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Educating Medical Students for Work in Culturally Diverse Societies

Educating Medical Students for Work in Culturally Diverse Societies

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Context Recent attention has focused on whether government health service institutions, particularly in the United Kingdom, reflect cultural sensitivity and competence and whether medical students receive proper guidance in this area.

Objective To systematically identify educational programs for medical students on cultural diversity, in particular, racial and ethnic diversity.

Data Sources The following databases were searched: MEDLINE (1963–August 1998); Bath International Data Service (BIDS) Institute for Scientific Information science and social science citation indexes (1981–August 1998); BIDS International Bibliography for the Social Sciences (1981–August 1998); and the Educational Resources Information Centre (1981–August 1998). In addition, the following online data sets were searched: Kings Fund; Centre for Ethnic Relations, University of Warwick; Health Education Authority; European Research Centre on Migration and Ethnic Relations, University of Utrecht; International Centre for Intercultural Studies, University of London; the Refugee Studies Programme, University of Oxford. Medical education and academic medicine journals (1994-1998) were searched manually and experts in medical education were contacted.

Study Selection Studies included in the analysis were articles published in English before August 1998 that described specific programs for medical students on racial and ethnic diversity. Of 1456 studies identified by the literature search, 17 met the criteria. Two of the authors performed the study selection independently.

Data Extraction The following data were extracted: publication year, program setting, student year, whether a program was required or optional, the teaching staff and involvement of minority racial and ethnic communities, program length, content and teaching methods, student assessment, and nature of program evaluation.

Data Synthesis Of the 17 selected programs, 13 were conducted in North America. Eleven programs were exclusively for students in years 1 or 2. Fewer than half (n=7) the programs were part of core teaching. Only 1 required program reported that the students were assessed on the session in cultural diversity.

Conclusions Our study suggests that there is limited information available on an increasingly important subject in medical education. Further research is needed to identify effective components of educational programs on cultural diversity and valid methods of student assessment and program evaluation.

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CENTURIES OF MIGRATION HAVE made society in the United Kingdom multiracial, multiethnic, and multicultural.[1] However, it was not until 1991 that the United Kingdom decennial national census inquired about an individual's race or ethnicity.[2] Minority groups were defined as black Caribbean, black African, black other, Indian, Pakistani, Bangladeshi, Chinese, other Asian, or other nonwhite. Based on the census classifications, 3 million of a population of 55 million were defined as members of a minority racial or ethnic group, with wide regional variation. For example, almost 60% of those from minority groups reside within the West Midlands or greater London areas.[3]

Medical students studying and working at health service institutions within these areas undoubtedly meet and work with diverse groups.[4]

The UK National Health Service recently has been described as "a long-established, white-dominated organisation [which] is liable to have procedures, practices and a culture that tend to exclude or to disadvantage nonwhite people."[5] This comment resulted from a police investigation into the unprovoked racist murder of a black teenager.[6] This acknowledgment of institutional racism signals the need for medical education and the National Health Service to examine their policies and practices to ensure that they reflect cultural sensitivity and competence. Recommendations and materials are available both in the United States and United Kingdom for medical educators who wish to develop such programs.[7-11] Despite these resources, little attention has been paid in UK medical curricula to how physicians will be effectively prepared to meet the needs of a diverse local population.[12]

To our knowledge, this article presents the first published literature review to identify and comprehensively describe the individual programs that have been conducted in undergraduate medical courses that provide teach-

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ing and learning of cultural diversity, in particular, racial and ethnic diversity. The findings of this literature review are part of the first stage in a project to implement teaching of cultural diversity in a UK undergraduate medical course.

METHODS

Data Sources

A systematic search was performed using Medical Subject Headings and text words, in English, of the following 5 databases: (1) MEDLINE, (2) Bath International Data Service (BIDS) Institute for Scientific Information (ISI) science and (3) social science citation indexes, (4) BIDS International Bibliography for the Social Sciences, and (5) Educational Resources Information Centre (ERIC). Searches were conducted from 1963 to August 1998 for the MEDLINE database and from 1981 to August 1998 for BIDS and ERIC.

Search terms included *medical education, education-medical, educational measurement, teaching, curriculum, higher education, medical schools, medicine, medical students, minority groups, ethnic groups, culture, sociology, ethnic minority, ethnicity, diversity, diversity (faculty), diversity (institutional), diversity (student), inequalities, racism, race relations, prejudice,* and *socioeconomic factors.*[13]

In addition, a search of the following Web sites and online data sets was undertaken: Kings Fund[14]; Centre for Ethnic Relations, University of Warwick[15]; Health Education Authority[16]; European Research Centre on Migration and Ethnic Relations, University of Utrecht, the Netherlands[17]; International Centre for Intercultural Studies, Institute of Education, University of London[18]; and the Refugee Studies Program, University of Oxford.[19]

These searches were supplemented by a citation search using the BIDS ISI science and social science databases. All references appended to each index article also were reviewed. We manually searched articles published in *Medical Education and Academic Medicine* (1994-1998) and conferred with key medical educators within the British system.

Selection of Studies

Included in the analyses were articles that described, in English, programs specifically for medical students related to teaching and learning about cultural diversity, in particular, racial and ethnic diversity.

All abstracts were reviewed by 2 authors (R.F.L. and P.M.A.) independently. Disputed abstracts were referred (to P.S.G.) for a decision.

Data Extraction

Information about the programs that had been conducted was extracted and tabulated, including year of publication, setting, year of students who participated, whether a program was required or optional, teaching staff, involvement of minority racial and ethnic communities, program length, content and teaching methods used, nature of any student assessment, and type of evaluation of the educational intervention. We developed a narrative classification of the published data.

RESULTS

We identified 1456 articles, from which 17 programs that had been presented between 1967 and 1997 met the inclusion criteria and were analyzed (TABLE).

Setting

All programs were set in the United States, Canada, Australia, or the United Kingdom, with the majority (n = 13) in North America. The sessions were almost exclusively developed under the auspices of departments of family medicine, community medicine, preventive medicine, behavioral science, psychiatry, or educational development. However, members of departments of pharmacology and anthropology were involved in 2 initiatives.[20,21] One program arose in response to students witnessing insensitive and inappropriate behaviors by faculty.[22] Students then acted as sole facilitators for the session that was developed.

Nearly all the programs described were for medical students in years 1 or 2 of their training. Exceptions were the University of Pittsburgh (Pittsburgh, Pa) program[23] (second- and fourth-year students); the program described by Kaufert et al[21] (first- and fourth-year students); and the program at the University of Queensland, Brisbane, Australia (fourth-year students).[24]

Motivation for Program Development

One of the documented motivations for developing a program to enhance cultural competence was a perception of negative discrimination. The program at the University of Southern California School of Medicine (Los Angeles), was based on the results of a student-conducted survey that demonstrated that 17% of first-year medical students at this institution were from minority groups (defined as blacks, Asians, and Hispanics), in contrast to the 86% of patients at the teaching hospital. The University of Pennsylvania (Philadelphia) program[25] was initiated after students expressed concern to faculty staff about insensitive behavior by their teachers.

Teaching Methods

Six programs involved members of minority ethnic communities who volunteered to be interview subjects or simulated patients for the students. The students conducted interviews individually or in pairs[21,23,24,26,28] or questioned volunteers as part of a small group discussion (Table).[20]

In 3 programs, members of minority nonmedical community groups were key organizers of the teaching program and served as resources.[26,29,30]

One group convened a panel of experts, consisting of 2 Native Canadian interpreters, 2 patient advocates, and a physician, who participated in discussions of video vignettes with students.[21]

Two interventions reported the use of video recordings of simulated consultations that had been developed in cooperation with local communities.[22,29] Chugh and coworkers[31] developed simulated consultations based on information gained from semistructured interviews with 21 migrants to Alberta, Canada.

Three programs seemed to rely exclusively on physicians or faculty[32-34] who reported on their experience of cross-cultural medical care, with minimal evidence of patients being asked to describe their own personal experiences of health care services.

Two programs promoted the development of language skills to enable students to acquire sufficient skills to work effectively in Spanish as well as in English.[28,30] One of these provided classroom teaching and experiential learning with Latino physician preceptors[28]; the other included conversation groups, as well as classroom teaching, visits to community projects, and a student-financed 8-day visit to Mexico.[30]

Three programs reported the use of questionnaires[20,22,24] before and after teaching sessions. In most programs, this appeared to be part of an attempt to measure change in knowledge or attitudes. Two questionnaires were developed de novo.[20,24] Other projects used questionnaires only once (eg, Nora et al,[30] who used the misanthropy and ethnocentrism scale of Sullivan and Adelson[35]). Lacey[32] used questionnaires as an integral part of the teaching session and as a basis for discussion.[36]

Other methods included review of case histories or transcripts in small groups,[20,32,37] role play,[22,25] panel[33] and case presentation, research projects,[23,38] and clinical clerkships.[23,28,38]

Program Content

Many courses addressed attitudes and health beliefs, alternative healing systems, demographics, complementary medicine, and language barriers. The student-initiated programs[22,25] took a broader view of cultural diversity and included sexual orientation and alcoholism as well as ethnicity. These sessions explicitly set out to discuss racism and prejudice and encourage participants to challenge offensive behaviors. Substance abuse and specific diseases were covered in research projects,[23,38] guest lectures, and workshops.[29]

One program[33] took a theoretical approach and considered the anthropological and sociological theories of attitude development. In general, sessions had a practical focus.

One report mentioned conducting experiential seminars with faculty, using video and role play scenarios similar to those used with students.[25] Opportunities for reflection by teachers on their own attitudes and beliefs were not mentioned.

Student Assessment

Ten of the 17 programs were either optional for students or there was no indication that they were a required course component. Only 1 of the 7 required programs was reported to have assessed students on their case presentations and contributions in tutorials.[24] Assessments in the optional courses included student self-assessment of competence,[26] tests in either written or oral proficiency in Spanish,[28,30] or written reports of research projects.[23] One group planned to develop 2 stations in an Objective Structured Clinical Examination.[20] One station was intended to assess and reinforce the students' skills in taking a patient's health beliefs history. The other would provide an opportunity to incorporate a patient's health beliefs into a negotiated treatment plan.

Evaluation

The majority of articles described 1 or, occasionally, 2 years of experience. An exception was Rogers and Coulehan,[23] who documented 16 years of an elective program run by the University of Pittsburgh in collaboration with Navajo people and the Indian Health Service in Arizona and New Mexico. Because of the program's short duration, evaluation methods relied heavily on assessment of student satisfaction immediately following a session.[20,22,24,26,33] The University of Pittsburgh program[23] described the percentage of students who participated in the undergraduate program and then went on to work in the Indian Health Service, the health gains to the community members who participated in teaching and learning, and students' research publications.

Evaluations shed some light on the most appropriate time to teach cultural content. Kaufert et al[21] reported a content analysis of the discussion that took place when their selection of vignettes was used with first- and fourth-year medical students. The first-year students lacked clinical knowledge and concentrated on the apparent sociocultural factors; fourth-year students focused on the clinical interaction they had witnessed. The wider sociopolitical and economic context and patient experiences of racism received little attention because students perceived this as being beyond their influence.

COMMENT

Few publications exist on a topic that is increasingly important in the United Kingdom and elsewhere.[8,39] The instructional initiatives are varied and the majority are directed at medical students early in their education. Since the majority of programs reported have been set in the United States, the teaching methods may not apply elsewhere. Few specialties other than family medicine, community medicine, and psychiatry have reported sponsoring such courses for medical students. Students who participate in an identical program at different stages in their education will have different priorities and learning objectives.[21]

Publication bias is the most important source of bias in systematic reviews.[13] Although considerable effort was made to locate relevant studies, some may have been omitted from this review, since only English-language publications were searched. We did not search for the term *cultural competence* or for terms specifically relating to language, translation, or interpreting services. Relevant publications after August 1998 also have not been included. We deliberately narrowed the focus of this review by setting out to identify programs that specifically addressed ethnic and racial diversity. A broader view of culture and diversity could have been adopted that incorporated, for example, sex, age, disability, or sexual orientation. Data extraction was difficult, as the reporting of details and results was often incomplete or vague. We did not

Table. Studies Reporting Teaching Programs on Cultural Diversity for Medical Students

Study	Setting	Student Year	Student Participation/ Program Length	Teaching Staff	Method
Gupta et al,[37] 1997	Yale University, New Haven, Conn	1	Required/6 hours plus introductory talk (time unspecified)	Course director, physician, faculty facilitators	Small groups, case histories, presentation, group discussion
Farnill et al,[26] 1997	University of Sydney, Australia	2	Optional/16 hours	Community volunteers as interviewees, faculty psychologists	Small groups, video recording and observation of student interviews with community volunteer, group discussion
Shah et al,[29] 1996	University of Toronto, Ontario	Not stated	Optional	Invited native experts	Lectures, workshops, seminars, videos
Gill and Adshead,[27] 1996	University of Leeds, England	2	Required/4 afternoon sessions	Faculty, volunteer families as interviewees	Small groups, role play, family interviews in pairs, presentation and discussion
Nora et al,[30] 1994	Rush Medical College, Chicago, Ill	1 and 2	Optional/60 hours plus 8-day visit to Mexico	Faculty, community experts	Conversation groups, classroom teaching, small groups, visits to community projects in United States, meetings with local population and health service providers in Mexico
Chugh et al,[31] 1993	University of Calgary, Alberta	Not stated	Not stated	Faculty	Small groups, 2 simulated patients
Rubenstein et al,[20] 1992	Medical College of Pennsylvania, Philadelphia	2	4 hours	Medical folklorist, faculty, community participants	Whole group teaching, small group discussion with community members and of case histories, health promotion
Johnston,[25] 1992	University of Pennsylvania, Philadelphia	1	Required/2 hours	Faculty	Small groups, student-produced video, role play, discussion
Copeman[24] 1989	University of Queensland, Brisbane, Australia	4	Required	Doctors, Vietnamese health worker, patients at a women's or Aboriginal and Islanders health center as interviewees	Whole class symposium, history taking and presentation
Mao et al,[22] 1988	University of Southern California School of Medicine, Los Angeles	2	Required/4 hours	Students as facilitators	Small groups, video vignettes, discussion and role play
Lacey,[32] 1988	Southern Illinois University, Springfield	1	Required/2 hours	Faculty	Small groups, questionnaire on personal social characteristics and demography, analysis of a consultation transcript, use of a "self examination in trans-cultural issues" questionnaire[37]
Gonzalez-Lee and Simon,[28] 1987	University of California, San Diego	2	Optional/12 to 15 h/wk for 3 consecutive quarters	Faculty, Latino physician preceptors	Classroom language teaching and cultural immersion, history taking, experiential learning
Wells et al,[33] 1985	University of California, Los Angeles	1	Required/1 day	Community physicians, faculty	Panel presentation and discussion, small groups and reading list
Rogers and Coulehan,[23] 1984	University of Pittsburgh, Penn	2 and 4	Optional/6- to 12-week elective	Faculty, Indian Health Service physician, community health project workers	Experiential learning, research project
Kaufert et al,[21] 1984	University of Manitoba, Winnipeg	1 and 4	Not stated	Native Canadian interpreters, patient advocates, a physician	Panel discussion "trouble case" videos, small group seminars
Nurge,[34] 1975	University of Kansas/ University of New Mexico, Kansas City/Albuquerque	Not stated	Optional/4-week elective	Not stated	Experiential learning
Paterson-Kimball,[36] 1970	Yale University, New Haven, Conn	1	Optional/16 hours of seminars, 8-week elective	Faculty medical officer on Navaho reservation, epidemiological control officers	Seminars, clinical clerkship, research project and presentation

Content	Cultural and/or Racial/ Ethnic Group	Student Assessment	Course Evaluation
Religion, complementary medicine, language barriers	African Americans, Latinos, Asian Americans, gay/ bisexual men and women	Not stated	Student feedback via focus groups
Language and communication, interviewing skills, life histories of people from different cultures	Australians with non–English-speaking backgrounds who spoke sufficient English to be interviewed	Self-assessment of competence	Questionnaire to students and volunteers on quality of experience, analysis of videotapes by psychologist using novel rating scale and factor analysis
Native family, violence, urban native health, substance abuse, community healing, mental health, nutrition, women and health	Canadian First Nation and Aboriginal people	Not stated	Questionnaires to participants, institution, and speaker
Language, greetings and names, customs and health beliefs, traditional remedies and healers, experiences of the health service	African, Caribbean, Pakistani Punjabi (Muslim), Indian Punjabi (Hindu), Bangladeshi, Sikh, Chinese	Not stated	Content analysis of student questionnaires
Spanish-language teaching, demography, cultural practices, health beliefs, use of interpreters, acquired immunodeficiency syndrome, nutrition	Hispanic American and Mexican populations	Written assessment of student English-Spanish translations, multiple-choice questionnaire on knowledge of demographics and Hispanic health and cultural issues	"Misanthropy" scale of Sullivan and Adelson,[37] discussion sessions, student questionnaires on international seminar experience
Language barriers, sex of health care practitioner, religion, personal economics of illness, importance of clinical assessment	Salvadorean, East Indian	Not stated	Not stated
Health beliefs and their implications for patient-physician relationships and health promotion, resources available for further learning	Working- and middle-class Americans who were members of minority communities, immigrants to the United States, white proponents of New Age healing	Plan 2 stations in an Objective Structured Clinical Examination and written submission of health beliefs case history	Short-answer presession and postsession tests of student knowledge of alternative practices and beliefs, student satisfaction and personal health beliefs questionnaires
Insensitive and inappropriate behaviors	African Americans, gay men, women	Not stated	Not stated
Problems of recent non–English-speaking immigrants and the Australian health system	Aborigines, recent non–English-speaking immigrants to Australia	Case presentation and participation in tutorial	Precourse and postcourse questionnaires on knowledge, sociocultural factors, and attitudes toward Australian Aborigines; student self-assessment of competence in 2 clinical situations to highlight awareness of communication difficulties
Influence during consultation of ethnic and sociocultural differences in physician and patient	Hispanic Americans, lesbians, and people with alcoholism	Not stated	Student satisfaction questionnaires, presession and postsession questionnaires on student attitude
Alternative healing systems, health beliefs, demographics	Latin American culture, minority ethnic groups	Not stated	Data from questionnaire on personal social characteristics and knowledge of demography
Spanish language acquisition	Latinos	Oral proficiency test in Spanish	Number of students who passed oral proficiency tests
Theories of attitude development	Minority ethnic groups in the United States	Not stated	Student satisfaction questionnaires
Health care provided by Indian Health Service, research project subjects included solvent abuse, *Haemophilus influenzae* type b disease, rheumatic fever control	Navajo population	Written report of research project	Student career choice, publications arising from research projects, community health gains
Patient-physician interaction in terms of immediate clinical encounter, diverse cultural understandings of exchange, wider socioeconomic/political context	Native Canadian	Not stated	Content analysis of discussion during sessions
Disease-oriented tables describing vectors and possible contribution of social and environmental factors, reading list	Navajo people, "Spanish Americans and Anglos"	Not stated	Not stated
Geographical, cultural, social, and health aspects of the Navaho reservation and tribe	Navaho people	Not stated	Student feedback

contact the authors for clarification. In addition, our medical education experts include representatives from outside the United Kingdom.

Despite these limitations, our review highlights the need for programs in multicultural education as part of the medical core curriculum, as well as training programs for medical educators. Because evaluations of the programs took place early in the students' education, it was not possible to chart improvements, or the lack thereof, in knowledge and attitudes toward cultural, racial, and ethnic diversity as students neared medical practice. Such information is important because the literature documents cases in which attitudes actually deteriorated as students progressed to the later years of their medical education.[40] If students respond less appropriately to diverse populations as they advance, then vertically integrated programs of teaching and learning that extend beyond year 2 are essential. Further research is needed into valid and appropriate methods of student assessment and program evaluation.

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