Designing a Cultural Competency Curriculum: Asking the Stakeholders

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Abstract

Background: The design of a cultural competency curriculum can be challenging. The 2002 Institute of Medicine report, Unequal Treatment, challenged medical schools to integrate cross-cultural education into the training of all current and future health professionals. However, there is no current consensus on how to do this. The Department of Native Hawaiian Health at the John A. Burns School of Medicine formed a Cultural Competency Curriculum Development team that was charged with developing a curriculum for the medical school to address Native Hawaiian health disparities. By addressing cultural competency training of physicians, the team is hoping to help decrease the health disparities found in Native Hawaiians. Prior attempts to address culture at the time consisted of conferences sponsored by the Native Hawaiian Center of Excellence for faculty and clinicians and Problem Based Learning cases that have imbedded cultural issues.

Objective: Gather ideas from focus groups of Native Hawaiian stakeholders. The stakeholders consisted of Native Hawaiian medical students, patients and physicians. Information from the focus groups would be incorporated into a medical school curriculum addressing Native Hawaiian health and cultural competency training.

Methodology: Focus groups were held with Native Hawaiian medical students, patients and physicians in the summer and fall of 2006. Institutional Review Board approval was obtained from the University of Hawaii as well as the Native Hawaiian Health Care Systems. Qualitative analysis of tape recorded data was performed by looking for recurrent themes. Primary themes and secondary themes were ascertained based on the number of participants mentioning the topic.

Results: Amongst all three groups, cultural sensitivity training was either a primary theme or secondary theme. Primary themes were mentioned by all students, by 80% of the physicians and were mentioned in all 4 patient groups. Secondary themes were mentioned by 75% of students, 50% of the physicians and by 75% of patient group. All groups wanted medical students to receive cultural sensitivity training, and all wanted traditional healing to be included in the training. The content of the training differed slightly between groups. Students wanted a diversity of teaching modalities as well as cultural issues in exams in order to emphasize their importance. They also felt that faculty needed cultural competency training. Patients wanted students to learn about the host culture and its values. Physicians felt that personal transformation was an important and effective tool in cultural sensitivity training. Cultural immersion is a potential teaching tool but physicians were concerned about student stages of readiness and adequate preparation for cultural competency training modalities such as cultural immersion.

Conclusions: Cultural competency or sensitivity training was important to patients, students and physicians. The focus group data is being used to help guide the development of the Department of Native Hawaiian Health's cultural competency curriculum.

Introduction

The United States is becoming more culturally and ethnically diverse. This diversity is present in the State of Hawai'i which has no one majority ethnic group.[1,2] Many minority populations suffer from "significant disparities in health care and health outcomes."[2] In Hawaii, Native Hawaiians suffer from some of the highest rates of health disparities.[3-7]

Nationally there is recognition that addressing health disparities requires multiple approaches.[2] With the groundbreaking 2002 Institute of Medicine report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," there has been a concerted national focus to addressing health disparities suffered by minority communities through improved training of healthcare providers. A recommendation has been to develop comprehensive cross-cultural curricula that can be integrated into medical education.[8] However, several researchers have noted that the utilization of health services interventions such as provider trainings in culturally appropriate care is an important, but not the only, approach to reduce these inequalities.[2,9]

On the federal level, the Office of Minority Health recognized the need for culturally competent care and developed the national standards for culturally and linguistically appropriate services in health care (CLAS standards). They define cultural competence as "a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enable effective work in cross cultural situations."[10] Components might include awareness of cultural differences and the dynamics of differences as well as an awareness of one's own cultural values.[11] Regulatory agencies, such as the accrediting body for US medical schools, the Liaison Committee for Medical Education, now requires medical schools to address cultural competency training.[12]

Nevertheless, there is no consensus on the best way to teach or train providers in culturally competent care. For example, there has been no standardization of the content, assessment or integration of training curriculum.[13,14] In particular, none that have developed thus far focus on the needs of Hawai'i's Native Hawaiian community.

The Department of Native Hawaiian Health (DNHH) at the John A. Burns School of Medicine (JABSOM) at the University of Hawai'i was formed to address the health disparities and healthcare needs of the Native Hawaiian (NH) population. The Cultural Competency Curriculum (C3) Development project within the DNHH was tasked to develop a comprehensive and effective cultural competency training curriculum for JABSOM medical students, the future physicians caring for Native Hawaiians. The C3 project team is multidisciplinary, consisting of faculty from the Departments of Native Hawaiian Health, Family Medicine, and Psychiatry (currently this faculty member is at the School of Social Work). There are two community members: one works at the Queens Medical Center and the other is the retired head of the Office of Health Parity at the Hawaii State Department of Health.

The C3 team realized that it needed to consider what Native Hawaiians would want in a cultural competency curriculum directed at Native Hawaiian health. Review of local literature revealed that poor communication, apprehension, fear and mistrust are thought to underlie many of the disparities suffered by Native Hawaiians. In addition, NH patients feel that Western medical care can be culturally inappropriate (for example: emphasis on the individual rather than the individual in relationship to family or ignoring holistic aspects of health). Native Hawaiians also expressed a preference to

see NH health professionals and utilize traditional healing services. Similar to some of the national literature, the importance of the role of culture in understanding health beliefs, attitudes and behaviors was identified.[15-17] The C3 team decided to further identify specific components that should be included in a curriculum targeting Native Hawaiians.

Methodology

The C3 team started with focus groups of stakeholders. Since the DNHH is focused on addressing Native Hawaiian health disparities, we decided that Native Hawaiians were the primary stakeholders and that included not only Native Hawaiian patients, but also the physicians and medical students treating NH patients. The C3 team chose to focus on Native Hawaiian physicians and students, hoping that they might provide some unique insights into cultural competency training content at JABSOM.

Focus groups were chosen as they are an effective way to collect information about perceptions, feelings and thoughts around specific issues. They collect qualitative data from focused discussions featuring predetermined but open ended questions.[18] Previous researchers have found that Native Hawaiians prefer to share their experiences orally and face to face (compared with surveys or telephone interview), allowing them to gauge the researcher's "intent, sincerity, and trustworthiness as information is exchanged."[16,19]

The team conducted a series of focus groups of stakeholders in the summer and fall of 2006. Groups discussed various aspects of Native Hawaiian health including aspects of training for medical students. Prior to conducting our focus groups, we sought, and received, Institutional Review Board (IRB) approval from both the University of Hawaii as well as the Native Hawaiian Health Care Systems. The focus groups each had a facilitator and two scribes. One scribe took notes and the other recorded on flip charts. All sessions were tape recorded. All participants filled out written consent forms.

Native Hawaiian Medical Students

At the time of the focus group meetings, there was no formal cultural competency training for all JABSOM medical students. Most of the students' early exposure to Native Hawaiian health and related issues occurred through a few Native Hawaiian Problem Based Learning (PBL) cases scattered throughout the first and second years of training. Later in their medical training, some, but not all, of the students would get some cultural competency training from certain community clinic rotations. The NH medical student focus group was asked to explore whether Native Hawaiian health care issues were being adequately addressed within PBL and the current curriculum overall. In addition, the focus group asked for medical student input into the design of a cultural competency curriculum. In early fall of 2006, there were 8 Native Hawaiian medical students in years 2 and 3. We chose second and third year students for the focus groups as we thought their memories of the PBL cases would be the most current. Fifty percent of the students participated (N = 4, groups = 1). We had one male and three female students.

Native Hawaiian Patients

Native Hawaiian patients were recruited from the island of Moloka'i as well as the Native Hawaiian civic clubs on the island of O'ahu. Moloka'i was chosen due to the high percentage of NH residents living in a rural community. Recruitment was done through a contract with Na Pu'uwai, the Native Hawaiian Health Care System on that island. Native Hawaiian patients from Oahu were recruited from the Pearl Harbor Hawaiian Civic Club after discussions with their leadership. The civic club is one of the 52 members of the Association of Hawaiian Civic Clubs. Within their mission, the clubs advocate for health policy affecting Native Hawaiians and they have been willing to collaborate on research projects in the past. The Pearl Harbor Civic Club members came from both suburban and urban O'ahu.

A total of thirty-four patients participated in one of four focus groups (N = 34, groups = 4). Focus groups ranged in size from 6 to 9. Participants were of mixed gender and ages and came from a variety of communities (rural, suburban, and urban). Patients were asked to share good and bad experiences with doctors as well as comments or recommendations from a patient perspective for the future training of doctors.

Native Hawaiian Physicians

Native Hawaiian physicians were recruited from a pool of physicians that had participated in one of three conferences organized by the JABSOM Native Hawaiian Center of Excellence (NHCOE) and the 'Ahahui o na Kauka (Association of Native Hawaiian Physicians). The conferences all took place on the Island of Kaho'olawe and included cultural competency training. Of note, the training paired a CME (Continuing Medical Education) curriculum with an intense cultural immersion experience/curriculum provided by the Protect Kaho'olawe 'Ohana.[20,21]

Ten Native Hawaiian physicians participated in two separate focus groups (N = 10, groups = 2). Physicians present represented both genders, a mix of specialties and both academic and clinical practice. They were asked to address two main questions: what should a cultural competency curriculum for medical students include and could cultural immersion activities be a useful adjunct to that curriculum?

Evaluation

Qualitative analysis was done on all transcripts looking for primary and secondary themes.[17] Transcriptions of the audio recordings were read and compared with scribe notes and flip charts. Members of the C3 team then analyzed the data looking for primary and secondary themes. Primary themes were mentioned by all students, by 80% of the physicians and were mentioned in all 4 patient groups. Secondary themes were mentioned by 75% of students, by 50% of physicians and were mentioned in 75% of the patient groups. Speakers were initially identified by first name or initial and after initial transcript review looking for themes, deidentified to a number. Speakers mentioning the theme more than once were only counted once. Consensus was reached among team members prior to comments being assigned to a theme.

Results

Medical Student Group

There was one primary and two secondary themes that arose. The primary theme was mentioned separately by all four students and had to do with the need for more cultural sensitivity training. All

four students felt that there needed to be more done to stress the importance of cultural understanding in patient care. They had several suggestions on how to do this. First, they felt that multiple teaching modalities, as well as repeat exposure, were needed. For example, they suggested that teaching modalities include not only PBL cases, but lectures and colloquia and clinical rotations in Native Hawaiian communities. They were very worried about perpetuating stereotypes in the PBL cases. In particular, the students discussed cases where condescending attitudes were present or where fellow students "mocked the case after class." They also felt that in order for cultural issues to be taken seriously by medical students that they needed to become "high yield" (occur on exams). For example, no one wanted a learning issue on traditional NH diet because "it wasn't going to be on the test." There was a strong feeling that cultural issues as well as psychosocial topics needed to have better resources. Students didn't like having to spend a lot of time looking for resources for issues that weren't going to be on exams (low yield). Finally, they felt that the school needed to address diverse student backgrounds especially as it relates to basic understanding of culture and cultural differences. The Native Hawaiian students were aware of the wide range of backgrounds of their fellow students and that many of the students just "don't understand" or "don't know what's inappropriate" with respect to cultural issues.

There were two secondary themes. First, the students felt that there needed to be teaching about traditional medicine in the medical school curriculum. Second, they felt that PBL tutors needed to be trained to be culturally sensitive and that the tutors needed to actively encourage the students to explore the cultural and psychosocial issues in the various cases. They were concerned that there was too much variability in the way that PBL tutors approached cultural and psychosocial issues. (In JABSOM, PBL tutors come from diverse backgrounds, ranging from clinical MD volunteers to MD faculty to basic science PhD faculty).

Native Hawaiian Patients

Although patients came from a variety of backgrounds, five primary themes that were addressed in all patient groups and four secondary themes that were addressed in three of the four patient groups were identified. Primary themes included: customer service related issues (waiting times, rushing the visit), whether there was respect/caring for the patient (trust issues, sensitivity to fears), interpersonal skills of the provider (listening, communicating), thoroughness of care (knowledge of patient, follow up) and finally issues around costs of medical care.

Secondary themes involved issues around medical office staff shortfalls, continuity of care, responsibilities of the patient for their own care and cultural sensitivity training. With respect to the latter, patients wanted formal cultural sensitivity training for students. Many shared stories to emphasize this point. One touching story had to do with the cultural clash that occurred with a *kupuna* (elder) dying at a local hospital. The large family wanted to gather around and tell stories and play music, but the nurse wanted the room to be quite and calm. Patients also wanted students to learn about traditional medicine and to be open about the patient's use of the traditional and alternative medicines. They wanted the doctors, especially "non-local" ones, to learn about the "host culture," to incorporate the patients' cultural values into treatment as well as "involve the family in treatment" plans.

Native Hawaiian Physicians

Native Hawaiian physician focus groups had one primary and two secondary themes. The primary theme was cultural sensitivity training leading to personal transformation. For example, the physicians spent time defining what was meant by "cultural immersion." Most felt that the Kaho'olawe experience was a personal journey that included cultural experiences. For many, a personal transformation occurred that allowed for a feeling of "connectedness" to the ancestors and the land. As part of this transformation, physicians developed an increased awareness of spirituality and pride in the knowledge and culture of their ancestors. They also acquired a sense of generational responsibility.

There were two secondary themes. The first centered on the impact of the experience on their medical practices. At least ½ of the physicians felt that the Kaho'olawe experience improved patient communication, increased knowledge of and openness to traditional healing, and made them more aware of the conflict that can occur between cultures (for example: Western and traditional medical practices).

The other secondary theme focused on the components of a cultural competency curriculum, or sensitivity training, for medical students. Physicians were quite concerned about the diversity of the backgrounds of students as well as the stages of readiness of the students to learn new attitudes, behaviors or skills. They felt that self-awareness and self-reflection were critical. Discussions of the culture of medicine and potential conflicts with that culture were needed. The physicians wanted students to be exposed to traditional healing practices. With respect to immersion experiences, physicians were worried about giving the students adequate preparation. Since the personal transformation experiences of Kaho'olawe were what made the immersion so powerful, they worried about how prepared a student might be for similar experiences. Preparation suggestions ranged from self-reflection and awareness exercises to learning about the history and culture of Native Hawaiians to preparation of the students' "hearts and souls" (emotional/spiritual preparation). Physicians wanted students to know that "there are other powerful ways to learn that aren't evidence based." Finally, the physicians thought that the medical school itself should be more culturally adept. Suggestions included learning about JABSOM's "sense of place" which should incorporate the history, geography and genealogy of the campus as well as the adoption of certain cultural practices into its values and traditions.

Discussion

The design of a cultural competency curriculum can be challenging. The 2002 Institute of Medicine report challenged medical schools to "integrate cross-cultural education into the training of all current and future health professionals." The first challenge is whether one can ever truly achieve cultural "competence" in another's culture. In fact, the C3 team prefers to use the terms "cultural humility" or "cultural sensitivity" as the team doesn't believe that one can truly be "competent" in another's culture. In addition, the team strongly believed that in order for "cultural competency training" to be effective, learning needed to occur on multiple levels: intellectual, emotional, visceral and even spiritual. The question was where to start. Using focus groups of Native Hawaiian stakeholders to help guide decisions around the design of a curriculum proved to be extremely valuable.

Interestingly, all groups of stakeholders agreed that students needed to be exposed to, or taught about traditional medicine. In addition, all groups agreed that cultural sensitivity training was important for medical students. They differed regarding the content that should be covered (with the exception of traditional healing practices). From our medical student focus group we learned that there was concern about stereotypes in the some of the JABSOM PBL cases and they were not an effective teaching tool for cultural issues. Students wanted cultural sensitivity training to involve multiple teaching methodologies and target faculty as well as students. An important point was raised of needing to include culturally related information on exams in order to elevate their "importance" to medical students (make them "high yield").

Native Hawaiian patients were focused on the patient-physician interaction and communication. However, with respect to their desire for medical students and doctors to have cultural sensitivity training, they were concerned about "non-local" physicians learning about the host culture. They also wanted physicians to incorporate cultural values, such as the involvement of family, in treatment plans.

Native Hawaiian physicians were asked to address their personal experiences in a cultural competency training curriculum that included a CME program with intense "cultural experiences." The curriculum was actually designed to include "cultural immersion." Physicians valued this experience greatly. In fact, the experience appears to have been deeply moving and facilitated personal transformation as well as increased connection to and pride in their culture. For many it improved their medical practices. Physicians acknowledged that cultural immersion could be a useful teaching tool but were worried about the student's readiness for the experience.

Study Limitations

Limitations to the study should be noted. First the use of focus group methodology can be subjective, both in the information collected from participants and in its analysis. Secondly, participant numbers were small. The pool of Native Hawaiian medical students and physicians was very limited. Finally, the patient participants may not have been representative of the larger Native Hawaiian population. For example, most of our participants had medical insurance. It's possible that focus groups that included uninsured NH patients might result in different conclusions. The C3 team hoped that using participants from diverse sociogeographic backgrounds and consensus by team members on data extraction and interpretation would address some of these limitations.

Conclusion

The C3 team took the information from these focus groups and used it to prioritize teaching efforts. Curricular time and funding has proved to be challenging, particularly for teaching interventions such as the cultural immersion experience. As a result, the team has had to gradually incorporate lessons and strategies into the JABSOM curriculum. In the future, the C3 team hopes to incorporate most, if not all, of the suggestions raised by the focus groups into the JABSOM curriculum. The results of this study have been extremely helpful as the cultural competency curriculum has developed and continued to evolve. Based on this experience, focus groups such as those in this study can be a useful tool in designing cultural competency training for other schools or departments attempting to address health disparities.

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