

The challenges of integrating cultural competence into undergraduate medical curricula across Europe: experience from the C2ME “Culturally competent in medical education” project

Patricia Hudelson[1], Nisha Dogra[2], Kristen Hendrickx[3], Petra Verdonk[4], Marie-Louise Essink-Bot[5], Jeanine Suurmond[6]

Corresponding author: Dr Patricia Hudelson patricia.hudelson@hcuge.ch

Institution: 1. Geneva University Hospitals, 2. University of Leicester, 3. University of Antwerp, 4. VUmc, 5. AMC-University of Amsterdam, 6. AMC-University of Amsterdam

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Abstract

Providing high quality care to socially and culturally diverse populations is challenging. Many organizations concerned with quality and equity in health care have called for physician training in cross cultural communication as one strategy for ensuring patient-centered health care for all, but little is known about how to effectively and sustainably integrate such teaching into the medical school curriculum.

The C2ME “Culturally Competent in Medical Education” is a European project whose aim was to contribute to the integration of cultural competence teaching in undergraduate medical curricula across Europe. In order to foster exchange among medical schools about cultural competence training, C2ME organized a symposium at the 2014 European Association for Communication in Health Care (EACH) conference. The symposium highlighted the variety of teaching approaches and methods that are used to teach cultural competence as well as the institutional challenges that make integration of cultural competence into the curricula difficult. There is a need for greater exchange of experiences and best practices among European medical schools to overcome these challenges.

Keywords: Cultural competence, medical education

Article

Introduction

Providing high quality care to socially and culturally diverse populations is challenging. Difficulties may arise from the diversity of patients’ health beliefs, values, preferences behaviors and healthcare needs

and from the challenges of communicating effectively across language and cultural differences. Communication barriers complicate the task of identifying and responding effectively to patients' needs and expectations.

Many organizations concerned with quality and equity in health care have called for physician training in cross cultural communication as one strategy for ensuring patient-centered health care for all (General Medical Council and Postgraduate Medical Education and Training Board, 2005; National Quality Forum (NFQ), 2009; The Joint Commission, 2010). Both the EU and the WHO Regional Office for Europe have called for cultural competence training of health professionals as part of a broad strategy to tackle health inequities and ensure quality health care for increasingly diverse populations (Council of Europe, 2011; World Health Organisation, 2010).

This has resulted in a number of organizations developing principles and standards for cultural competence training of physicians (American Institutes for Research, 2002; Gilbert, 2003; Liaison Committee on Medical Education, 2014; Like, Steiner, & Rubel, 1996; Van Herwaarden, Laan, & Leunissen, 2009)

However, despite a burgeoning literature on methods for teaching different components of cultural competence (American Institutes for Research, 2002; Beach et al., 2005), less is known about how to effectively and sustainably integrate such teaching into the medical school curriculum. Difficulties include a lack of clarity on what should be taught and when, a lack of institutional leadership and support for cultural competence teaching, a lack of faculty development for cultural competence teaching and a lack of evaluation of the effectiveness of such teaching (Cuff & Vanselow, 2004; Dogra, Reitmanova, & Carter-Pokras, 2009, 2010; Lipson & DeSantis, 2007; Lu, Tsai, & Tseng, 2014; Wachtler & Troein, 2003).

These difficulties are common to medical curriculum change in general, and recommendations of the International Association for Medical Education (AMEE) for integrating professionalism into the curriculum seem equally relevant for cultural competence: agree on learning objectives, structure the curriculum to integrate learning across all years, develop a curriculum framework that takes into consideration different learning models, ensure adequate role modeling, and assess trainee learning (O'Sullivan, van Mook, Fewtrell, & Wass, 2012). Faculty development, in particular, has been touted as an instrument of curricular and institutional change (Steinert, Cruess, Cruess, Boudreau, & Fuks, 2007), and may be an effective strategy for effectively and sustainably integrating cultural competence into the medical curriculum (Mihalic, Dobbie, & Kinkade, 2007) and reaching those medical teachers who still see cultural competence as a "politically correct irrelevance that is simply common sense" (Dogra et al., 2009)(p. 5). While a few examples exist in the literature of training initiatives for medical faculty (Berger, Conroy, Peerson, & Brazil, 2014; Ferguson, Keller, Haley, & Quirk, 2003; Kai, Spencer, & Woodward, 2001) (Perlman, Christner, Ross, & Lypson, 2014), more mapping and exchange of experiences and "best practices" across institutions regarding the integration of cultural competence into medical teaching is needed to move the field forward (Dogra et al., 2009).

The C2ME Project

The C2ME project "Culturally Competent en Medical Education" is a European project funded by the EACEA ERASMUS Life Long Learning Program of the EU, involving medical schools in 11 European countries. The aim of C2ME was to facilitate the integration of cultural competence teaching in the undergraduate medical curriculum and address some of the key challenges mentioned earlier (Suurmond,

Hudelson, & Dogra, 2015).

In an effort to foster an exchange of experiences among C2ME and other institutions, a symposium was organized at the 2014 European Association for Communication in Health Care (EACH) conference. At the symposium, several C2ME partners presented their cultural competence training programs. Differences and similarities in approaches to cultural competence were highlighted, and discussion focused on identifying common challenges and promising practices across institutions. Below, we summarize the main points from the symposium.

Diverse approaches for common goals

Participants were generally in agreement about the knowledge, attitudes and skills needed to work effectively with diverse patient populations. Those mentioned included:

- Respect and tolerance for difference
- Awareness of one's own culture (including medical culture), and its impact on communication and care
- Awareness of the risks of stereotyping and prejudice in healthcare
- Knowledge of the social, cultural and linguistic factors that affect communication and care
- Knowledge of the sociodemographic and epidemiological characteristics of locally relevant patient populations
- The ability to explore/identify social and cultural factors affecting care
- The ability to exchange information in a way that is relevant and understandable for the patient (including working with an interpreter)

However, different vocabularies were used to discuss the challenges and strategies related to caring for diverse populations. While some C2ME project partners talked about “(cross/inter/trans)cultural competence”, others talked about “diversity training”, and yet other talked about developing “migrant friendly” hospitals and services. Some partners focused on the care of “migrant” populations (often narrowly focused on asylum seekers and undocumented immigrants), while others were more focused on racial/ethnic minorities. Dimensions of diversity (nationality, language, legal status, race/ethnicity, gender, socioeconomic status) were also given different levels of consideration. It was noted that the lack of a common vocabulary both reflect and result in different aims and strategies in medical education and can make it more difficult to recognize common ground when it exists.

The organization of medical studies also differed across C2ME partner institutions and influenced when and how cultural competence appeared in the curriculum. Undergraduate medicine may be taught in four, five or six-year programs, with some institutions using a problem-based approach to learning. Cultural competence topics may be introduced at different moments in the curriculum, sometimes as obligatory courses and sometimes as electives. Some topics may be covered in one-time encounters, while others may involve several teaching encounters over one or more years. These differences reflected context-specific experience, constraints and opportunities.

The time and resources allocated for cultural competence teaching also varies, and leads to different strategies to ensure cultural competence teaching. For example, some institutions have social scientists and other cultural competence specialists on staff while others rely on general medical staff to teach

cultural competence topics.

Teaching and assessment methods also vary widely, and include online lectures, videos, reflective exercises, role-plays, community visits, and self-directed learning, and reflective writing. A number of innovative methods have been developed, but forums for exchange of methods and materials among European institutions (such as MedEdPortal.org in the USA) are lacking.

Common challenges

Despite the considerable diversity with regards to the emphases and approaches to cultural competence training in Europe, the following issues appear to be common across C2ME institutions, and echo findings from several North American studies (Dogra et al., 2010; Flores, Gee, & Kastner, 2000; Loudon, Anderson, Gill, & Greenfield, 1999; Mihalic et al., 2007):

- Cultural competence teaching is frequently initiated and sustained by a small number of interested “experts”, usually those working closely with vulnerable migrant populations (often asylum seekers and undocumented migrants).
- Specific faculty development activities aimed at expanding the cultural competence teaching pool are rare.
- Formal faculty recognition of cultural competence teaching is often lacking.
- Curriculum time devoted to cultural competence topics is often limited and precarious. Seemingly well-established courses may be cancelled to make room in the curriculum for other, more highly prioritized subjects.
- Cultural competence teaching may occur in isolated blocks, rather than be integrated across the curriculum.
- Cultural competence topics are often addressed separately from other learning objectives, and identified as a specialized field of relevance mainly to health care professionals working with vulnerable migrant populations.
- Formal assessment of students with regards to cultural competence learning objectives is rare.

The need for greater exchange of experiences and best practices

In order to address some of these challenges, C2ME has developed a curriculum assessment tool, guidelines for integrating cultural competence content into the medical curriculum, and teacher training modules to strengthen cultural competence teaching capacity (www.amc.nl/C2ME). However, much still remains to be done.

The Council of Europe has encouraged greater exchange of experiences and good practice among its member states to achieve these goals (Council of Europe, 2006). The C2ME project was successful in initiating exchange of experiences among its partners, but we encourage other interested individuals and organizations to join in the discussion by joining our LinkedIn page:

<https://www.linkedin.com/groups/C2ME-Culturally-Competent-Teachers-Medical-6543126/about>.

Take Home Messages

Notes On Contributors

Patricia Hudelson, PhD, is a medical anthropologist at the Geneva University Hospitals. She teaches and conducts research on cross cultural communication in healthcare.

Nisha Dogra is Professor of psychiatry education and an honorary consultant in child and adolescent psychiatry at the University of Leicester nd13@leicester.ac.uk

Kristen Hendrickx is a general practitioner and professor at the department of Family Medicine in Antwerp. She is responsible for the implementation of diversity in the curriculum.

kristin.hendrickx@uantwerpen.be

Petra Verdonk is a psychologist and assistant professor. She coordinates the longitudinal pathway Interculturalization and Diversity at the VUmc. Her research focuses on gender and diversity in medical education and public health. p.verdonk@vumc.nl

Marie-Louise Essink-Bot MD PhD is professor of Public Health at the Academic Medical Center - University of Amsterdam, The Netherlands. Her research and teaching focus on ethnic and socio-economic inequalities in healthcare. m.l.essink-bot@amc.uva.nl

Jeanine Suurmond is a researcher and teacher in the Department of Public Health, Academic Medical Center/University of Amsterdam, Amsterdam, the Netherlands. Her work focuses on migrant health and cultural competency, and she is project coordinator of C2ME. j.suurmond@amc.uva.nl

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Appendices

Declaration of Interest

The author has declared that there are no conflicts of interest.