EDITORIAL

Why Culture Matters in Medical Education

The concept of a series of articles on the cultural dimensions of medical education came from our experience teaching medical students, residents, and fellows in a large pediatric institution, Cincinnati Children's Hospital Medical Center. This tertiary pediatric hospital and training center has both a culturally diverse patient population, including the local population and national and international referrals, and a diverse healthcare provider pool. The most striking observation we have made in the area of cultural competence and diversity is the narrow definition many people apply to the concept of "culture." Most consider ethnicity and country of origin as the primary characteristics of culture and often ignore other important defining features such as age, gender, sexual orientation, socioeconomic status, and regional or family customs. A more inclusive definition of culture is needed whenever there is interpersonal and professional interaction of healthcare providers and patients whose "cultures" are dissimilar. This is also true in a teaching setting, whether it be a high school or a medical institution, where dissimilar backgrounds and culture of teacher and learner must also be addressed as this is also an interpersonal interaction and the success of that interaction can profoundly affect learning outcomes.

DEFINITION OF CULTURE

The definition of culture eludes most of us perhaps in part due to the complexity of the concept and the many disparate definitions that have previously been suggested. There is lack of consensus about the meaning of culture and yet the notion of culture seems to permeate so many aspects of our lives including personal tastes, manners, beliefs, values, worldviews, and actions. Although culture is usually thought of as national identity, the scope has broadened to include many aspects of social difference including but not limited to race, ethnicity, gender, social class, religion, and sexuality. Even though much of culture in the nationalistic sense is tangible and visual (e.g., food, clothing, housing, rituals, etc.), many elements of culture cannot be "seen" such as socioeconomic status, religion, and sexual orientation.

A broader definition of "culture" is an integrated pattern of learned beliefs and behaviors that are shared among groups. These beliefs and behaviors include thoughts, communication styles, ways of interacting, views of roles and relationships, values, practices, and customs [1, 2]. A simpler definition is "a total way of life of a people" [3, p. 4]. Culture can be expanded to include many factors which encompass many aspects of daily life and social influences/factors. The result is that we are all "culturally different" given our different family backgrounds, religions, occupations, disability, gender, socioeconomic status, sexual orientation, etc. Beyond race and ethnicity, we all are part of and influenced by multiple cultures. Each of us is a multi-cultural individual with many sets of cultures in different contexts which may or may not coincide [4].

Another definition which suggests the complexity of defining culture is a "dynamic and creative phenomenon, some aspects of which are shared by large groups of people and other aspects which are the creation of small groups and individuals resulting from particular life circumstances and histories" [5, p. 433]. Howard [6] stated that culture can be defined as a community of individuals who share a worldview and interpretation of their lives and actions.

Traditionally, matters of culture have been left to the anthropologists studying remote tribal groups in faraway lands. In medicine, culture has often been addressed as straightforward linguistic differences that are managed by interpreters or as a knowledge topic that is managed by mandatory diversity training for all employees or by using the "Epcot Center approach" where food, dance and the more tangible and "superficial" aspects of culture are used to celebrate multiculturalism [4].

In defining culture, it is important to remember that "one size does not fit all" which suggests that cultural behavior is determined by multiple factors and is likely a product of history, patterns of behavior associated with economic activity, and the influence of philosophical and religious views. People often structure their worlds and determine their social interactions based on their culture. The common characteristics of culture are that it come from adaptive interactions between humans and environments, has shared elements, and is transmitted across time periods and generations [7].

CONCEPTS RELATED TO CULTURE

Because there can be semantic confusion with the word culture itself and the tendency to equate culture as synonymous with race, ethnicity or nationality, several concepts that relate to culture are important for a full understanding of culture. *Ethnocentrism* is the belief that your own ethnic or cultural group is better in comparison to others and often leads to negative judgments about other ethnic, national and cultural groups. In most cases, ethnocentrism occurs from a position of cultural majority and thus power and privilege [8]. *Stereotypes* are overgeneralized beliefs about people from social groups [9]. When stereotyping, we apply group qualities to individuals from a particular social group, and this often does not accurately describe individual group members. An example of stereotyping is assuming that all Asians are high achievers in school or that all Irish are heavy drinkers. Stereotyping is a common occurrence because we tend to be "cognitive misers" who think simplistically and overgeneralize because we want to conserve our cognitive resources by taking shortcuts and approximations in our thinking [10]. This often results in making errors in attributions about the reasons behind other people's behaviors [11]. With our often limited

worldviews, alternative frames of reference can be a challenge to accept, and sometimes not knowing can arouse fear and other unsettling emotions [12, 13].

Prejudice is a negative and generally unjustified judgment of another person on the basis of his or her social or cultural group identity [9]. Prejudice is unjustified because the overgeneralizations are applied to all members of a group (e.g., all Jewish people are "money grubbers"). Prejudice can be negative or positive but negative prejudice is the judgment that encourages disadvantage and discrimination whereas positive prejudice includes feelings of respect and admiration [14]. An example of positive prejudice is the notion that all people with a British accent are smart. Prejudice reflects thoughts and feelings and has given rise to many of the "isms" in society including sexism, racism, ageism, and ethnocentrism. *Discrimination* is the enacted unjust behavior resulting from prejudice (e.g., not renting a house to a gay couple because of homophobia). Discrimination differs from prejudice in that it involves an action. In contrast to prejudice and discrimination, *multiculturalism* is the notion that all cultural groups should be recognized as equal and that each cultural group is unique with its own set of shared values, norms and customs which should be respected in their own right [8].

Other concepts related to culture include etics, emics, and various constructs related to cultural competence. *Etics* refer to universal principles or aspects of behavior that are consistent across cultures. *Emics* denotes culture-specific principles or aspects of life that differ across cultures. *Cultural competence* is often used synonymously with cultural diversity, cultural sensitivity, and cultural awareness, although each term signifies something different. *Cultural diversity* is about cultural differences. *Cultural sensitivity* is the knowledge that both cultural similarities and differences exist. *Cultural awareness* is being conscious of cultural similarities and differences. Cultural competence can be defined at the individual level and at the organizational level. At the individual level, cultural competence requires personal growth through first-hand knowledge, interactions with cultural groups, and an examination of one's own biases. Over time, like the definition of culture, cultural competence has widened in scope to encompass three dimensions: 1) awareness of one's own assumptions, values, and biases; 2) understanding the world view of culturally diverse clients/patients [customers, students]; and 3) developing appropriate intervention strategies and techniques [15]. Organizationally, cultural competence is a set of values, behaviors, attitudes, policies, and practices that enable staff to work with multicultural populations [16].

CULTURAL COMPETENCE AND MEDICINE

Culture provides a way of seeing the world and in part determines the patterns of behavior in everyday life. There are many advantages of a culturally heterogeneous global system, and these advantages extend beyond business and societal issues [17]. Intercultural experiences may enhance creativity and innovation due to individuals synthesizing experiences from different cultures and creatively combining them [18].

Amidst such diversity of cultures and our changing world, it is easy to resort to the "tried and true" in search of a familiar and seemingly safe and traditional monocultural identity. However, the consequences of such behavior may perpetuate bias and oppression that already exist and increase misunderstanding between individuals, communities and societies. We all have different intercultural frameworks. When we encounter different norms and values we tend to experience a loss of social support, reference group and social status and encounter different attributions of behavior. It is typical to look for consensual validation from others to confirm that our ideas, values, and behaviors are correct. If someone is perceived as different, then it can undermine such security [19]. Lamentably, prejudice and discrimination are common reactions when people are perceived as culturally different, and these actions can result in a lowering of self-respect for and learned helplessness in the targets [20, 21].

Cultural competence in medicine is "a set of congruent behaviors, knowledge, attitudes, and policies that come together in a group of healthcare professionals that enables effective work in cross-cultural situations. It combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services and treatment [22]. Being culturally competent does not require that healthcare professionals are experts in every cultural group with "recipes" to describe each culture [23], but that they strive to acquire knowledge, skills, attitudes, awareness, and experiences in the pursuit of lifelong development of cultural competence. See the article in this supplement by Allard and Waithe for further information on cultural competency training in medical education.

CULTURAL DIMENSIONS OF MEDICAL EDUCATION

In this supplement, we attempt to raise awareness about various aspects of the cultural dimensions of medical education. In recent years, much attention has been paid to cultural competence and issues surrounding diversity in the medical arena emphasizing the potential negative effects on health outcomes when cultural factors are not recognized and incorporated into the physician-patient relationship. This includes all aspects of the interaction from the initial history and physical examination to the evaluation and treatment plans. Regulatory agencies such as the Accreditation Council on Graduate Medical Education have mandated education and training in this area [24]. As these recommendations are being incorporated into medical training, educators are becoming aware of the parallels with the medical educator-trainee relationship and how cultural issues can significantly affect the learning outcomes as well.

The same changes in our society that have led to the need for cultural competence in healthcare providers similarly affect medical education and suggest a need for incorporation of these concepts into medical education.

1) Changing Demographics

We are a globally diverse society with an explosion of linguistic differences and cultural differences. These differences extend to medical educators and learners and negatively affect learning outcomes when ignored. At the same time, recognition of differences and sensitive cooperation can benefit both educator and learner.

2) Health Beliefs/Worldview

People have different health beliefs and practices and this is related to their cultural background. Similarly, beliefs about educational systems, methods, and even learning outcomes can vary among cultural backgrounds. These differences require acknowledgement, compromise, and agreement on common ground to achieve optimal outcomes.

3) Health Disparities

In the U.S. there is research to support that racial and ethnic minorities receive differential and less optimal technical healthcare than White Americans across diseases and care settings which cannot be explained by lack of insurance or socioeconomic factors alone [25, 26]. In addition, racial/ethnic minority patients utilize healthcare services less frequently, report being less satisfied with their care, have less access to care, and use fewer health care resources as compared to white patient populations [27]. As compared to White Americans, racial/ethnic minorities in the U.S. consistently have higher rates of infant mortality, disease burden, and premature death rates [25], are in poorer overall health, and are more likely to be uninsured [27]. Empirical research in the field supports joint consideration of race/ethnicity combined with social class in order to examine health disparities [28]. The same disparities exist in educational systems (e.g. "chilly climate" for women in American higher education [29]; inadequate educational opportunities for low-income and marginalized populations [30]). It is incumbent on both healthcare providers and medical educators to make every effort to eliminate lack of or ill-practiced cultural competence from the provider side as these health disparities are addressed and resolved.

In this supplement, the contributing authors concentrate on medical education with reference to the education and training of medical students, residents, and other medical trainees. Some of the authors also discuss the importance of interdisciplinary work (e.g. medical and nursing providers) and, more broadly, education and learning in general. All of the contributors to this supplement happen to live in the United States presently and were born in the U.S. However, as we suggest above, this does not mean that every contributor shares the same culture since the U.S. has true multiculturalism as a result of its rich history of immigration. Therefore, this does mean that the majority of contributions in some way relate to cultural issues in medical education within the U.S. Whenever possible, we have also included aspects of international medical education.

Although U.S. born, a number of the contributors have lived, worked and traveled internationally. The contributors of this supplement have different religious and spiritual beliefs. We live and were born in different geographic regions of the U.S., some from rural areas and some from urban and suburban areas. We are of mixed genders, have different sexual orientations and relationship status. Some of us have children and some grandchildren, some of whom are not biological (adopted, foster). We are of different races and ethnicities. We are of varying ages (mid 30's to 65+) and academic disciplines. Not all of us work in academic institutions. Our families of origin are different. Some of us care for aging parents and/or live with extended relatives. Our professional socialization is different. At a more micro level, we have minor cultural differences in communication, humor, nonverbals, personality, and style.

Medical education in general is complex and must take into account many factors including adult learning, teaching methods, learning styles, curriculum development, assessment techniques, continuing education, and e-teaching and learning technologies. Within each of these realms, medical education has a responsibility regarding the inclusion of the cultural dimensions. The articles of this supplement address the integration of these cultural elements into medical education.

To explore the cultural dimensions of medical education with regard to training medical residents to care for vulnerable populations, Tiffiny Diers, MD and colleagues describe the competencies associated with "the adaptable physician" (a new breed of physician who can lead primary care locally and globally). The information in this article helps define additional competencies needed for primary care physicians to be successful in caring for increasingly at-risk populations of patients.

Charles Schubert, MD and his colleagues detail teaching advocacy in multicultural settings. In their article, the authors consider the importance of multiple factors within the cultural realm and some specific courses and rotations in medical training that relate to advocacy and medically underserved and underrepresented minority populations.

Amy Blue, PhD and colleagues share a culture and diversity curriculum developed at their institution, the Medical University of South Carolina (MUSC) College of Medicine. This curriculum is meant to educate future physicians about culture and diversity issues in healthcare. The authors include a description of their program, associated learning activities, challenges to implementation, and factors for success.

Lisa Vaughn, PhD, Farrah Jacquez, PhD , and Raymond Baker, MD, MEd review the socio-behavioral literature on the importance of cultural context in health attributions and beliefs. Because of the difficulty in uncovering cultural health beliefs using traditional physician/patient methods, non-traditional methods to investigate cultural health beliefs are outlined. In addition, the authors consider alternative philosophies to medical education.

Michael FitzGerald, PhD addresses the role that cultural factors play in medical learner evaluation by describing how cultural differences can affect evaluation accuracy. He illustrates some of the more specific ways such differences might contribute to performance problems.

Ingrid Allard, MD, MSEd and Wilma E. Waithe, RD, CDN, PhD offer an expanded framework of cross-cultural physician-patient communication. The authors review culturally sensitive teaching and learning methodologies in medical education in order to distinguish key elements of the culture of Biomedicine. They explore underlying cultural assumptions that may affect medical educators and highlight communication skills which are required to build effective physician-patient relationships.

Rebecca Phillips, PhD and Lisa Vaughn, PhD author an article on the diverse ways of knowing and learning including the way in which technology has affected learning. The information in this article will help medical educators consider individual differences in learning styles, learning environments, and approaches to learning and how they are related to the cultural backgrounds of the learners.

Kathleen Burklow, PhD and Lisa Mills, PhD share their experience of implementing a community-based participatory research (CBPR) partnership between researchers from an independent community-based research organization and a team of five female residents living in an economically disadvantaged, medically underserved community. Their article suggests factors for medical students, residents, fellows and faculty to consider when adopting CBPR strategies to partner more effectively with underserved and culturally diverse populations.

The final article of the supplement by Daniel Groesseheme, DMin, BCC and colleagues provides an interesting look at the changing face of medical education which includes the incorporation and the role of religion/spirituality, complementary and alternative medicine, and osteopathy compared to traditional approaches to medical education. Familiarity with these other approaches to patient care will lead to an expanded view of the scope and breadth of instruction required in medical education.

We anticipate that this supplement will offer a much needed examination of issues in medical education that are often minimized and left unexplored due to the pressures on medical educators to teach an increasing expansive and technical curriculum. Although there is a time and learning commitment needed to effectively integrate cultural elements into medical education, the results add immeasurably to physician education, patient satisfaction, and health outcomes.

REFERENCES

[1]   Donini-Lenhoff FG, Hedrick HL. Increasing awareness and implementation of cultural competence principles in health professions education. J Allied Health 2000; 29(4): 241-5.
[2]   Robins LS, Fantone JC, Hermann J, Alexander GL, Zweifler AJ. Improving cultural awareness and sensitivity training in medical school. Acad Med 1998; 73(10 Suppl): S31-4.
[3]   Geertz C. The interpretation of cultures: selected essays. New York: Basic Books 1973.
[4]   Vaughn LM. Families and cultural competency: where are we? Fam Community Health 2009; 32(3): 247-56.
[5]   Guarnaccia PJ, Rodriguez O. Concepts of culture and their role in the development of culturally competent mental health services. Hisp J Behav Sci 1996; 18: 419-43.
[6]   Howard GS. Culture tales: a narrative approach to thinking, cross-cultural psychology, and psychotherapy. Am Psychol 1991; 46: 187-97.
[7]   Triandis HC. Culture and Psychology: a history of the study of their relationship. In: Kitayama S, Cohen D, Eds. Handbook of Cultural Psychology. New York: The Guilford Press 2007.
[8]   Shiraev E, Levy D. Cross-cultural psychology: critical thinking and contemporary applications, 4th ed. Boston, MA: Allyn & Bacon 2010.
[9]   Allport G. The nature of prejudice. Reading, MA: Addison-Wesley 1954.
[10]   Fiske ST. Social cognition. In: Tesser A, Ed. Advanced Social Psychology. New York: McGraw-Hill 1995.
[11]   Forsterling F. Attribution : an Introduction to Theories, Research, and Applications. Philadelphia, PA: Psychology Press 2001.
[12]   Ito TA, Larsen JT, Smith NK, Cacioppo JT. Negative information weighs more heavily on the brain: the negativity bias in evaluative categorizations. J Pers Soc Psychol 1998; 75(4): 887-900.
[13]   Kunda Z. Social Cognition: Making Sense of People. Cambridge, Mass: MIT Press 1999.
[14]   Blaine B. Understanding the Psychology of Diversity. Los Angeles, CA: Sage 2007.
[15]   Sue DW, Sue D. Counseling the Culturally Diverse: Theory and Practice, 4th ed. New York: John Wiley & Sons 2003.
[16]   Pérez MA, Luquis RR. Cultural Competence in Health Education and Health Promotion. San Francisco, CA: Jossey-Bass 2008.
[17]   Bochner S. Culture shock due to contact with unfamiliar cultures [online]. Bellingham, WA: Center for Cross-Cultural Research, Western Washington University 2003 [Retrieved 2008 Nov 14]. Available from: http: //www.ac.wwu.edu/~culture/Bochner.htm.
[18]   Brislin RW. Cross-cultural Encounters, Face-to-Face Interaction. New York: Pergamon Press 1981.
[19]   Fitness J, Fletcher G, Overall N. Interpersonal attraction and intimate relationships. In: Hogg MA, Cooper J, Eds. The Sage Handbook of Social Psychology. Thousand Oaks, CA: Sage 2007.
[20]   Horowitz CR, Davis MH, Palermo AG, Vladeck BC. Approaches to eliminating sociocultural disparities in health. Health Care Financ Rev 2000; 21(4): 57-74.
[21]   Prochaska JO, Norcross JC. Systems of Psychotherapy: A Transtheoretical Analysis. 5th ed. Pacific Grove, CA: Brooks/Cole Pub 2003.
[22]   Association of American Medical Colleges [Online]. [cited 2009]. Available from: http: //www.aamc.org/meded/tacct/culturalcomped.pdf. 2005.
[23]   Gilbert J, Galanti G, Eds. Cultural Competence and Pediatric Care. Pediatric Grand Rounds; Los Angles County Department of Health Services and University of Southern California Women's Hospital 2005.
[24]   Accreditation Council for Graduate Medical Education (ACGME). Pediatric program requirements [Online]. [cited 2008]; Available from: http: //www.acgme.org/acWebsite/downloads/RRC_progReq/320_pediatrics_07012007.pdf.
[25]   Devi S. US health care still failing ethnic minorities. Lancet 2008; 371: 1903-4.
[26]   Smedley BD, Stith AY, Nelson AR, Eds. Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare. Washington, DC: National Academies Press 2002.
[27]   Mead H, Cartwright-Smith L, Jones K, Ramos C, Woods K, Siegel B. Racial and Ethnic Disparities in U.S. Health Care: a chartbook. Commonwealth Fund 2008; pub no 1111.
[28]   Chen JT, Rehkopf DH, Waterman PD, *et al*. Mapping and measuring social disparities in premature mortality: the impact of census tract poverty within and across Boston neighborhoods, 1999-2001. J Urban Health 2006; 83: 1063-85.

[29]   Sandler BR, Hall R. The Campus Climate Revisited: Chilly for Women Faculty, Administrators and Graduate Students. Washington, D.C.: Association of American Colleges and Universities 1986.

[30]   Forde ML. A Higher Education Transition Pedagogy for Marginalized Populations: 21st Century Challenges, Opportunities, and Benefits for a High-tech, Global Economy. Oxford International Round Table for Community College Presidents; St. Antony's College 2001.

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