Cultural competence in health care education. Systematic review of teachers’ perspectives

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Introduction: To provide appropriate care for all patients, culturally competent healthcare professionals are needed. This in turn means that the educators of these healthcare professionals need to be appropriately skilled to teach cultural competence (CC). To ensure good quality teaching, better understanding of the skills needed is required. The aim of this study is to explore the current state of the cultural competency of healthcare educators.

Methods: A systematic review using three databases (ERIC, PubMed and PsycINFO) was performed. Within these databases search terms were used such as: teachers and/or educators, medical and/or nursing education, and CC or cultural diversity. Inclusion criteria were empirical studies written in English or in Dutch, articles about healthcare educators’ experience of CC, methods to teach CC to teachers, and evaluation of teach the teacher programmes. Eighteen qualitative and quantitative articles met the inclusion criteria. The quality was assessed based on established criteria for reporting studies. We performed a qualitative thematic content analysis of the articles and produced an analytic narrative in which data were related back to the research question.

Results: We categorized the findings according to the definition of CC by researchers and respondents, educators’ CC, and their perspective about teaching CC. No standard definition of CC was given by researchers and respondents. Definitions varied from a multidimensional approach of diversity to a more essentialist approach of ethnicity as a main determinant of culture. Teachers self-reported as CC but also doubted abilities and self-confidence in teaching CC as how to prevent students from stereotyping patients, and how to deal with student diversity. Previous training is positively related to CC in educators but little is known about programmes completed. Teachers describe teaching CC as fragmented, and integration of CC across curricula as lacking. Perceived barriers are: teaching CC is not prioritized and lacks resources such as curricular time; educators’ uncertainty about central aims and philosophy of CC training; difficulties with teaching culturally diverse students; educators’ experiences of student resistance towards CC or even disrespect. Teachers themselves felt challenged by having to reflect on their own values. Different needs such as receiving support by faculty management were expressed. Teaching strategies used include teachers’ and students’ own experiences.

Discussion and Conclusions: Our findings showed that teachers although generally self-reported as competent, had doubts. CC training can support teachers to reflect on their own social identities including cultural background in several ways. First, CC training should include teacher reflexivity as well as how to stimulate student reflexivity. Second, CC training should include an intersectional approach towards diversity; a multidimensional approach helps to understand how identities and their intersections play a role in health and health care. Third, teachers need skills training such as facilitating small group discussions and dealing with diverse student groups. Fourth, institutional support for teaching CC and the structural integration of CC in healthcare education is warranted.

Cultural diversity needs to be prioritized and implemented at institutional level in health care and medical education. Teachers need support and training to teach CC.

#7D2 Toward a diversity-responsive medical curriculum

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Introduction: Variations in health and care needs between different cultural groups have prompted medical schools to implement diversity topics into their curricula. Often, such efforts are focused at cultural aspects of diversity, which can lead to cultural essentialism and induce rather than resolve stereotypes. Therefore, a more complex conceptualization of diversity is needed. The intersectionality paradigm can provide a framework for diversity teaching in medical education [Powell Sears, 2012]. The framework assumes that individuals experience multiple interacting and mutually reinforcing social identities, according to for instance
gender, sexuality, social class, race and ethnicity. The intersection of identities creates unique and dynamic social locations, which occur within a context of sustained and reproduced power differences and relate to various forms of privilege and disadvantages [Hankivsky, 2014]. This study was aimed at using an intersectionality approach to evaluate the diversity-responsiveness of a medical curriculum.

**Methods:** We used a two-phase data collection and analysis protocol within a case study design. In phase one, we defined essential learning objectives through semi-structured interviews with school stakeholders and a literature search. In phase two, we screened the written curriculum for diversity content and compared it with the objectives defined in phase one.

**Results:** We identified essential learning objectives in three areas of medical education (medical knowledge and skills, patient-physician communication, and reflexivity), and grouped their content according to the social locations culture, sex & gender (including sexual orientation) and class and their intersections. We found that most diversity-related curriculum content pertained to medical knowledge and skills. While culture was addressed on different educational levels and throughout the curriculum, limited attention was paid to its role as a determinant of health and healthcare use. Sex & gender was addressed mostly on a biomedical level through reproductive health and urogynaecological issues. Sexual orientation was marginally addressed. ‘Class’ was addressed only in relation to socioeconomic differences in life expectancy. Intersections of culture, sex & gender and class remained unaddressed. For instance, the gendered topic ‘termination of pregnancy’, was addressed from a white, secular, middle-class perspective, and reproductive issues were largely addressed from a heterosexual perspective.

**Discussion and Conclusions:** Diversity-related curriculum content mostly referred to biomedical aspects of culture and sex. The curriculum’s diversity responsiveness could be improved by an operationalization of diversity that goes beyond biomedical traits of assumed homogeneous social groups. We therefore suggest that the medical school advances its diversity education in all areas of education and throughout all learning objectives by addressing both biomedical and sociocultural aspects of patients’ intersecting identities, and by taking into account the larger societal context that influences health outcomes of individuals and groups. Relevant issues involving class/socioeconomic status deserve more focus throughout the curriculum, as do issues related to sex/gender and sexual orientation. An intersectional approach to communication and reflexivity training, both considered elementary in the education of physicians, can enhance medical students’ critical thinking and self-awareness. To sustain the mainstreaming of diversity teaching, medical schools should aim to apply the intersectionality approach not only on a curricular level, but also on an institutional and compositional level.

**References:** Hankivsky O. Intersectionality 101. The Institute for Intersectionality Research & Policy, SFU, April 2014.

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**Louder than Words: Power and Conflict in Interprofessional Education Articles, 1954-2013**

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**Introduction:** Interprofessional education (IPE) aspires to enable collaborative practice. Current IPE offerings, while rapidly proliferating, lack evidence of efficacy and theoretical grounding. Our research aimed to explore the historical emergence of the field of IPE and analyze the positioning of this academic field of inquiry. In particular, we sought to investigate to what extent power and conflict—elements central to interprofessional care—figure in the IPE literature.

**Methods:** We used a combination of deductive and inductive automated coding and manual coding to explore the contents of 2,191 articles in the IPE literature published between 1954 to 2013. Inductive coding focused on the presence and use of the sociological (rather than statistical) version of power: one about hierarchies and asymmetries between the professions. Articles found to centrally be about power were then analyzed using content analysis.

**Results:** IPE publications have grown exponentially in the past decade. Deductive coding of identified articles showed an emphasis on students, learning, programs and practice. Automated Inductive coding of titles and abstracts found a potential of 129 articles about power, but manual coding found only 6 articles that put power and conflict at the centre. Content analysis of these 6 articles revealed 2 that provided tentative explorations of power dynamics, 1 that skirted around this issue, and 3 that explicitly theorized and integrated power and conflict. An analysis of 6 articles revealed that provided tentative explorations of power dynamics, 1 that skirted around this issue, and 3 that explicitly theorized and integrated power and conflict. A content analysis of these 6 articles revealed 2 that provided tentative explorations of power dynamics, 1 that skirted around this issue, and 3 that explicitly theorized and integrated power and conflict.

**Discussion and Conclusions:** The lack of attention to power and conflict in the IPE literature suggests that many educators do not foreground these issues. Educational programs are expected to transform individuals into effective collaborators, without heed to structural, organizational and institutional factors. In so doing, current constructions of IPE veil the problems that IPE attempts to solve.
Beliefs about workplace learning and organisation in postgraduate medical education – a qualitative case study of three paediatric departments

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Introduction: Several studies have examined how doctors learn in the workplace, but research is needed to shed light on how work organisation influences how junior doctors learn in the workplace and to help answer how learning opportunities in the workplace can be organised more explicitly. This knowledge is needed to help medical education planners face the challenges and tensions in organising specialist training in clinical departments.

This qualitative case study examines how doctors’ perceptions of learning are shaped by the daily work routine and the workplace organisation. We examine residents’ and faculty’s attitudes and beliefs regarding resident training, including their views on how contextual or organisational factors influence the organisation and planning of medical specialist training. This qualitative case study examines how doctors’ perceptions of learning are shaped by the daily work routine and the workplace organisation. We examine residents’ and faculty’s attitudes and beliefs regarding resident training, including their views on how contextual or organisational factors influence the organisation and planning of medical specialist training. Focus is on the daily activities of the residents and how they engage in learning during work. This is compared to the beliefs regarding educational planning of workplace learning of both residents and consultants responsible for medical education (CRE) in order to elucidate any hindering factors in the organisation of daily work in regard to the specialist training of residents.

Methods: The study consists of a short time ethnographic observational case study in three paediatric departments in Denmark combined with focus group interviews with 9 consultants responsible for medical education and 16 residents. Interviews were audio-recorded and transcribed. Observational field-notes and interview data was entered into NVivo 10 qualitative analysis software. Data was read iteratively and analysed using a data driven thematic analysis approach to identify major themes, which were further categorised and abstracted to answer the research question. To guide our theoretical understanding we used the concept of workplace affordances by Billett and the notions of “espoused theory” and “theories-in-use” by Argyris and Schon.

Results: Participants’ beliefs regarding workplace learning in medical training focus on patient care and apprenticeship between junior and senior doctors. Data suggest that beliefs regarding workplace learning and the organising of work are not always in congruence with what is practiced in the reality of everyday work. Views and beliefs regarding “training versus production” were found to be a potential conflict between residents, who see it as contradictory, and consultants who see production as conducive to learning. Continuity in tasks and in patient care is believed to be of importance but challenges the organising of the daily work routines. The learning culture and managers’ role in the department are essential contributions to creating a successful work organisation in regards to learning.

Discussion and Conclusions: This case study provides valuable insight into the factors influencing the learning process and the organisation of daily work, e.g. the availability of supervising specialists, continuity of patient care and the affordance and structuring of work in accordance with Billett’s workplace affordances theory. Managers and educational planners should inform residents more explicitly of their beliefs and assumptions on which they plan and structure daily work. This might help break down tensions created by viewing production and training as opposing each other, and help residents and faculty to engage and participate more focused in workplace training.