical years can reinforce and extend the lessons of the preclinical years. Specific lessons can be included during general clerkship orientation or inserted into the content of individual clerkships. The school also may set aside a day for all residents and attendings to participate in required educational group sessions. One PRIME school used the general clerkship orientation as an opportunity to teach about interpretative services, the appropriate use of interpreters and how to obtain these services in the hospital. Another school set aside a day in which all clerks were required to participate in cultural diversity training.

Community participation

Extending the opportunity for learning outside the walls of the medical school, the exam room and the hospital supports and reinforces the point of culturally competent medicine. Opportunities for personal involvement with community individuals of diverse backgrounds usually are plentiful in geographic areas close to the medical school or can easily be established elsewhere. Free or volunteer clinics, community health centers, individual student projects, school clinics, migrant health clinics, homeless shelters and health fairs with a focus on specific populations—including the elderly, teenagers or the growing Hispanic population—provide experiential learning opportunities that reinforce the lessons from more formal educational settings.

Notes:

- ¹ Knowles, M. (1984). *Andragogy in Action*. San Francisco, Calif.: Jossey-Bass. *The Adult Learner: A Neglected Species, 3rd Ed.* Houston, Texas: Gulf Publishing. *Self-directed Learning* (1975). Chicago, Ill.: Follet.
- ² LCME. (2003) Full text of LCME accreditation standards. LCME, Washington, D.C. (www.lcme.org/standard.htm)
- ³ Whitman, N.A. (1982). *There Is No Gene for Good Teaching: A Handbook on Lecturing for Medical Teachers*. Salt Lake City, Utah: University of Utah School of Medicine.
- ⁴ LCME, Functions and Structure of a Medical School, Part 1, Section D, Curriculum Management. (www.lcme.org)
- ⁵ Tostenson, D.C., et al., eds. (1994). *New Pathways to Medical Education: Learning to Learn at Harvard Medical School*. Cambridge, Mass.: Harvard Press.

- ⁶ Kolb, D.A. (1984). *Experiential Learning: Experience as the Source of Learning and Development*. Englewood Cliffs, N.J.: Prentice-Hall.
- ⁷ Betancourt, J.R. (2003). Cross-cultural medical education: conceptual approaches and frameworks for evaluation. *Academic Medicine*, 78: 560-569.
- ⁸ Tervalon, M. (2003). Components of culture in health for medical students' education. *Academic Medicine*, 78: 570-576.
- ⁹ Davis, B.G. (1993). *Tools for Teaching*. San Francisco, Calif.: Jossey-Bass.
- ¹⁰ Lowman, J. (1984). *Mastering the Techniques of Teaching*. San Francisco, Calif.: Jossey-Bass.
- ¹¹ *Cultural Competence Compendium* (1999). Chicago, Ill.: American Medical Association.

Cultural Competency Initiatives in the Medical School Setting: Tips on Evaluation

Amy Abel, M.P.H.

Learning Objectives

Following the completion of this chapter, the reader should be able to:

1. Develop key evaluation questions about cultural competency training efforts.
2. Determine measures for program- and student-level assessment efforts.
3. Understand evaluation options based on schools' experiences and needs.
4. Understand barriers to evaluation efforts.

Developing Evaluation Questions

As sound as a plan for culturally competent medical education may be, as smoothly as it may seem to run, curriculum groups should assess how their efforts are received. This chapter will help steer curriculum directors, faculty, students and others toward appropriate, action-oriented methods of evaluation.¹

When starting a curriculum overhaul, curriculum committees ask questions. When ending one, they do the same thing. The first step in the evaluation of any program or initiative is figuring out what those questions are. Develop them by going through the following steps:

- Look at the original funding or project proposal for the purpose and objectives;
- Clarify if objectives have stayed the same or changed;
- Outline the project that will be implemented to meet the objectives;
- Revisit expectations and areas of interest with project leaders; and
- Draft questions and review them with key stakeholders for revision and approval.

These steps keep expectations realistic and the evaluation task definable—both critical in the process. In large, multiyear projects with multiple leaders (who often change over the course of the project), having a clear outline of the evaluation questions and choices that were made about what to answer versus what was “out of reach” keeps the vision of the curriculum project consistent over time. An evaluation plan that identifies the measures, as well as the methods, for data collection can't be developed until all the players agree to the evaluation questions.

For example, the PRIME Advisory Council had a list of key questions and anticipated sources of information that would be used to answer the evaluation questions for the PRIME project. The questions, and the methods of retrieving answers to them (e.g., telephone interviews, site visits, student questionnaires), were revisited every year to be sure that expectations and evaluation

needs were being met. In this way, planning the evaluation process acted as a check on the curricular implementation from year to year.

Different evaluation questions are required for each situation. Questions need to be shaped by and be appropriate for the project, driven by what resources are available and specific about what actionable results they will yield.

Some examples of the questions used by schools in the PRIME diversity curriculum project are illustrated in Figure 5-1.

Figure 5-1

1. How was the cultural competency curriculum change implemented? What changed because of the implementation?
 - What was the role and extent of involvement for students, faculty and/or community participants (i.e., amount of time, number of individuals, nature of in-kind contributions)?
 - How was placement of cultural competency issues in the curriculum decided? What were the key factors that contributed to this decision?
 - How was the content of what was taught or offered to students decided? Who selected the information and teaching methods? What was the rationale for this selection?

2. What did students learn from the information or experience?
 - What attitudes changed?
 - What skills were acquired?
 - What specific knowledge was gained?

These evaluation questions should focus on identifying areas that can be changed, reorganized or altered to get a different result or to improve the outcome of the effort. For example, course directors need to determine if changes in the content of an elective class will improve participation and interest or perceived relevance of the material. Questions about content asked in short questionnaires, using either the Likert rating scale or open-ended questions, would yield the needed results. Departments and faculty may need to determine whether different or more resources are needed for a class or student field experience to be more successful.

Feedback from faculty, course directors or even community organizations, obtained at the close of a meeting or during semistructured telephone interviews, can also help shed light on resource limits and possibilities.

Levels of Evaluation

Curriculum evaluation: Question 1 in Figure 5-1 was the PRIME evaluation question for the curriculum-level evaluation. It is also an example of the basic questions asked about most medical school curriculum reform evaluation efforts: How was it done? What happened as a result?

Think of the first “how” question as part of the five basic journalism questions that are part of any process evaluation—who, what, where, when and how—which will determine the nuts and bolts of an idea and its implementation. Outcomes measures, on the other hand, are gathered to respond to the second question, the ever-important, “So what?”

Examples of measures used in the PRIME project, as well as in other curriculum evaluation project approaches, are in Figure 5-2 (next page).

Figure 5-2: Process and Outcomes Measures for the PRIME Evaluation

Process— Who, What, When, Where, How?	Outcomes— So What?
<ul style="list-style-type: none"> • Types of activities/content selected for incorporation in the curriculum and the basis/rationale for decisions • Faculty support/time invested, both funded and in-kind • In-kind time of students and administrators in developing classes or implementing changes • Extent of dissemination on campus or in the community through published articles, posters or presentations • Research ideas generated and/or faculty research projects in area of cultural competency • Changes in curriculum content over time (number and type of electives, content change in biomedical classes, type of standardized-patient exercises) 	<ul style="list-style-type: none"> • Student perceptions about sufficiency of cultural competency content in curriculum — Global measures for student perceptions of the extent and sufficiency of their cultural competency training; specifically, questions about the extent to which students perceive that diversity is incorporated in their curriculum and how equipped they feel to provide care for and interact with a diverse patient population • Funding attracted by curriculum or program ideas that helps start new classes and initiatives or expands existing ones • Sustainability of efforts over time—what changes, evolves or has long-term funding/support or a place in the curriculum?

The data for process and some outcomes measures are “anecdotal” or qualitative, which in many cases are the most reliable and cost-effective means for capturing the nuances of what happens over time. Collecting qualitative data requires reports, interviewing and talking with key people involved in a project or curriculum. People who are directly involved in the project are the best sources of information, including:

- Deans (particularly those responsible for multicultural affairs or similar areas)
- Curriculum committee members
- Faculty course directors
- Course content instructors or advisers (which may include community members)
- Students

Every interaction can be an opportunity to collect information for evaluation. Results from course evaluations—which may already be required for medical school classes—even the agenda and minutes from departmental, curriculum committee or course directors’ meetings help in the evaluation process.

Making Evaluations Count

PSU continues to reform its curriculum, an effort it began in 1992. But data collected by the school through recent evaluations of those reforms has allowed the school to catalog program-level efforts by culture and diversity, report progress and assess the extent to which key people were involved—including examining challenges with student involvement.

As a result of the evaluation, PSU was able to identify changes in the content of its problem-based learning cases, as well as the key challenges for implementation, which helped the course directors make program adjustments.

Some of the school’s efforts with curriculum reform in recent years include:

- A new, required course, “Patients, Physicians and Society,” incorporating the patient’s perspective on illness, health and healing;

continued

- Large discussion with small breakout sessions that introduced the culture of medicine and medical education, as well as alternative and non-Western medical practices;
- Restructured problem-based learning case studies, incorporating some element of culture into the cases and removing any pre-existing stereotypes or offensive material in the cases;
- New standardized patients representing a larger, diverse group, in addition to having the third- and fourth-year medical students, who have already been exposed to the new curriculum, serve as standardized patients and model behaviors that may come about in a clinical encounter with patients from diverse cultural groups.

Student-level evaluation: Another level of evaluation that should be studied is how well the need for and functions of cultural competency within a medical school curriculum are being communicated to and absorbed by medical students. Typically, this is assessed by measuring changes in attitudes, knowledge or skills of medical students in the area of cultural competency.

It is critical to have the evaluation appropriately suited to medical students' exposure to and experience with cultural competency and diversity initiatives and what each program is attempting to influence in those students. Figure 5-3 is a reproduction of Betancourt's key strategies for evaluation that are "matched" to the education approach.²

Figure 5-3: Evaluating Student in Cross-cultural Education

Educational Approach That Focuses On...	Should Use Evaluation Strategies Such As...
Attitudes	<ul style="list-style-type: none"> • Standard surveying • Structured interviewing • Self-awareness assessment • Presentation of clinical cases • Objective-structured clinical exam (OSCE) • Videotaped/audiotaped clinical encounter • Journaling, self-reflection
Knowledge	<ul style="list-style-type: none"> • Pre- and post-tests (multiple-choice, true-false, etc.) • Unknown clinical cases • Presentation of clinical cases • OSCE
Skills	<ul style="list-style-type: none"> • Presentation of clinical cases • OSCE • Videotaped/audiotaped clinical encounter

Betancourt, 2003

For example, MU and SLU included such one-time experiences as the BaFa BaFa exercise and "Welcome to the State of Poverty" as part of their cultural competency initiative. Both exercises have students consider an experience from another person's perspective in an attempt to influence both attitudes and knowledge. For single sessions like these, it makes the most sense to have participants do a before-and-after assessment—typically short paper-and-pencil instruments—supplemented with group discussion.

UMass also has designed a pre- and post-test to measure student knowledge before and after the school's Multicultural Interclerkship, focusing on measuring knowledge and skills they learned from their time in their fields. A baseline instrument is administered to students before the clerkship and another completed at the close of the experience several months later.

Valid and tested instruments are available for the “standard surveying” to measure student attitudes and knowledge. For example, through PRIME:

- The Multicultural Assessment Questionnaire, a student self-report instrument, was used by WFU³ as part of evaluating its cultural curriculum reform efforts.
- UMass developed a battery of questions to assess students’ awareness of cultural issues and attitudes; these questions have been modified and used for assessing cultural awareness and attitudes by PRIME pilot schools and others.
- MUSC developed a series of 10 questions that focused on asking students to rate the importance of physicians modifying care to accommodate patients’ health beliefs. After one year of implementing cultural competency and diversity initiatives, program directors noted a slight increase in perceived necessity of these initiatives among medical students.
- Standardized patient cases/scenarios are used to incorporate the cultural aspects of health, patient practices and beliefs into student training—notably at PSU, UMass, SLU and other schools. OSCEs can evaluate what students have learned about diversity and the impact of culture. Tools to more accurately evaluate student performance with OSCEs are being developed at SLU, where the PRIME curriculum provided the school with the opportunity to develop and test an instrument that will be used with the four-hour workshop, “Taking a Culturally Appropriate History.” Specifically, SLU is refining an instrument administered before and after a two-week training course to measure students’ competency in medical interviewing. Results from SLU’s quarterly report from the instrument’s first administration in January 2003 indicated that the instrument was valid and reliable.

Cultural Awareness Interview Rating Form

(Developed by faculty at Saint Louis University School of Medicine)

The student:	Yes	No
1. Greets patient using title (Mr., Mrs., etc.) and last name.		
2. Determines cause for visit.		
3. Asks patients about health beliefs regarding the cause of illness.		
4. Asks what patient expects from the visit.		
5. Asks patients what is most feared about the condition.		
6. Asks patients what treatment is most culturally appropriate.		
7. Avoids judgmental statement about patients’ beliefs.		
8. Maintains neutral facial expression when discussing patients’ beliefs.		
9. Avoids condescending statements.		
10. Does not make assumptions about patient’s situation.		
11. Inquires about role of family and significant others in decision-making.		
12. Uses lay terms (avoids jargon).		
13. Uses open-ended questions.		
14. Makes an empathetic statement.		
15. Asks for final questions.		

Other schools incorporated an experiential or service-learning component to build skills and instill the values of community-oriented primary care. It is a great idea to have organizations or other community-based partners evaluate student performance in these cases, and it is most easily accomplished if the medical school course director provides community members with a

review format.

In these situations, self-reflection through journaling may be incorporated as part of the class requirements—but they should be avoided for use in evaluation. The content analysis is challenging because there is no set format for the reflection, and the experiences are often intensely personal and reluctantly shared.

Evaluation of the Program by Students

Student perceptions of the value, usefulness or quality of subjects, course materials or case examples can also be used to tweak curriculum content and set the context for analyzing results of student performance in courses or exercises. As described by PSU (see “Making Evaluations Count,” page 33), student feedback gathered through informal meetings was used to modify the content of standardized patient reviews, as some material was initially considered stereotypical. Lack of interest by, or “poor” performance of, students in standardized patient cases could be a reflection of these perceptions, rather than the students’ abilities to accurately determine and integrate the patients’ perspectives in a culturally competent manner.

Evaluation Challenges

Generating culturally competent health-care providers is a desired outcome of the medical education process—both because of LCME requirements and the reality that culture has an impact on health practices and beliefs of patients. There are, however, some fundamental barriers to evaluating efforts to “teach” cultural competency in the context of medical education.

Lack of standardization: The first primary challenge is that what should be taught, who should teach and the expected cultural competency results are not standardized.

This is why medical schools experiment and tailor their respective programs. There is an abundance of literature on what the “core” elements of cultural competency should be in a curriculum—so much so that the Center for California Health Workforce Studies and the University of California, San Francisco, Department of Family and Community Medicine are assessing common themes, concepts, objectives and methods in cultural competency education in an effort to catalog what exists in medical schools.⁴

The level and extent of experimentation, however, also mean that it is impossible to entirely transpose evaluation approaches that have been tested and developed at one institution to another attempting change. Because schools have implemented approaches differently over time (often within the confines of existing resources, not through fully funded research efforts), building on the strengths of their faculty and the needs of their students, evaluation approaches that have grown out of these efforts are similarly diverse. A school should adopt them for use only if they match its needs, assets and methodology.

Evaluating integrated vs. elective efforts: Electives or course add-ons to the curriculum are often considered easier first steps to introducing new content. PRIME emphasized the importance of integrating lessons and experiences that teach and demonstrate the value of cultural diversity across the four-year medical school curriculum. Integrated approaches, which alter existing course content, materials and exercises rather than adding culture as a separate study area, do pose greater methodological challenges to evaluating the impact on students:

- A “control” group often cannot be established if students in each year are all exposed to similar information and experiences. The proxy for this is often using third- or fourth-year students as the “control” if classes/content are implemented during the first- or second-year curriculum.
- Unless longitudinal efforts to evaluate the impact of the curriculum are in place, only a “slice” of the ultimate effect may be evident in student-level evaluations from a single year.
- If the value of diversity and cultural competency is seamlessly incorporated in medical education, students may not “see” these elements as separate or distinct ideas in their curricula or classes, rather as part of the unified whole of their medical education. The value of or impact from any one element, class or idea cannot be separated from the entire experience.

Skill, attitude and knowledge changes are difficult to measure

Knowledge, attitudes and skills are a common foundation and a typical range of measures included and desired from student-level evaluation of cultural competency educational efforts. Evaluation of these three features is challenging for the following reasons:²

- It is difficult to candidly measure students' "cross-cultural attitudes" because of medical students' desire to give socially appropriate answers.
- Knowledge and fact-based evaluation about other cultures has been both disparaged in practice (primarily out of fear that information leads to stereotyping and inappropriate assumptions) and does not lend itself to "cross-cultural" educational evaluation.
- Evidence from studies showing the importance and impact of cultural competency is often considered "soft science." In the face of biomedical content, evaluating student reactions to information about culture and diversity may be less positive or considered less useful.

The ultimate challenge in using measures of skills, knowledge or attitudes is that they are a short-term view of results. Lack of long-term outcome studies that track students from their education through residency and full-time clinical practice—to monitor the role of cultural competency training in their patient treatment and interaction—leaves this area open to further research. As evaluation results from Wake Forest's PRIME project found, it was not possible to directly translate changes in skills, knowledge and attitudes into future clinical practice.³

Funding, timing and other constraints also mean that two key questions remain consistently unanswered (and potentially unanswerable) from existing efforts to evaluate curricula aimed at developing culturally competent health-care providers.

First, how does providing materials, information and experiences that relate to cultural competency influence a medical student over the course of four years and affect their plans for medical practice? Second, what is the ultimate impact of culturally competent providers on health outcomes?

HRSA has an interest in determining the effects of instilling in future physicians a greater appreciation of the role of culture in health and health practices. Given the demographics of the medically underserved and most vulnerable populations in the United States—recent immigrants, uninsured, low-wage workers and migrant farm workers, for example—translating information, learning and practices of cultural competency into patient-centered and sensitive care is an important long-term outcome. However, a link between patient health outcomes, the provision of culturally appropriate care and the content of a clinician's medical education are yet to be clearly established.

These questions cannot be answered by the PRIME curriculum projects or by most projects with a limited span of five years. Betancourt notes that connecting medical education to outcomes requires a step-wise assessment across many years that covers whether students learn and use what is taught and then an assessment of whether what is taught has an impact on the care they provide to patients.²

Additionally, the attitudinal, skill or knowledge changes measured in evaluation efforts may not come from anything taught or offered to the medical student, but from experiences, relationships and interactions outside of the educational process. Changes may register over time through questionnaires or other student assessments and be attributed to initiatives that are not responsible for the change.

Advice and Lessons From PRIME Evaluation

A few key lessons about effectively implementing an evaluation related to cultural competency and medical school curricula emerged from the PRIME project:

1. For large, multiyear projects, set the evaluation questions and expectations for the results with key people involved in (or funding) the effort and review the key questions and methods being used for evaluation on at least an annual basis. There are many important but still unanswered questions that projects like PRIME can contribute to but not entirely answer.
2. Use a combination of general process measures that can help explain the who, what, when, where and how questions about a program or project with evaluation of outcomes that

continued

can answer the “so what” question.

3. Make evaluation an integral part of existing activities, not a stand-alone or separate effort. This is particularly critical when evaluation must be conducted with existing resources. Use every interaction as an opportunity to gather information on how the process of implementation is going, and use existing student-level evaluation or assessment efforts—graduation questionnaires, existing course evaluations, and entrance or orientation questionnaires—to ask questions and collect data.

4. Do not underestimate the value of qualitative and anecdotal information or overemphasize the role that “quantitative” data play in measuring progress. Implementation of new and challenging ideas is as much about how things occurred and who was involved as they are about what was accomplished. Reports, phone calls and discussions at strategic planning meetings all count as valid ways to obtain this level and type of evaluation feedback in a project like PRIME.

5. Make use of surveys and questionnaires that have already been developed, particularly in the area of cultural competency and medical school education. Although there is little standardization in methods or content, there are many instruments that have been tested and used at medical schools across the country that will serve most evaluation efforts well.

Evaluation Resources

- PRIME Curriculum Web site/Core Components reference (www.amsa.org)
- Tang, T.S.; Fantone, J.C.; Bozynski, M.E.A.; Adams, B.S. (2002). Implementation and evaluation of an undergraduate sociocultural medicine program. *Academic Medicine*, 77: 578-585.
- Tervalon, M. (2003). Components of culture in health for medical students' education. *Academic Medicine*, 78: 570-576.
- Wear, D. (2003). Insurgent multiculturalism: rethinking how and why we teach culture in medical education. *Academic Medicine*, 78: 549-554.
- Dolhun, E.P.; Munoz, C.; Grumbach, K. (2003). Cross-cultural education in U.S. medical schools: development of an assessment tool. *Academic Medicine*, 78: 615-622.
- Beagan, B.L. (2003). 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. *Academic Medicine*, 78: 605-614.
- *W.K. Kellogg Foundation Evaluation Handbook* (www.wkkf.org)
- Rossi, P.; Freeman, H.; Lipsey, M.; eds. (1999). *Evaluation: A Systematic Approach, 6th Ed.* Thousand Oaks, Calif.: Sage Publications.

Notes:

- ¹ Bloom, S. (in print). Cultural competency in medical schools: a case study of change. Unpublished doctoral dissertation. Temple University, Philadelphia, Pa.
- ² Betancourt, J. (2003). Cross-cultural medical education: conceptual approaches and frameworks for evaluation. *Academic Medicine*, 78: 560-569.
- ³ Crandall, S.; George, G.; Marion, G.; Davis, S. (2003). Applying theory to the design of cultural competency training for medical students: a case study. *Academic Medicine*, 78: 588-594.
- ⁴ Dolhun, E.P.; Munoz, C.; Grumbach, K. (2003) Cross-cultural education in U.S. medical schools: development of an assessment tool. *Academic Medicine*, 78: 615-622.