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Training Faculty for Cultural Teaching

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Chapter 3

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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 researchers[1] 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 training[3] 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 model[4] (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 profession[5] 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 questions[12] 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

***L*ISTEN**

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?"

***E*LICIT** 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?"

***A*SSESS** 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?"

***R*ECOMMEND** 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?"

***N*EGOTIATE** 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.

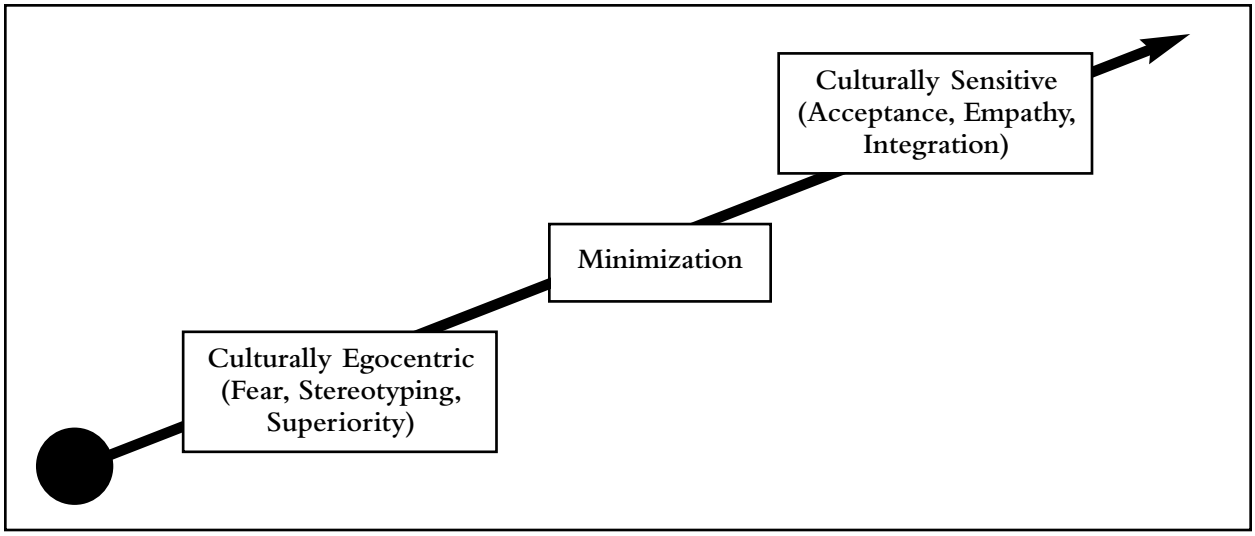
Additionally, intention–to-change data, which measures participants' motivation to improve cultural competency in clinical care and teaching, can be helpful in determining how behavior or attitude might have been modified as a result of the training program, especially when compared with follow-up reports 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



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