

National Center for Medical Education, Development, and Research Communities of Practice Webinar

Cultural Competency in Medical Education and Clinical Practice

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National Center for Medical Education, Development and Research

*The aim of the center is to address the needs of persons who are LGBTQ, Homeless, Migrant Farm Workers (vulnerable populations).

*Translate research findings into Medical Education curriculum and clinical practice into primary care training and practice guidelines.



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Webinar Series

- Second webinar of a four part series
- Collaboration with National Health Care for the Homeless Council and the National Center for Medical Education, Development and Research
- Featuring NCMEDR Center Staff and CoP Members
- Upcoming Dates
 - March 29, 2019: Trauma Informed Care for Vulnerable Populations
 - June 29, 2019: Harm Reduction (Substance Use Disorders)

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Today's Speakers

- **Patricia Matthews-Juarez, PhD**
 - Senior Vice President for Faculty Affairs and Development, Professor, Department of Family and Community Medicine, Program Director, National Center for Medical Education, Development and Research, Director, Research Training Core, Health Disparities Research Center of Excellence, Meharry Medical College
- **Rueben Warren, D.D.S., M.P.H., Dr. P.H., M.Div**
 - NCMEDR Communities of Practice Member
 - Professor & Director, National Center For Bioethics in Research and Health Care, Tuskegee University
- **Linda Behar-Horenstein, PhD**
 - NCMEDR Communities of Practice Member
 - Distinguished Teaching Scholar & Professor, Colleges of Dentistry, Education & Pharmacy CTSI, Educational Development & Evaluation HRSA Faculty Development Program, University of Florida



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Patricia Matthews-Juarez, PhD



Objectives

1. State why it is important to become a culturally competent practitioner.
2. Consider how presentation examples can be modified and infused into medical education curriculum.
3. Consider how curriculum changes would augment student understanding of culture, health, and adherence to patient care.
4. Speculate on transformative changes needed in medical education curriculum to promote culturally competent practices.

Rueben Warren,
D.D.S., M.P.H., Dr. P.H., M.Div



Ethics

- What is Ethics?
 - Set of rules, principles, values, and ideals of a particular group of people. The systematic study of morals, concepts, and theories, typically in departments of philosophy.
 - Bayer, R., & Beauchamp, D. (2007). *Public health ethics: Theory, policy, and practice*. New York: Oxford University Press.

Bioethics

- Applied ethics focusing on doctor-patient relationships and how changes in the health care system affect it.
 - Daniels, N., Kennedy, B. P., & Kawachi, I. (2007). Why justice is good for our health: The social determinants of health inequalities. In R. Bayer & D. Beauchamp (Eds.), *Public health ethics: Theory, policy, and practice*. New York: Oxford University Press.

Public Health Ethics

- Public health strives to improve the quality functioning and longevity of populations. Because public health is viewed, by some very broadly, public health ethics assumes an equally broad conceptual base. Public health ethics places emphasis on the ethical problematic related to interests and health of groups, the social justice of the distribution of social resources, and the positive or social rights of individual. The study of public health ethics requires the practitioner to effectively conceptualize and operate between the tension of individual rights and collective interest. As with public health, it also seeks to resolve the ethical problematic most efficaciously.

- Bayer R & Beauchamp, DE. *Public Health Ethics: Theory, policy and practice*. New York: Oxford University Press. 2007.

- Callahan, D & Jennings, B. Ethics and Public Health: Forging a Strong Relationship. *American Journal of Public Health* 92: 2002, 169-176



- **San** means: *to return* **ko** means: *to go* **fa** means: *to look, to seek and take*
-
- **The concept of SANKOFA is derived from King Adinkera of the Akan people of West Afrika. SANKOFA is expressed in the Akan language as "se wo were fi na wosan kofa a yenki."**
- **Literally translated it means "it is not taboo to go back and fetch what you forgot".**
- **"Sankofa" teaches us that we must go back to our roots in order to move forward. That is, we should reach back and gather the best of what our past has to teach us, so that we can achieve our full potential as we move forward. Whatever we have lost, forgotten, forgone or been stripped of, can be reclaimed, revived, preserved and perpetuated.**
- **Visually and symbolically "Sankofa" is expressed as a mythic bird that flies forward while looking backward with an egg (symbolizing the future) in its mouth.**



Linda Behar-Horenstein, PhD



Introductory Remarks



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Culture, Defined



- Behaviors and frames of reference that individuals use to understand the world and how to live in it.
- People from the same cultural background can interpret their oral health illness in different ways.

The Necessity of Culturally Competent Care: Lessons from Dental Education

Rationale 1

- US oral healthcare disparities are profound.
- Differentially impacts racial/ethnic minorities in spite of socioeconomic status, gender, age, educational attainment, and geographic location.
 - Non-Hispanic Black and Mexican American adult (aged 35–44 years) untreated tooth decay is nearly twice that of non-Hispanic White counterparts.

Rationale 2

- Need to understand to access-to-care barriers:
 - Patient–provider differences in culture and language.
 - Perceived (or actual) provider or staff discrimination against non-concordant patients.
 - Role of social responsibility, sensitivity and knowledge of access to care.

What is Known

- All cultures have belief systems that explain what causes illness, disease treatments and cures, which in turn influence individual compliance with health care and willingness to make behavioral change.
- Ethnic group perspectives are central to healthcare beliefs, and behaviors at the macro and micro levels.

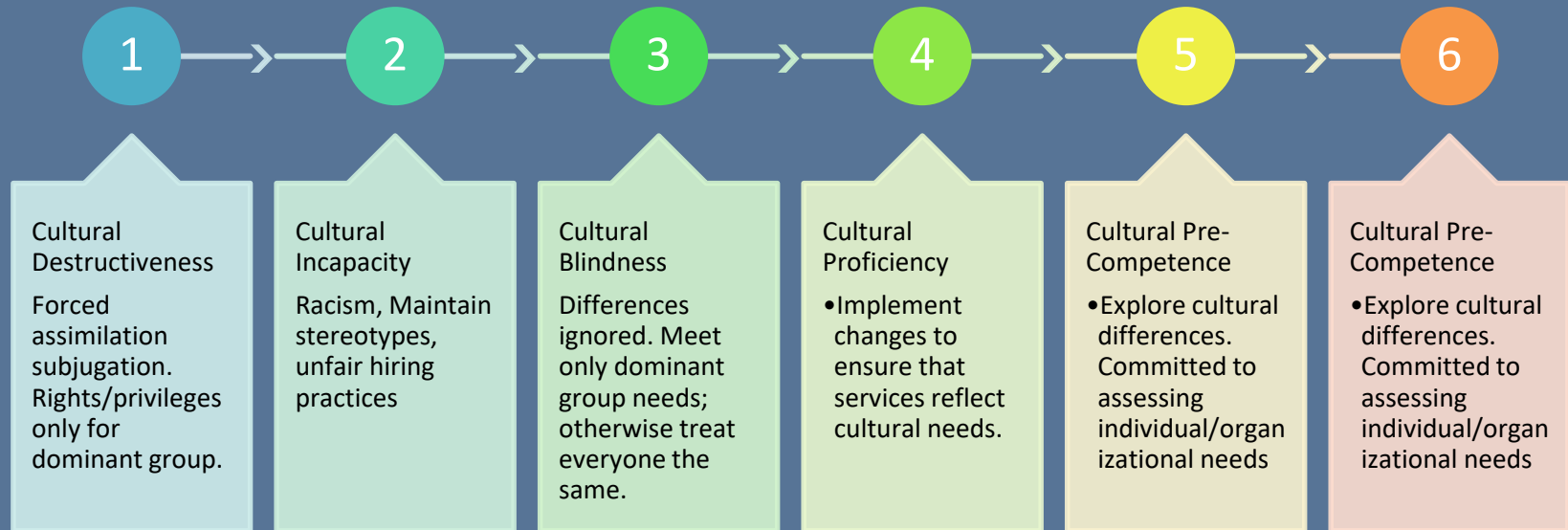
Developing Culturally Competent Practitioners

- Challenges facing dental educators is not dissimilar from medical educators.
- Problem resides from neglect in curriculum development, teaching, experiences and assessment.
 - Cannot expect students/faculty to know what they have not experienced.

Our Approach to Fostering Cultural Competence

- Provide opportunities to recognize cultural beliefs, attitudes and skills.
 - Via classroom teaching
 - Via reflective writing
 - Via out of class assignments; interacting with individuals unlike themselves
 - Offer in class feedback thematic content of overall reflective writings

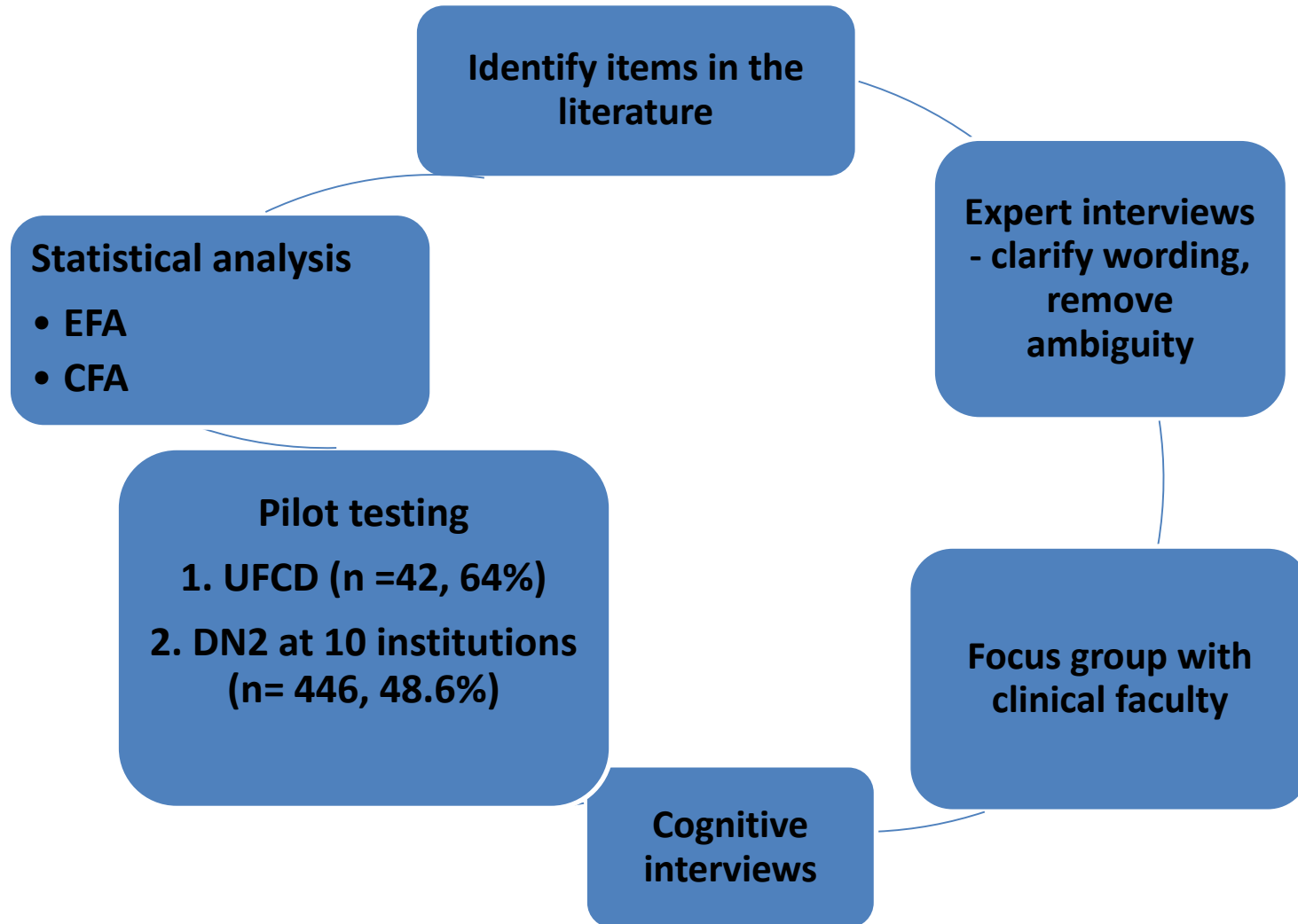
Continuum of Cultural Competency



Our Approach to Fostering Cultural Competence

- Measure baseline and post-test changes.
 - Locate a scale
 - Develop a scale

Scale Development



Assessing Cultural Competence

- Alongside the quantitative measure of cultural competence, we also conducted three additional mixed methods studies to **measure and describe** how **reflective writing assignments** and **interviewing** influenced student expression of cultural competence.
- We tested the reflective writing assignments by different teaching methods and student characteristics to see if they influenced outcomes.

Evoking Belief Changes

- Students were asked to respond with a minimum of 500 words to instructor questions in two reflective writing assignments.

Reflective Writing Assignment #1	Reflective Writing Assignment #2
Describe personal awareness along 8 categories: race, gender, ethnicity, social class, sexual orientation, personal ability, faith, and cultural groups	Students responded to similar set of questions following interview.
Assignments graded using a rubric . Written instructor comments were also provided.	Assignments graded using a rubric. Written instructor comments were also provided.

Compared Text Responses to Two Questions

- Assignment #1: (1) Define YOUR world—what does it encompass?”, and (2) “What are some of your assumptions?”
- Assignment #2: “As a result of conducting the interview with the assigned individual, describe the insight you acquired about your values and prevalent assumptions in your cross-cultural relationships and ways in which they are similar or different from the previous experiences you have had.”

Evoking Belief Changes

- Prior to completing the 2nd reflective writing, students had to go find someone unknown to themselves, outside of class, on their own time based on one of the following criteria (distributed to each student)
 - **a sexual orientation**
 - **religious affiliation**
- **personal able-ness (mentally or physically challenged)**
 - **first language**
 - **social class**
 - **racial/ethnic group**
 - **gender, or**
 - **national origin.**

and conduct a face to face interview:

Study #1 Teaching approach

- Lecture
- Instructor created four role play scenarios; selected a student who engaged with an actor, to role play during class.
- Automated response system questions.
- Instructor summarized thematic content of student responses observed in 1st reflective writing.

Selected Examples: Thematic Content, Assignment #1

Membership in Cultural Groups

- Those who reported engaging in ethnic celebrations, belonging to sports teams, churches or college student groups reported a sense of affiliation and/or pride.

Others reported having:

- Belonged to “clicks in school” and having no such memberships, and “I am pretty sheltered my whole life”.

Values for People Like/Different from Me

- “Respect their different views.”
- “They are not different from me, I just do not know them.”
- “Sometimes feel guilty for being white.”

Beliefs about People, Same/Different from Me

- “People who are like me... I can understand where [they are coming from].”
- “Everyone is entitled to their own beliefs as long as they don’t impose them on others.”
- “Even in your own race or culture, individuals have various differences.”

Assumptions About Those Different from You

- “They have things to teach me and I have things to teach them.”
- “I tend to categorize people based on how different they are ... based on past experience with members of a cultural group.”
- “I try not to judge...I do have preconceptions....”

Study #2 Teaching Approach

- Instructor provided an abbreviated overview of characteristics exemplifying cultural competence, barriers to its development, the impact of inequity on health, and a description of social–historical and socio–political impacts.
- Working in small group, students responded to instructor questions.
- Instructor summarized thematic content of student responses observed in 1st reflective writing.

Study #3 Teaching Approach

- Exclusive use of small group discussions and instructor questions: “What does a competency look like?” and “Provide some examples of when you experienced culturally insensitive communication. How did you feel as a result?”
- Student replies to placed on paper 30 x 42, were posted on walls.
- Using museum approach, students view each group’s responses.
- Instructor summarized thematic content of student responses observed in 1st reflective writing.

Table 2. Word categories and examples in the identifying underlying dimensions of the factor analysis

Word Category Name Used by LIWC Program	Most Frequent Words in LIWC Category Found in Text by NVivo
Adverb	Also, even, just, around, well, become
Cause	Make,* based, because
Certain	Never, always, fact, certain, every
Discrepancy	Want, need, must
Exclusive	Just, something, without
Family	Family(ies), parents, mother, father
Human	Person, individual
Inclusive	Open, come, close, around
Insight	Assume,* different, belie,* know, think, feel, learn,* find, become, understand
Impersonal pronoun	Someone, things, others, everyone, thing, mine, something, everything
Negative emotion	Wrong
Past	Thought, made, found, felt, told, helped, got, seemed
Perception	Feel, hard, white
She-he	She/he, her, him
Social	Family, parents, culture,* person, someone, individual, marriage, mother, friend,* social, question*
Tentative	Assume,* sometimes, may, lat, someone, something
We	We, our

*Includes any endings with this root word

Note: The original LIWC category names were misleading; these names are more representative of the actual words from the category that appeared in the text.

Purposeful Instructional Goals

- Instructional activities challenged dental students' personal biases, while exposing them first hand to the “lived realities” of others.

Findings Across Studies

- Students recognized unconscious biases and reported an increase in personal cultural competence.
- Increased word count, and type of words used in 2nd reflective writing demonstrated active reflection in which students questioned previously held assumptions derived from their social worlds.
- Students engaged in reflection and showed changes beyond course content.

Selected Student Perceptions Across Studies

Overall, resulted in increased student awareness concerning how people with influence on their lives impacted their attitudes. For example,

1. In spite of strong religious beliefs, Melissa, a URM female, supported same sex marriage and surmised that being raised in the presence of others who were less religious than her family enhanced her openness.
2. URM female, Charisse, questioned her suppositions about single parent households. Learning that her interviewee grew up with one parent diagnosed with HIV, she recognized that perhaps a single parent could fulfill the role of two.

Selected Student Perceptions Across Studies

3. Steven, a White male, discovered that gender did not change the formation of beliefs and practices among males and females.

4. Norman, a White male, became aware of his tendency to make generalizations and conceded that this practice was unwise.

Selected Student Perceptions Across Studies

- 5. A URM male, Joe, gained a better understanding of a person from a different faith, culture, family life, and school environment compared to his own and asserted that making premature postulations about people from different cultural backgrounds was “ill advised”.

Selected Student Perceptions Across Studies

- 6. Maria, a White female, confessed that she thought of African-Americans as underachieving and that she derived such attitudes from family members and by witnessing personal behaviors among some African-Americans.

Overall Findings

- Across three consecutive studies, findings showed statistically significant **and** qualitative differences.
- Findings showed that students began to rethink previously held assumptions about cultural beliefs, experienced an increased awareness of their unconscious biases, and promulgated change in cultural beliefs - - with just two writing assignments and an interview.

Challenges for Medical Educators

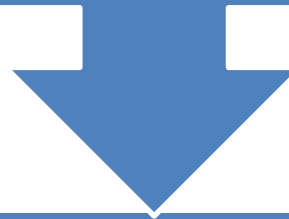
- **Evidence-based challenges.** Assessing pre- and post-test changes in knowledge, beliefs and skills is only one component of developing culturally competent medical practitioners.
- Surveys results do not always represent what is observed in practice.
- Urge the use of qualitative and quantitative approaches.

Practice-Based Challenges for Medical Educators

- Promote a recognition of how culture influences individual perceptions of health.
- Raise awareness of how practitioner beliefs, stereotypes and prejudices impacts attitudes, interactions, and care towards others unlike ourselves.

Other Curriculum Transformations


Place dental and medical students together in FQHCs to experience healthcare disparities and address health needs of vulnerable populations.



Engage medical and other health professional students in IPE projects designed to respond to community oral healthcare problems.

Developing cultural proficiency requires


1. Acknowledging the historical persistence of educational, social, and economic gaps.



2. Ensuring that communication with patients promotes patients understanding of their medical conditions and how to execute self-care. Best accomplished by observing and studying the quality of interactions.

Developing cultural proficiency requires

3. Examining individual beliefs and practices without judgment and providing interventions to correct erroneous beliefs.



4. Moving from viewing culture as a problem towards embracing, esteeming, and appreciating its influential role.

Conclusions

1. Forge partnership plans of care that ensure patient-provider understanding. Primary providers should explain their understanding of patient need for care.
2. Focus on providing treatment and solidifying patient intent to comply. Ask the patient to restate treatment plan.
3. Develop care plan that is respectful and responsive to patient's cultural mores, traditions and beliefs.

References

- Alrqi H, et al. Evaluating a cultural competency curriculum: changes in dental students' perceived awareness, knowledge, and skills. *J Dent Ed.* 2015;79(9):1009–1015.

<https://www.ncbi.nlm.nih.gov/pubmed/26329024>

- Behar-Horenstein LS, et al.. Addressing oral disparities via educational foci on cultural competence. *American Journal of Public Health Supplement.* 107 2017;(51):S118-S23.

<https://www.ncbi.nlm.nih.gov/pubmed/28661820>

- Behar-Horenstein LS, Feng X. Enhancing cultural competence among dental students through active teaching and experiential learning. *Qual Rep.* 2017; 22(4):1169–1185.
- Behar-Horenstein LS, Feng X, Isaac CA, Lee B. Dental students' expression of cultural competence. *J Ethnogr Qual Res.* 2017;11:171–187.

References

- Behar-Horenstein LS, et al., Developing dental students' awareness of health care disparities and desire to serve vulnerable populations through service-learning. *J Dent Ed.* 2015;79(10):1189–1200.

<https://www.ncbi.nlm.nih.gov/pubmed/26427778>

- Behar-Horenstein LS, Garvan CW. Relationships among knowledge, efficacy and practices instrument, color-blind racial attitudes scale, deamonte driver, and defining issues test 2. *J Dent Ed.* 2016; 80(3):355-364.
- Behar-Horenstein LS, Garvan CW, Feng X, Su Y, Catalanotto F. Assessing cultural competence among State of Florida dental hygiene faculty. *J Dent Hyg.* 2016;90(3):176-180.

References

- Behar-Horenstein LS et al., The knowledge, efficacy, and practices cultural competency instrument: a validity study. *J Dent Ed.* 2013;77(8):998–1005.
<https://www.ncbi.nlm.nih.gov/pubmed/23929569>
- Garvan et al. Developing and testing the knowledge, efficacy, practices in- instrument, short-form cultural competence instrument. *J Dent Ed.* 2016;80(10): 1245–1252. <https://www.ncbi.nlm.nih.gov/pubmed/27694299>
- Gundersen D, et al., Dental students' perceptions of self-efficacy and cultural competence with school-based programs. *J Dent Ed.* 2012;76(9): 1175–1182. <https://www.ncbi.nlm.nih.gov/pubmed/?term=Gundersen+D%2C++Dental+students%E2%80%99+perceptions>

References

- Behar-Horenstein LS et al., The knowledge, efficacy, and practices cultural competency instrument: a validity study. *J Dent Ed.* 2013;77(8):998–1005.
<https://www.ncbi.nlm.nih.gov/pubmed/23929569>
- Garvan et al. Developing and testing the knowledge, efficacy, practices in- instrument, short-form cultural competence instrument. *J Dent Ed.* 2016;80(10): 1245–1252.
<https://www.ncbi.nlm.nih.gov/pubmed/27694299>
- Gundersen D, et al., Dental students' perceptions of self-efficacy and cultural competence with school-based programs. *J Dent Ed.* 2012;76(9): 1175–1182.
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CoP Roundtable Discussion

- Questions & Answers

Thank You

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