Cultural Competent Curricula – barriers tot the integration of cultural issues in the medical programme

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Introduction

That cultural competences should be part of every student's medical education has been regularly argued (e.g. Betancourt, 2003). In societies that become more and more multicultural, future physicians need to have cultural competences in order to focus on all patients needs, including patients from foreign descent. Yet, cultural issues are scarcely integrated in the curricula of medical schools. Research from the US (Flores et al, 2000; Tervalon, 2003), Canada (Azad et al, 2002; Flores, 2000), and Europe (eg The Netherlands (van Wieringen et al, 2003) and Sweden (Wachtler& Troein 2003)) has shown that this is an international issue. Not much is known about the barriers to the integration of cultural issues in the medical programme. In this article we will provide an overview of the several factors that impede the integration of cultural issues in the curriculum. We will propose a theoretical framework in order to distinguish different kinds of barriers and will finish with some recommendations to tailor interventions.

Barriers to and incentives for successful integration of cultural issues in the organization

There is some research, for example in the US (Betancourt 2002) but also in the Netherlands (Logghe 1998), about organizations that have successfully implemented cultural issues. The successful organizations had the following factors in common (Logghe, 1998):

- There is a policy to hire and promote minorities in the health care workforce;
- There is a perspective on the integration of cultural issues in the organization;
- There are structures (such as working groups) to develop ideas and specific themes;
- There is a system of consultation or exchange of experiences;
- There is support from the management and a freedom to develop ideas;

There are also impeding factors, in terms of absence of the above mentioned successful factors, as well as some other impeding factors:

- There is a lack of diversity of the workforce and there is no policy to hire and promote minorities in the health care workforce;

- There is no perspective on the integration of cultural issues in the organization.
- Professionals are insufficient cultural competent.
- There are no structures to develop ideas (such as working groups); there is no system of consultation or exchange of experiences;
- There is no support from the management or a freedom to develop ideas;

The research that identified these barriers was not about the barriers to the integration of cultural issues in medical curricula. Yet, we believe this research gives great insight into main barriers to the integration of cultural issues in an organization and may well be used to describe the main barriers to changes of medical curricula as well. In the next, we will illustrate these barriers with literature on the integration of cultural issues in the curriculum.

Barriers to integrate cultural issues in the curriculum

Diversity in health care workforce

Minorities in the US make up 3 percent of medical school faculty (Betancourt et al 2003). This is not representative for the society (in the US 28 percent of the population), nor for the student population (about 11 % of all graduates in the US are from underrepresented minority groups; estimated in the Netherlands is that between 5 to 20 % of the medical students are of foreign descent (Van Wieringen et al, 2001). The presence of immigrant teachers would not only make the totality of the workforce of medical teachers more representative of the multicultural society in general, but it is also argued that the skills, experience and qualifications of culturally and linguistically different employees may be used in the teaching (Josipovic, 2000). Betancourt and his colleagues (2002) suggest that minority health care professionals in general may be more likely to take into account sociocultural factors when organizing health care delivery systems to meet the needs of minority patients. As they argue: "under-representation of minorities on faculty at medical schools and schools of public health prevents a nuanced understanding of community needs from being shared through the critical avenues of role modeling and teaching. Ultimately, inadequate minority representation in governance, administrative, and clinical leadership roles causes health care systems to be disconnected from the minority communities they serve" (Betancourt et al, 2003, p. 296).
In most countries there is no policy to deal with the general lack of diversity in medical school faculty (?). There is no policy to employ more medical teachers from minority groups, to increase the number of students from minority groups or to reduce barriers to study or to work. There is hardly any insight in possible factors that may account for the higher drop-out

of students from minority groups. Factors like language problems or difference in ideas about what good health care is, seem to play a role (Hoek et al, 2005). Teachers say they have problems with the ethnic diversity of students (Kai et al., 2001).

Cultural competent teachers

Several authors have pointed out the general lack of specialized teaching and learning resource material (Azad et al. 2002; Van Wieringen et al. 2003; Kai et al 1999; Kai et al. 2001). Furthermore, research has shown that teachers are hesitant and apprehensive about their abilities to develop or deliver teaching in this field because they lack relevant training and experience themselves. In particular, prejudice and racism seem to be difficult issues for teachers to raise (Beagan, 2003a?). Hence, medical educators may tend to teach cultural sensitivity, but avoid more challenging issues such as prejudice and racism (Kai et al, 2001). This may be reinforced by the resistance from students who prefer a 'recipe' approach with an emphasis on the passive acquisition of knowledge about how a behaviour or disease might be different in an ethnic minority group, rather than a 'person-centered' approach that may prompt reflection and examination of their own attitudes (Shapiro et al. 2002). It may be easier for teachers to avoid this challenge, particularly if they experience a lack of support form colleagues or lack practical suggestion to facilitate training in ways that appropriately interactive (Kai et al, 1999). Kai and his colleagues conclude that the majority of educators may have little better grasp than their learners. If they are practitioners they may be, or they may feel, no more competent at responding to ethnic diversity than those they teach (Kai et al 2001).

Besides, medical teachers may simply be unwilling to teach about cultural issues. A report from the Multicultural Health Education Project Committee in 1991 highlights a number of obstacles to the inclusion of multicultural health content in the curricula of medical schools. These include amongst others insufficient members of faculty prepared to teach the subject (Azad et al, 2002; Beagan, 2003b?) .

The role of the management

Although the management (Head of department, curriculum developers etc) generally seem to be positive about the integration of cultural issues in the curriculum (Van Wieringen et al, 2001), it is unclear to what extent they actively support these processes. Arguments over pressures on limited time and (financial) resources in an already overcrowded curriculum may disguise latent hostility or discomfort (Kai et al, 1999). Beagan (2003a) found that developers

tended towards courses with a content that would be seen as academically rigorous, rather than anything that might be perceived as subjective or 'touchy-feely'. Cultural competence, just as communication skills, palliative care, professionalism and medical ethics are often seen as outside of the body of legitimate 'scientific knowledge' (Wachtler & Troein, 2003). Just because of this, these topics run the risk of being combined to one course (Beagan, 2003a) as a dumping ground for pre-existing courses displaced by curricula change. Research in the Netherlands showed that the implementation of cultural diversity in the medical education, depended mainly on the personal interest of the teacher and on specific choices of the medical students (Van Wieringen et al. 2003). Swedish research suggests that students have the impression that whether or not cultural competence was discussed in courses depended on the group's and tutor's interest (Wachtler & Troein, 2003). The implementation of cultural issues seems often to be dependent of the enthusiasm of a particular teacher, rather than being an integral part of the curriculum. This makes it vulnerable to change.

A perspective on the integration of culture in the curriculum/organization

Medical school course directors have several resources for teaching about cultural issues, including textbooks and cultural competence models (Flores et al, 2000), but there does not seem to be an integrated view generally. Several authors argue that cultural competency is not clearly defined in the curricula and that the subject is not thematically presented (Azad et al, 2002; Wachtler & Troein, 2003). Ethnic diversity is usually not totally absent from courses but is often presented in single lectures and seminars or as a discussion of something extra to the course ("now we are going to talk about minority patients", Facilov)). A review of published educational programmes in the US, the UK, Canada and Australia, on cultural and ethnic diversity for medical students found that the content of programmes was commonly limited to the discussion of health beliefs, alternative healing systems, and language barriers (Loudon, et al 1999). Courses which promote reflection upon attitudes, or explicitly promote sensitivity to stereotyping, prejudice and racism appear to be rare (Kai, Bridgewater & Spencer 2001). Teaching about cultural issues tend to be about the passive acquaintance of knowledge, e.g. about how a behaviour or disease might be different in a particular group, rather than encouraging self-reflexivity and self-awareness (Beagan 2003a). The danger of such an approach is that learning about others can become one of voyeurism, stereotyping, exotication, identifying the 'deviant' features of "those peoples" lives. It can heighten the boundaries of "us" versus "them" rather than lowering those boundaries.

Weisman et al (2005) found in a large study of 2000 residents, that residents receive 'mixed educational messages' about the importance of cultural issues in the curriculum (Weisman et al 2005; Betancourt et al 2005). On the one hand it is stressed that it is important to be competent in the care to minorities, on the other side, this kind of education is hardly assessed or evaluated with the residents, nor is there enough time to train and deliver effective cross-cultural care. These findings bring to light a need for improvement in cross-cultural education. In order to achieve cultural competence, an organized and systemic approach is needed (Azad et al, 2002), but this seems to be missing from most medical curricula.

Structures to develop ideas (e.g. working groups of different members) or the possibility of consultation

Journals like Medical Teacher, Academic Medicine and Medical Education pay attention to the teaching of culture issues at a some regular basis. They provide a forum for the development of different ideas about teaching materials and about improving the cultural competence of teachers. The yearly European conference on medical teaching (AMEE), however, barely pays attention to the teaching of cultural competence, to the implementation of cultural issues in the curriculum or to the cultural competence of teachers.

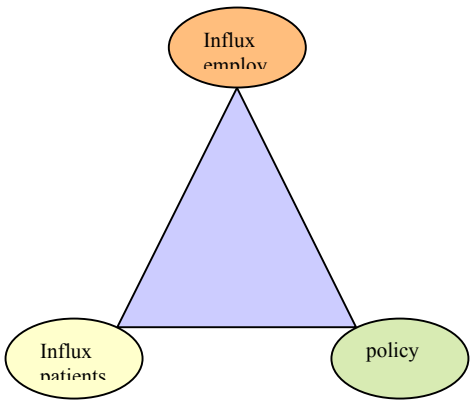
Research in the Netherlands (Van Wieringen et al, 2001) found that medical teachers would appreciate a national expertise centre to discuss problems and dilemmas and a data bank of literature and educational material. Policy makers, however, do not see the benefit of a national expertise centre. In the Netherlands an interfacultary workgroup of a relatively small group of medical teachers (Platform Multicultural Medicine) meet about three times a year to talk about cultural issues and medical education. Most probably other countries know these kinds of local networks too.[1]

It is clear that all these factors are related to each other. The question is: if we want to overcome these barriers, where is best to start? In the next we will discuss a model in order to gain more insight in the relationship between all the factors.

[1] In Europe as well as in the US there are several initiatives to develop networks and to exchange ideas and expertise. In the European project of Migrant Friendly Hospitals, hospitals from 12 member states of the European Union cooperated together with a scientific institution as co-ordinator, experts, international organisations and networks. These partners agreed to put migrant-friendly, culturally competent health care and health promotion higher on the European health policy agenda and to support other hospitals by compiling practical knowledge and instruments. In the US several sites are available for professionals in the health care (eg www.diversityrx.org; www.culturalcompetence2.com). Despite the fact that there are all kinds of existing networks for professionals, they are not specifically focused on or serving medical teachers.

Towards a model of the implementation of cultural issues in an organization

Kai and colleagues (Kai et al. 1999) have suggested a model for negotiating successful change in medical education. Their model describes a step-by-step procedure, starting with establishing the need for, and barriers to, change, as well as the need for lobbying and consulting with heads of departments and curriculum groups. Additionally, the involvement of teachers is solicited and a programme may be developed, implemented and evaluated. Although this model gives several excellent suggestions for change (some of them we will discuss later), it does not explain the barriers to and incentives for change in medical education. Also, and may be more importantly, it is a model with cumulative stages, while research shows that organizations may be in several stages in the process at the same time or follow a different subsequence of stages rather than to follow the proposed model (Logghe 1998). The processes of the integration of cultural issues in curricula, may be represented by a pyramid (Logghe, 1998). The metaphor of the pyramid allows for change at several levels at the same time. Whereas the model of Kai et al (1999) proposes a linear, cumulative process, the pyramid describes several simultaneous processes: [dit is niet echt een pyramide, nog invoegen andere tekening model, Logghe 1998]:



The pyramid consists of four corner points: one corner represents the influx of minority employees, the other three corner points represent the influx of minority patients, the policy with regard to the integration of cultural issues, and the policy with regard to minority employees (Logghe).[2] The base of the pyramid and the four corner-points are the fundaments of an integral integration of cultural issues within an organization. If one of the corner-points is missing, this integral policy will be less strong. Thus, if an organization focuses mainly on a policy with regard to the integration of cultural issues, and less on the influx of employees

[2] Een academisch ziekenhuis is nog gecompliceerder en eigenlijk een mix van twee organisaties: de universiteit en het ziekenhuis.

from minority groups, the implementation process in totality will be less strong. In contrast, when an organization aims for an 'and-and-strategy', and take into account the influx of employees and patients, as well as develop specific policies, the basement for such a policy will be stronger.

The pyramid represents a model of continuous change, rather than a linear process with a start and an end. Important in managing these processes is the concept of the learning organization (Logghe 1998), i.e. the idea that an organization develops itself continuously. In the learning organization identity, mission or tasks are not static but are open to continuous change (Logghe 1998). Changes should not be pressed top-down upon employees, but the identity of the organization is developed within different groups in the organization. At the same time, the management should have a clear vision on how to implement cultural issues in the organization. The task of the management in such an organization is to be clear about their vision, to inspire employees to share this vision, and to support employees to translate this vision in concrete actions. Central in this model is the vision of the management and the extent into which they manage to inspire others as well as facilitate possibilities for development. One thing the model does not take into account is the economic and political context (see Grol & Wensing, 2004). In times when relationships between different (ethnic and religious) groups are tense, it may be extra difficult for the management to carry out a vision on cultural sensitive education or on the need for cross-cultural care.

Conclusions and Recommendations

In this article we have discussed several barriers to the implementation of cultural issues in the medical curriculum. There is a central role for the management of medical schools to overcome these barriers. In the following we give some suggestions:

Institutional leaders should have a clear unapologetic and forthright message that multiculturalism and respect for others are central to care nowadays, and they should promote continuing educational activities that encourage such (Jann et al 2005). For instance, an institutional leader may introduce a multicultural education session and then remain in the auditorium for the duration of the presentation. This simple, yet powerful act of leadership communicates how valuable it is to have access to this training, not previously available to physicians of earlier generations (Jann et al 2005).

Focus the entire organization on the opportunity to improve services and business as a whole, including improvement in patient satisfaction (Betancourt, 2002). Use existing structures to integrate new initiatives into the system (Betancourt, 2002, p. 9). Components of cultural competence may be integrated into many different aspects of the educational curriculum, "so the effort is not viewed as an added burden to an already busy resident schedule (Betancourt et al, 2002). The general concept of patientcenteredness is consistent with the concept of cultural competent care and may be used to propose a health care that is excellent for all patients. General standards to evaluate the performance of students can easily be adapted as to include cultural competency (Seeleman et al 2005).

Heads of departments and curriculum groups should provide support and encourage new teaching and learning roles. Unanticipated difficulties should be addressed quickly before they become a focus for opposition to change (Kai 1999). Teachers may lobby and consult with heads of departments and curriculum groups to establish need for change (Kai 1999).

In order to increase the ethnic diversity among medical teachers, students and doctors requires sensitivity, careful preparation and support. Further experience is needed, however, of how to achieve this successfully (Kai et al 1999). Some recommend the use of community resources: students and faculty may be recruited from major ethnic groups residing in a medical school's surrounding communities (Flores et al, 2000) (Kai et al, 1999) (Betancourt et al 2002).

Empower clinicians to teach the skills to students and trainees (Kai 1999). It is important for teachers to anticipate discomfort and resistance of some learners. Common examples in their experience include learner's reluctance to acknowledge their own culture and background as important to health encounters and being encouraged to reflect upon their own attitudes as "being told what to think". To avoid reinforcing stereotypes, curricula should balance exposure to diversity with accompanying efforts to promote reflection upon attitudes, beliefs, and biases (Beagan 2003a). Students should be supported to develop skills for critical self-awareness, and to develop understanding of power and privilege. Moreover such training must be continued throughout the undergraduate and graduate training. Training needs to be integrated across the different stages of the medical curriculum and not only in the early undergraduate years. Students should see what they are being taught actually being practiced by their clinical teachers (Kai, 1999). Medical teachers may organize themselves in groups where they exchange education material and discuss educational problems or dilemmas.

Some medical schools only have one module, why other schools have a more integrated view (Tervalon 2003). It may be asked why some medical schools succeed in implementing cultural factors, why other medical schools have not. Is it because some schools have a better understanding of these factors? Is the management more supportive? Is the context an important incentive to change? (cf Grol & Wensing, 2004) More research may help us to understand these factors better and may help to implement cultural issues, not marginally but as an integral part of the total medical curriculum.

Literature

Association of American Medical Colleges. Minority students in medical education. Facts and figures XI. Washington: AAMC; 1998. (in betancourt 2003)

Azad N, Power B, Dollin J. Cultural sensitivity training in Canadian medical schools. Acad Med, 2002, 77,3, 222-8.

Beagan, BL. 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". Acad Med, 2003a, 78, 6, 605-614.

Beagan, BL. ' Is this worth getting a big fuss over?' Everyday racism in medical school. Med Educ, 2003b, 37: 852-860.

Betancourt JR, Green AR, Carrillo JE. Cultural competence in health care: emerging frameworks and practical approaches. The Commonwealth fund, 2002.

Betancourt JR. Cross-cultural medical education: conceptual approaches and frameworks for evaluation. Academic Medicine, 2003, 78, 6, 560-569.

Betancourt JR, Green AR, Carillo JE, Ananeh-Firempong O. Defining cultural competence: a practical framework for addressing racial/ethnic disparities in health and health care. Public Health Rep, 2003, 118, 293-302.

Flores G, Gee D, Kastner B. The teaching of cultural issues in U.S. and Canadian medical schools. Acad Med, 75, 5, 451-455.

Grol R, Wensing M. What drives change? Barriers to and incentives for achieving evidence-based practice. MJA, 2004, 180 (6 Suppl): S57-S60.

Hoek F, Vermaas M, Wolffers I. Vroeg gestruikeld. Medisch Contact, 2005, 29/30, 1208-1211.

Kai J, Spencer J, Wilkes M, Gill P. Learning to value ethnic diversity – whay, why and how? Med Educ, 1999, 33, 616-623.

Kai J, Bridgewater R & Spencer J. '"Just think of TB and Asians", that's all I ever hear' medical learners' views about training to work in an ethnically diverse society. Med Educ 2001, 35, 250-256.
Kai J, Spencer J, Woodward, N. Wrestling with ethnic diversity: toward empowering health educators. Med Educ, 2001, 35: 262-271.
Logghe, K. Interculturalisatie van zorginstellingen in de praktijk. In: Handboek Interculturele zorg.1998?
Loudon, R, Anderson P, Gill P, Greenfield S. Educating medical students for work in culturally diverse societies. JAMA, 1999, 282,: 875-880.
Seeleman C, Suurmond J, Stronks K. Een arts van de wereld. Etnische diversiteit in de medische praktijk. Houten/Antwerpen: Bohn Stafleu & Van Loghum, 2005.
Selleger VJ, Bonke B, Leeman YA. Etnische en religieuze diversiteit van eerstejaarsstudenten geneeskunde aan de Erasmus Universiteit Rotterdam. Ned Tijdschr Geneeskd 2003, 147 (17): 806-9.
Shapiro J, Hollingshead J, Morrison EH. Primary care resident, faculty, and patient views of barriers to cultural competence, and the skills needed to overcome them. Medical Educ, 2002, 36, 749-759.
Tervalon M., Components of culture in health for medical students' education. Acad Med, 2003, 78, 6, 570-6.
Van Wieringen JC, Kijlstra, MA, Schulpen TW. Interculturalisatie van het medisch onderwijs in Nederland. Een inventarisatie bij de faculteiten geneeskunde. Utrecht: Centre for Migration and Child Health, 2001.
Van Wieringen JC, Kijlstra, MA, Schulpen TW. Medical education in the Netherlands: little attention paid to the cultural diversity of patients. Ned Tijdsch Geneesk, 2003, 147, 17, 789-92.
Wachtler C., Troein M, A hidden curriculum: mapping cultural competency in a medical programme. Med Educ, 2003, 37, 10, 861-8.
Weissman JS, Betancourt J, Campbell EG, Park ER, Kim M, Clarridge B, Blumenthal D, Lee KC, Maina AW. Residents physicians' preparedness to provide cross-cultural care. JAMA, 2005, 294, 9, 1058-1067.