Developing a Culture and Diversity Curriculum: An Integrated Approach

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Abstract: In response to the need to educate future physicians about culture and diversity in healthcare issues, the Medical University of South Carolina (MUSC) College of Medicine developed a culture and diversity curriculum in the late 1990s. Institutional leadership, an approach that integrated learning activities into existing courses and clerkships, and use of local experts overcame initial curriculum implementation challenges of faculty resistance, an already full curriculum and lack of faculty familiarity with the subject area. Learning activities included first year problem-based learning cases, standardized patient scenarios and lecture presentations; third year activities included written reports about patients' cultural beliefs, standardized patient encounters, and learning points in case discussions. As the college's overall curriculum has evolved, the format of the learning activities has altered slightly, but the curriculum has continued. The college of medicine is one of six colleges on the MUSC campus. Current efforts in culture and diversity and factors contributing to the successful implementation of culture and diversity curricula across the colleges are described.

Keywords: Culture, diversity, curriculum, medical students.

INTRODUCTION

The need for addressing cultural competence in healthcare has been well documented [1-3]. The demographic changes expected in the United States demand that we prepare a workforce competent to meet the needs of a pluralistic society, and that quality culturally and linguistically appropriate services are available. The lack of diversity among the healthcare workforce poses additional challenges. For example, African Americans comprise 13% of the U.S. population but only 4% of the nation's physicians. There is also a presumption that patients prefer to see healthcare providers from similar cultural backgrounds [4].

The scope and existence of healthcare disparities are also well documented [2] but despite intense scrutiny, little has changed [5]. While finding the causes of healthcare disparities remains elusive, it is well accepted that developing the cultural competence of the healthcare workforce will improve outcomes for patients in cross-cultural relationships. There is additional evidence in support of the importance of diversifying the health professions [1].

Medical educators face the challenge of integrating cultural competency into curricula that are already academically challenging, time-constrained, and "full." This article outlines efforts made at one medical school, the Medical University of South Carolina (MUSC), to establish a culture and diversity curriculum, including some of the initial barriers and strategies used to address these barriers. A brief description of the learning activities within the college's cultural competency curriculum is included. Finally, current efforts toward preparing culturally competent healthcare practitioners across MUSC's entire campus are described as well as factors that have supported these efforts are discussed.

INSTITUTIONAL BACKGROUND

The Medical University of South Carolina (MUSC) College of Medicine is the oldest medical school in the southern region of the United States. Founded in 1824, its tripartite mission of educating future physicians, providing healthcare to South Carolinians, and advancing biomedical knowledge through research and discovery has a rich history. The College of Medicine is one of six health professions colleges at the MUSC; the others include colleges of Dental Medicine, Graduate Studies, Health Professions, Nursing and Pharmacy. With respect to cultural and ethnic populations in the state, African-Americans comprise the largest minority group, representing 28.6% of the state's population [6]. Importantly, South Carolina is also home to the Gullah or Sea Islands people, a distinct African-American subculture. Other minority groups and Latinos together account for approximately 2.7% of the state's population, though the Latino population in the state has increased during the past decade [7]. The institution serves the state's indigent population, many of whom are from cultural backgrounds different from the healthcare providers.

The establishment of a culture and diversity curriculum within the College of Medicine began in the late 1990s. The college had had a heritage of traditional medical education training, with great emphasis upon basic science lecture-instruction in the first two years of the curriculum and traditional inpatient-based, discipline-specific clerkships during the third and fourth years. Until a general curriculum change

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in the late 1990s [8], there had been few curricular innovations within the medical education program, and little emphasis, if any, placed on culture and diversity. In 1997, the University's Office of Diversity initiated a required two-hour Diversity training program during the College's general orientation for matriculating medical students. There was little apart from this experience to address culture and diversity in students' learning.

INITIAL CHALLENGES FOR CURRICULUM IMPLEMENTATION

The impetus to establish a culture and diversity curriculum within the broader curriculum grew from recognition that in order for future physicians to be effective treating patients from diverse backgrounds, medical students need instruction in this area. Several challenges were initially present when the movement to develop a culture and diversity curriculum in the college began. One challenge was faculty resistance because faculty did not perceive this as important learning content. This feeling was illustrated by one of the senior faculty member's statement during a curriculum committee discussing the need to introduce cultural competency in the curriculum, "What does cultural diversity have to do with medical education?" For many faculty who had been educated when consideration of cultural differences was not viewed as important for optimal patient care, their focus for medical education was on students' acquisition of basic science knowledge, clinical skills, diagnostic reasoning, and treatment plans. While the biopsychosocial model [9] has existed for many years, the inclusion of a patient's cultural background and issues of health disparities is a more recent addition within medical education training. When many of the faculty became aware of the benefit of attention to culture and diversity in improving healthcare outcomes, many faculty become eager to learn more themselves. Nonetheless, faculty resistance was an initial challenge.

A critical factor in overcoming such resistance was institutional leadership that recognized the value of culture and diversity in all facets of the institution's enterprise. Culture and diversity had been a central component of the institutions' strategic plan and educational objectives since the mid-1990s. Deans of each of the colleges had been charged with providing learning experiences in valuing a diverse population and in demonstrating sensitivity to diversity issues in all of their professional behaviors for their students, residents and fellows. Thus, while faculty resistance existed, institutional leadership insisted upon the need to address culture and diversity issues on campus.

Another challenge to establishing a cultural competency curriculum within the medical school was the issue of an "already full curriculum." There was tension regarding the introduction of new content and skills into a curriculum that faculty agreed was overloaded with facts for students to acquire and little time for students' reflective learning. The idea of a new, stand-alone course was not favored given that students' schedule was already full with classes, labs and clinical activities. Additionally, the general curriculum change was emphasizing integration of basic science content into broad course frameworks, rather than development of separate, "attention unit," courses based on a specific basic science discipline. Furthermore, the discussion of the new curriculum included an explicit goal to develop more self-directed learning opportunities and consequently reduce students' time in class. To balance the need for new content within the curriculum and yet not add substantive contact hours, it was agreed to integrate culture and diversity learning into existing courses through relevant activities and to offer co-curricular learning experiences as well.

An additional challenge to the creation of the curriculum was that few faculty felt comfortable with their own skills in this area. As stated above, many faculty were educated at a time when cultural competency and diversity in healthcare were not highlighted in training, and they were unsure how to bring these concepts into their own teaching with students. One of the authors (AB) has a background in medical anthropology and was able to provide expertise about cultural issues in medicine and draw upon existing work specifically related to cultural competency in healthcare. A few other faculty with an interest in the area and willingness to learn became important faculty champions and contributed to the development of learning experience and curricular materials. The presence of a few local persons either knowledgeable in this area or willing to develop some expertise was critical for the planning of the curriculum and development of learning materials.

DEVELOPING THE CURRICULUM

The opportunity to formally establish a culture and diversity curriculum presented itself through the application to the American Medical Student Association (AMSA) Promoting and Reinforcing Innovation in Medical Education (PRIME) request for small grant proposals for culture and diversity curricula in medical schools [10]. Application for the grant provided the impetus to discuss the need for integrating culture and diversity into the curriculum, and with funding, the obligation to develop the proposed learning activities. Given the curriculum reform underway within the college at the time, as well as curriculum time constraints, an integration of the curriculum within other courses was proposed. Additional opportunities for students' learning about culture and diversity issues in healthcare were planned through a speaker series that students could elect to attend. In this manner, all students were exposed to general concepts around culture and diversity in healthcare, and, for students interested in enhancing their knowledge, elective opportunities were available.

To introduce students to the importance of culture and diversity, first year orientation activities included a focus on heightening students' awareness of diversity through interactive exercises. In the first year course dedicated to behavioral science and patient interviewing skills, the "Doctoring Curriculum," learning activities included a problem-based learning case centered on a patient's cultural beliefs around health and use of traditional remedies, attention to patient healthcare beliefs during patient interviews in community-based preceptors' offices, practice addressing patients' cultural beliefs in classroom standardized patient interactions, and a lecture presentation outlining the fundamentals of cultural competency in healthcare. These activities were designed to address several of the AMSA PRIME designated learning objectives.

In addition to the learning experiences in the first year "Doctoring Curriculum", faculty members in the Family Medicine department were interested in enhancing students' learning about the role of culture in patient care within the required third year, four-week clerkship. Funded in part through the Health Resources and Services Administration Bureau of Health Professions (Grant #1 D56HP03357-01) during the 2001-2002 academic year, students were required to complete a self-directed learning project around cultural issues. To complete the learning activity, students were instructed to: 1) identify a "cultural issue" related to a patient interviewed; 2) research the issue through websites, published literature or knowledgeable persons; 3) reflect on what had been learned; 4) apply lessons learned from the reflections and research to thoughts about providing care in the future for patients; and 5) write up their issue, findings and reflections as a report. Activity instructions did not specify types of "cultural issues" students were to identify, but rather emphasized for students to look for differences in healthcare beliefs and practices between themselves and their patients. "Cultural" was intended to be broad and inclusive in its definition for the students' work. Faculty members read and commented on the assignments [11].

At this time, a station designed to assess students' skills in interviewing a patient with a health belief different from the biomedical model was incorporated into the clerkship's end-of-rotation Objective Structured Clinical Examination (OSCE). As a summative evaluation exercise, the station required the student to elicit a history of present illness and negotiate with the patient around the use of a home remedy based upon the patient's understanding of hypertension.

With changes in 2003 to an eight week clerkship, a new clerkship curriculum structure was needed, and subsequently, a shift occurred in the learning activities for the culture and diversity component. The overall clerkship curriculum changes included the development of Objective Structured Learning Experience (OSLE) stations to address students' clinical skill acquisition in targeted areas. The OSLE stations are designed as non-graded learning experiences where students interact in small groups to demonstrate skills required for the standardized patient interaction and then formally debrief their performance for instructive purposes with a faculty member. At the end of the clerkship, an individual student's performance is graded through a series of OSCE stations. The OSCE stations parallel those of the OSLE in terms of skills assessed, but patient complaints and other patient details are altered so that the station is not a duplicate of the OSLE encounter.

An OSLE station related to students' interviewing patients in a culturally sensitive manner was created, based in part upon the previous OSCE station [12]. Through the exercise, students learn a simple framework for practicing culturally competent care, the ETHNIC mnemonic [13]: Explanation (How do you explain your illness?) Treatment (What treatment have you tried?), Healers (Have you sought any advice from folk healers?), Negotiate (mutually acceptable options), (Agree on) Intervention, and Collaboration (With patient, family and healers). They also learn more about patient and physician explanatory models during the OSLE station.[14] At the end of the clerkship, students complete an OSCE station in which they are expected to apply the ETHNIC mnemonic during their interaction with a standardized patient.

Other third year clerkships introduced culture and diversity issues in healthcare, such as working with translators, as learning points in clerkship case-based discussions as part of the college's Foundations in Clinical Medicine course, a course incorporating basic science concepts into clinical clerkships [15]. The inclusion of culture and diversity into the cases, while not a central focus of course content, provided additional learning opportunities for students. To support student and faculty learning about culture and diversity in healthcare, a website (www.musc.edu/cultural) was developed to provide introductory information about a) cultural competency b) cultural competency in healthcare, c) communication with patients, d) working with interpreters, e) traditional beliefs of African-American and Mexican-American subcultures, f) religious and spiritual issues, and g) resources for further information.

As the medical school curriculum, including its culture and diversity component, has evolved since the late 1990s, integration of culture and diversity in healthcare has continued and evolved within courses. While structural changes and learning activities have changed in the "Doctoring Curriculum", now titled the "Foundations of Clinical Practice" course, the culture and diversity content previously established remains with few changes. Former problem-based learning cases have been reworked to case-based discussions, and additional course lectures present information about health disparities and cultural issues. The Family Medicine clerkship continues to focus on culture and diversity through the learning activities described above. The college is presently engaged in a new curriculum change effort that will further integrate basic and clinic science content into theme based modules, providing further opportunity for the inclusion of culture and diversity issues within the curriculum.

OTHER CULTURE AND DIVERSITY EDUCATION ACTIVITIES ON CAMPUS

As a result of institutional leadership's charge in the late 1990s for each dean to address culture and diversity issues within their college's curricula, efforts to incorporate culture and diversity in the curriculum elsewhere in the university have been tailored to the specific needs of each discipline. In Dental Medicine, didactic and experiential content was incorporated into the first and second year curriculum, and faculty mapped the third and fourth years to identify opportunities for clinical interaction with patients from diverse cultural groups [16].

Second year pharmacy students were presented an introduction to cultural competence, health belief systems, and explanatory models using video media [17] during the first semester. They experienced a role play exercise during the second semester in which they were asked to obtain a medication history and current meds list from a simulated patient who did not speak English. In the other colleges, cultural competence has been incorporated into courses addressing professional issues.

Co-curricular opportunities have also been developed to offer students rich opportunities for developing cultural competence outside of their individual programs of study.

The South Carolina Rural Interdisciplinary Program and Training (SCRIPT) elective and CLARION competition are two of such opportunities. Sponsored by the South Carolina Area Health Education Consortium (SC AHEC), SCRIPT was designed to provide rural healthcare settings with immersion experiences in rural lifestyles as part of an interprofessional team that collaborates in the development of a community focused health promotion activity [18]. For example, participants have researched means for eliminating health disparities and have learned how to communicate with state lawmakers to affect the policy-making process. At MUSC, a local version of the CLARION Competition [19] provides students an opportunity to participate in interprofessional teams to analyze a sentinel event by performing root cause and cost-benefit analyses and develop recommendations for systematic and policy changes to prevent reoccurrence of the sentinel event. Each case includes an element of the intersection of culture and medicine. For example, one case has involved a sentinel event that occurred in part as a result of a failure to use interpreter services for a patient with limited English proficiency. Thus through these and other activities, students' learning about culture and diversity in healthcare is interwoven into co-curricular activities on campus.

Other initiatives on campus are present and will continue in the future as vehicles for integrating cultural and diversity competence into students' learning and the institution's culture. The university has adopted the National Coalition Building Institute (NCBI) model to build leadership skills around coalition building, welcoming diversity, managing inter- and intra-group dynamics, understanding the effects of group membership on internal and external oppression, and teaching skills for shifting attitudes and handling controversial issues [20]. The university's interprofessional education initiative, "Creating Collaborative Care" (www.musc.edu/c3) also affords opportunities for increased culture and diversity learning. As interprofessional learning and team building experiences are developed, attention to cultural competence, diversity, and health disparities are included. Campus wide efforts with NCBI work and cultural competency learning are now further enhanced by the presence of a university-based team of experts in diversity training and cultural competency, including a director of training and intercultural education. The senior leadership team for NCBI is housed within the university's Office of Student Programs and is supported by faculty, staff and student affiliates across the campus to enhance culture and diversity in the academic programs and student organizations. Over 1,000 students across campus have been exposed to cultural competence training. In the first eighteen months of implementation over 300 persons on campus have completed NCBI training in the Welcoming Diversity model, including faculty, staff, student leaders and all first and second year dental students.

FACTORS FOR SUCCESS

A variety of elements have served to facilitate the development of culture and diversity curricula components within the MUSC College of Medicine and across the university's other colleges. As described above, institutional leadership's commitment and communication that culture and diversity are to be included in each of the colleges' curricula provided a valuable incentive for the development of learning activities, particularly in the face of early faculty resistance. Faculty with expertise in cultural competency and diversity work have provided their knowledge for the development of learning activities, identification of available learning resources, and time for presenting lectures and workshops for faculty and students. Such expertise has been a valuable resource for the institution given that many faculty are unfamiliar with culture and diversity in healthcare content. In addition to the availability of local experts, the presence of faculty champions willing to identify time in courses has been a critical factor in the development of curricular activities within the medical school and other colleges on campus. Another element that has contributed to the success of the culture and diversity curricula has been the use of multiple methods to deliver content, including didactic, experiential, multimedia, and reflection, and to assess learners' acquisition of knowledge and skills. Recognizing that students learn in different ways and that different courses and clerkships present their content through varied learning activities has been fundamental to the successful content integration. Similarly, assessment has varied in accordance with programmatic, course and clerkship objectives, including surveys, examination questions, reflection papers, and OSCE stations.

CONCLUSION

In response to the growing call for culture and diversity content within medical school curricula, the MUSC College of Medicine developed a culture and diversity curricula in the late 1990s. Through an integrated approach, several learning activities were incorporated into existing courses and clerkships. As the medical school curricula has evolved, specific culture and diversity learning activities have adapted to changes, and this content thread remains embedded within the larger medical education program. Collaboration with multiple campus entities to provide co-curricular and extracurricular activities continues to complement the evolution of the College of Medicine.

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