

A Cultural Diversity Curriculum: Combining Didactic, Problem-Solving, and Simulated Experiences

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The development of a cultural diversity curriculum in undergraduate medical education is timely because of the need to communicate with increasing numbers of patients of diverse racial, ethnic, linguistic, and religious backgrounds. The key goals of the Ohio State University College of Medicine curriculum are to: 1) establish the relevancy of cultural diversity training to clinical practice; 2) contrast the impact of non-Anglo and Anglo world views on health behavior; 3) develop basic cultural competency skills; 4) provide insights into the effects of discrimination on minority patients and professionals; and 5) understand some of the complementary medicine practices that patients use. The curriculum employs a combination of didactic lectures and demonstrations, clinical cases and vignettes for problem solving, and simulated experiences of discrimination through first-person accounts, videotapes, and patient and physician panels. We speculate that the development of cultural sensitivity in the undergraduate medical student will aid in increasing professional sensitivity to all patients.

The principal rationale for the inclusion of cultural diversity within the undergraduate medical curriculum is the need to communicate effectively with the increasing number of patients of diverse racial, cultural, linguistic, and religious backgrounds.¹⁻⁵ Current and projected changes in the racial and ethnic profile

of both the US population and the medical school class are of increasing diversity.⁶⁻⁷ In addition, there are national hospital and medical school mandates on cultural sensitivity for both health care delivery and medical education.⁸⁻⁹ To address this need, the faculty at the Ohio State University College of Medicine (OSUCOM) initiated the Human Diversity Curriculum within the Medical Humanities Course for first-year medical students in 1992-1993. The curriculum has been steadily expanded to its current 24-hour format comprised of 16 hours on racial and cultural diversity and 8 hours on complementary medicine.

Our goals are to raise awareness of how belief systems affect health behavior and to provide basic strategies for effective communication with patients of diverse backgrounds. Three teaching approaches are used: 1) *didactic lectures* to provide definitions of cultural diversity, population data, and contrasts in cultural world views; 2) *clinical cases and vignettes* on cultural misunderstanding that require problem solving; and 3) *simulated experiences* to place the medical student in the shoes of minorities. The latter was felt to be critical, as a way of providing deeper insight and empathy into the experience of discrimination.

The Diversity Curriculum

To establish the importance of the curriculum, we present students with clinical examples of cultural misunderstanding. In one example, a casual comment made by the physician about Santa Claus offends a Jehovah's Witness who does not believe in this figure. This example illustrates how cultural beliefs, which are often "invisible" in the absence of evident physical differences, can profoundly affect physician-patient communication. The Multicultural Experience Questionnaire provides an

aggregate profile of our students' real and hypothetical experiences (eg, interracial dating) with diversity (unpublished data, OSUCOM). In general, 70% to 80% of the student body respond positively to the question about perceived need for cultural diversity training. We emphasize that cultural sensitivity to diverse patients is simply an extension of professional sensitivity to the unique needs of all patients; because nearly all patients differ in some cultural beliefs from their physicians, cultural sensitivity is required in virtually all clinical encounters.

Differences among African, Asian, and Anglo (European) world views are highlighted to illustrate how the patient's philosophy of life (eg, Asian acceptance of disease as fate) and concepts of causation (eg, imbalance of yin-yang) alter health care-seeking behavior (eg, use of complementary remedies and practitioners before allopathic physicians).¹⁰ Communication is affected by culture. Because direct eye contact with authority figures is considered disrespectful in Asian cultures, avoidance of eye contact with physicians and nurses may be misinterpreted as evasiveness and insincerity. To whom you should communicate serious diagnostic and prognostic information varies by cultural group: to the white and African American *individual patient* or to their Hispanic and Korean *family members*.¹¹

The Canadian Broadcasting Corporation documentary "A Choice for K'aila" is used to present the dilemma of a Canadian-Indian family whose newborn infant developed life-threatening liver failure. Because of their cultural and spiritual beliefs, the parents chose not to comply with the recommended liver transplant, were reported to the authorities, and fled to another province. A visiting medical ethicist dissected the various parental, cultural, societal, medical, and legal points of view and challenged

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the medical students to seek a culturally sensitive solution other than simply handing the case over to social services.

Specific tips for communicating with diverse patients (eg, show respect for the patient's cultural beliefs about illness) are provided as basic tenets in a cultural competency approach.¹² In one case, an African-American woman brought her son for a school-mandated evaluation for hyperactivity. She began by querying whether the white physician was culturally competent to evaluate her son. A guided discussion centers around how the white physician felt when challenged and what the mother meant. Mutual understanding was eventually achieved when the physician discovered that the mother was concerned that, unless he had evaluated other African-American boys, he might label behavior that African Americans call "exuberant" as hyperactive.

A visiting professor described how cultural competency principles could be applied on a broader scale to health care delivery systems. Pregnant Hawaiian women would not use Western prenatal clinics, leading to excessive numbers of low birthweight infants. The Malama project moved prenatal nurses from the clinics to community social centers to work alongside native Hawaiian healers, resulting in their acceptance and use. An additional benefit was the shift in understanding of pregnancy from disease state (eg, "you've gained too much weight") to the culturally appropriate Hawaiian image (eg, "you are the most beautiful when you are pregnant"). Additional hypothetical cases are discussed in small groups of 12 to 15 students with one or two faculty facilitators (see sidebar). One hour of faculty development is provided to preview the cases, identify key discussion points, and reinforce techniques for handling small groups.

It became apparent through small-group discussions that the medical students who had gained prior experience as "minorities" had the greatest insight into the effects of discrimination. In one example, a deeply tanned white medical student was mistaken for an African American by an elderly white patient who refused to be touched until the student, in desperation, showed his tan

Cases and Vignettes For Small-Group Discussion

Mr. Sanchez, a 65-year-old Mexican-American man, is admitted for evaluation of bright red rectal bleeding. The son draws you aside and requests that, if something serious is found, you not tell his father either the diagnosis or prognosis. The son explains that in the Mexican culture, it is proper to inform the family of a serious diagnosis and let them handle it as a group. As the gastroenterologist, you perform colonoscopy and discover that he has colon cancer.

- How do you respond to the son's request?
- Is it your professional obligation to tell Mr. Sanchez the diagnosis? The prognosis?
- What will happen if you do so?

You are an African-American intern in general surgery at Ohio State who recently graduated from Stanford. After a sleepless night on call in the surgical ICU, your senior resident calls you over and assigns a new admission to you stating that "you'll understand this poor, black woman from the hills of Kentucky better than I."

- What is your resident implying to you? Is your resident simply dumping an unwanted patient on you?
- How do you respond to your resident?
- If you feel the resident's treatment is unfair, who else can you turn to?

line! The student was sensitized to the insidious psychological effects of racism. We recognized that similar, simulated experiences and videotaped vignettes could enhance a visceral sensitivity to the effects of discrimination.

A unique and moving personal account of the arbitrary effects of racism was given by our law school dean.¹³ Before age 10, he led the life of an apparently privileged white. But after his parents' marriage collapsed, he learned that he was biracial with devastating consequences. He was sent to live in the projects with his black grandmother and found that he faced many arbitrary barriers to opportunity, despite his academic achievements and high ambitions.

A 1992 NBC documentary, "Two Colors," depicts the disparate treatment of two young men, one black and one white, as they relocate in St. Louis. Within minutes of each other and from the same individual, the white applicant received encouragement and help, while the black applicant was told either that the job was filled or the apartment rented. Moderated panels allow the discriminatory experiences to be seen through the eyes of minority physicians and patients. Representing one of the four

major racial groups, each panelist is asked to recount one incident of bias or discrimination, to describe how they felt, and how they handled the situation. Written cases and videotaped vignettes on racial discrimination from the American Academy of Family Practice are discussed in small groups.¹⁴

Many patients use complementary medicine without the knowledge of their physicians.¹⁵ Our goal is to enhance student awareness of alternative practices so that they can ask appropriate questions about their use. Practitioners not only present the theory, but also demonstrate chiropractic, acupuncture, Maharisha Ayur-Vedic medicine, and other approaches.¹⁶ A two-hour alternative medicine health fair provides an opportunity for practitioners of mind-body medicine, movement therapy, yoga, transcendental meditation, guided imagery, Shiatsu massage, acupressure, rolfing, reflexology, homeopathy, and others to demonstrate their approaches on the students themselves.

Challenges for the Future

Written evaluations are gathered from the medical students and used to continually revise the curriculum. We have

found that the students express the most appreciation for the first-person physician experiences and the small-group discussions that allow active exploration of cases. We are planning to develop a pre- and postcurriculum questionnaire on attitudes toward minority patients and sensitivity to cultural differences to see if an impact on student attitudes can be objectively measured. Our long-term goal is to expand the hands-on diversity training by using simulated patients to present cultural barriers to communication and by increasing opportunities to interact with diverse patients in community settings during the third and fourth year.¹⁷ ■

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