SUMMARY:
USE OF FOCUS GROUPS TO DEVELOP INSIGHT INTO A CULTURAL COMPETENCE CURRICULUM
TOOLS FOR ASSESSING CULTURAL COMPETENCE TRAINING
STFM 39th Annual Spring Conference
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I. Basics about Focus Groups

A. Definition: "*People, assembled in a series of groups, who possess certain characteristics and provide data of a qualitative nature in a focused discussion*"
B. Purpose: *To uncover factors relating to complex behaviors or beliefs*
C. Participants:
- **homogeneous**
- **strangers**

D. Structure:
- **conducted in a series**
- **need multiple groups with similar participants to detect patterns**
- **typically 3-5 groups**

II. Why Do Focus Groups Work?

A. Attitudes and perceptions are formed and shaped in groups
B. Weakness of surveys, interviews, is that they assume
- **individuals really know how they feel**
- **opinions exist in isolation from the social environment**

C. Permissive environment gives license to disclose more honestly than in other forms of questioning
- **goes beyond presentation of the public self**
- **moderator avoids judgment, encourages alternative explanations**

D. Self disclosure occurs more readily with like people

III. Advantages of Focus Groups

A. Combine participant observation of group process with in-depth interviewing to assess attitudes and experiences
B. Allow moderator to probe and clarify responses
C. Yield believable, easily understood results
D. Get at deeper feelings and hidden attitudes

IV. Selecting a Focus Group

A.Homogeneity but sufficient variation to allow for contrasting opinions
B. Size: ideal 6-9; mini-group 4-5
C. Selection: randomization, snowball
- **our approach combined purposive sampling with sample of convenience**

V. How Focus Groups Work

A. Natural informal environment encourages self-disclosure
B. Organized around a question route

- introductory questions
- transition questions
- key questions
- summary and final question

VI. Moderating a Focus Group
- A. Moderating team – moderator and assistant
- B. Principles of focus group moderating
  - Positive regard
  - Respect for differences of opinion
  - Open, nonjudgmental atmosphere
- C. Ground rules
  - No right or wrong answers
  - Interested in all opinions
  - Tape recording
  - Confidentiality
- D. Debriefing

VII. Special Issues in Discussing a Cultural Competence Curriculum
- A. Students' difficulty in defining cultural competence (race/ethnicity vs. socioeconomic status, sexual orientation, disability)
- B. Students' difficulty in identifying the CCC
- C. Students' fear of being politically incorrect
- D. Students' tendency to believe attitudes can't be influenced
- E. Students' assumption that living in a multicultural context is synonymous with lack of bias

VIII. Analyzing Focus Group Data
- A. Triangulation of data:
  - audiotapes, transcriptions, debriefing meetings, independent researcher summaries of transcriptions identifying key words, phrases
- B. Theoretical triangulation
  - research team consisted of psychologist, family physician, undergraduate student, graduate student in sociology
- C. Purpose of analysis is to identify recurring attitudes and beliefs
- D. Analysis is both descriptive and interpretive
- E. Considers elements of frequency, extensiveness, and intensity
- F. Data compared both within and across groups
- G. Data grouped according to a systematic reduction into sets or categories suggested by the intervention protocol and emergent themes
- H. Identifying ideas or phenomena, flagging, then breaking down and assembling in new ways
- I. Analysis includes efforts to find disconfirming evidence and identify outliers
- J. Effort to find patterns, make comparisons

IX. Specific Themes from Cultural Competence Curriculum Study

- **Informal vs. formal aspects of the CCC**
- **Strengths and weaknesses of the CCC**
- **Self-awareness as a component of cultural competence**
- **Group specific knowledge vs. stereotyping**
- **Negative and positive bias**
- **Translational aspects of the CCC**
- **The CCC and political correctness**
- **The CCC and humanism**
- **Specific recommendations**

MODERATING A FOCUS GROUP

I. PRINCIPLES OF MODERATING

- A. Show positive regard for participants
- B. Express respect for participant opinions
- C. Create atmosphere of openness and non-judgmentalness
- D. Exhibit a friendly manner, sense of humor
- E. Listen, don't talk (be a moderator, not a participant)
  - a. Guide discussion
  - b. Don't become actively involved
  - c. Don't participate, share views, or engage in discussion
- F. Listen and think
  1. Keep past-present-future perspective
  2. What's been discussed, what is currently being discussed, where conversation needs to go
- G. Know boundaries of discussion
  1. Communicate boundaries
  2. Refocus tangential discussion

II. MODERATING TEAM

- A. Moderator
  1. Directs discussion
  2. Keeps conversation moving
  3. Occasional note-taking (key ideas, future questions)
- B. Assistant Moderator
  1. Comprehensive notes – word-for-word, in case equipment fails
  2. Mechanics/logistics/equipment/refreshments
  3. Occasional questions, probes
  4. Can give the oral summary

III. MODERATOR ROLES

- A. Seeker of wisdom –
  1. Goal is understanding, wisdom, insight
  2. Assumption that wisdom is to be found in group
- B. Enlightened novice
  1. Seems to have less knowledge than others in room
  2. Willing to listen and learn
- C. Expert consultant – moderator is expert
- D. Challenger
  1. More combative role
  2. Challenges participants to explain, amplify, justify views
  3. Risk of alienating participants
- E. Referee
  1. Moderates when strong opposing views

2. Ensures fairness, respect for all points of view

F. Therapist
   1. Seeks information on psychological motivation
   2. Why is that? How did you feel?

G. Writer – stands and writes on flip chart

IV. RECORDING

A. Tape recorder
   1. Set in plain view
   2. Mention briefly but avoid excessive attention
   3. Too much explaining creates inhibited atmosphere

B. Note-taking
   1. Written notes essential
   2. Back-up to tape
   3. Help identify key points on tape
   4. Use some kind of notetaking schema
   5. Write down
      a. Quotes, paraphrased quotes
      b. Major themes
      c. Questions that occur to you
      d. Ideas about study
      e. Observations about body language, group process, atmosphere
      f. Sketch of seating pattern
      g. Follow-up questions

V. MODERATOR PREPARATION BEFORE FOCUS GROUP

A. Complete familiarity with questioning route
   1. Be familiar with rationale for each question
   2. Don't ever read questions from printed sheet

B. Practice introduction and questions

C. Prepare equipment and arrange room

VI. INITIAL STRUCTURE OF THE SESSION

A. Opening (pre-session; 5-10 minutes)
   1. Participant arrives, greeted by team, made to feel comfortable
   2. Host role
   3. Complete demographic sheet (if necessary)
   3. Small talk/social conversation
   4. Refreshments (avoid during actual discussion)
   5. Avoid key issues
   6. Name tents

B. Beginning phase of discussion
   1. Introduction (2-4 minutes)
      a. Welcome – introduce self
      b. Overview of topic
   c. Ground rules – suggestions to guide discussion (list on flip chart)

1. No right or wrong answers, just express your opinion
2. Only one person should talk at once
3. Tape recording because don't want to miss any of your comments – please speak up
4. First name basis
5. Confidentiality – no names will be used in reports
6. Moderator role is to ask questions and listen – *I won't be participating in the discussion, but I want you to talk freely to each other*
6. Session will last about 1 ½ hours – *I'll be asking about a dozen questions; move from one question to the next, so don't spend too much time on any one question;* themes of questions listed on flip chart
8. Tendency for some people to talk, some people not to say anything: important to hear from each of you tonight because you've all had different experiences
7. Let's begin by finding out more about each other

d. Avoid asking participants if they have questions – time-consuming

C. First question
1. Ice-breaker
2. Gets everyone to talk
3. Emphasizes common background

D. Reemphasize value of differing points of view
1. Does anyone see it differently?
2. Are there any other points of view?

VII. SPECIAL TECHNIQUES

A. 5 second pause
1. Novice mistakes
a. Speed
b. Offering examples too quickly
2. Alternative: *Take a moment and think about your answer: We'll wait until you're ready to respond*
1. Used after participant comment
2. Prompts additional points of view

B. Probe – request for additional information
1. Use early to communicate importance of precision in responses, then use sparingly later in interview
2. Conveys desire for more detailed answers
3. Excessive probing time-consuming

C. Avoid asking questions in several different ways
1. Confusing
2. Time-consuming

D. Ask questions in conversational manner

E. If question not understood, switch quickly to parallel question

F. Modify sequence of the question or eliminate a question if it has been answered in previous discussion

VIII. RESPONDING TO PARTICIPANT COMMENTS

A. Head nodding

1. Use sparingly and consciously
2. Can be taken as agreement or approval

B. Short verbal responses

1. Neutral are acceptable – okay, uh huh, yes
2. Avoid good, excellent, correct that imply judgment

IX. PACING

A. Be careful early questions don't take up too much time
B. Pace questions, monitor clock
C. Later questions are most important

X. CONCLUDING THE FOCUS GROUP

A. Summarize main points, ask if accurate
B. Final question – have we missed anything
C. Thank participants, give incentive

1. Cash in envelope with participant name
2. Sign list stating: *"I have received $25 for participating in the focus group interview at (location) on (date)"*

XI. Debriefing with assistant moderator

A. What were important themes or ideas?
B. How did these differ from what we expected?; what occurred in earlier groups?
C. Any especially good quotes
D. Should we do anything differently for next focus group?

XII. CHALLENGES TO MODERATOR

A. Passive, quiet group

1. Call on individuals
2. Go around group answering a specific question
3. Use pauses and probes

B.. Shy respondent

1. Place directly opposite moderator – plenty of eye contact
2. Ask to speak up or continue because interested in their point of view

C. Excessively verbal group

1. Polite limit-setting
2. Review one-at-a-time rule

D. Outspoken group member

1. Expert – can inhibit other members in group
   a.. Emphasize everyone's expertise,
   b. Importance of all opinions
2. Dominant talkers –
   a. may or may not be experts
   b. Use body language, lack of eye contact

c. Verbal strategies – thank you, that's one point of view; other opinions?

d. Interrupt when necessary

e. Avoid harsh, critical comments – curtail spontaneity from rest of group

E. Group member who consistently goes off on tangent – rambling

1. Drone on, seem to feel obligation to say something
2. Discontinue eye contact after 20-30 seconds
3. When speaker stops or pauses, ask for other opinions, ask next question

F. Group which doesn't understand questions or task

1. Clarify/use parallel questions
2. Revise questioning route

G. Hostile group

1. Disrespectful, personal attacks
2. Reminder of ground rule to listen respectfully
3. Reminder not everyone in group needs to agree

H. Inappropriate personal disclosures

1. Emphasize seeking general information, not personal stories
2. Redirect back to main focus of group

I. Inarticulate group

1. More structure – switch to sentence completion, making lists
2. Avoid modeling answers

J. Nervous, tense group

1. Acknowledge difficulty of task
2. Use gentle humor

Adapted from Kroeger, Richard A. *Moderating Focus Groups.* Sage Publications, 1008

QUESTION ROUTE – MEDICAL STUDENTS' PERCEPTIONS OF THE USEFULNESS OF THE CULTURAL COMPETENCIES CURRICULUM

Introduction: We're going to talk for a bit about the extent to which your academic training has helped to prepare you for clinical encounters with patients from different cultural backgrounds. We'd like to ask you a few questions. We're particularly interested in differences of opinion, so don't be afraid to speak up.

1. **Overall, how useful and relevant has your academic coursework been in terms of preparing you for clinical encounters with patients from different cultural backgrounds?**
2. **What would you say has been its greatest strength?**
3. **What has been its biggest deficiency?**
4. **What are examples of information and/or skills you acquired by participating in the cultural competence curriculum that you have used in clinical settings?**
5. **What have you learned about why self-awareness is important in working with patients from different cultural backgrounds?**
6. **What is the biggest problem you've run into in caring for patients of different cultural backgrounds?**
7. **What have you learned in your training that has helped you deal with this problem?**
8. **Can you give an example of the following:**
    a. **How something you learned about patients'/families' healing traditions, practices, and beliefs helped in your care of a particular patient?**
    b. **How something you learned about stereotyping, bias, or discrimination helped in your care of a particular patient**
    c. **How something you learned helped you in using an interpreter in a particular patient encounter**
    d. **How specific communication skills you've learned helped in your interactions with patients from different cultural backgrounds**
        1. **How specific negotiating and problem-solving skills you've learned helped you in agreeing upon a mutually acceptable treatment plan with a patient from a different cultural background**
        2. **How specific methods you learned for increasing adherence to a treatment regimen helped you with a particular patient from a different cultural background**
9. **How could the cultural competencies curriculum be improved to better prepare students for interacting with patients from different cultural backgrounds in actual clinical settings?**
10. **Do you have specific recommendations about**
    a. **Where in the curriculum cross-cultural materials should be introduced?**
    b. **What should be taught? (What kind of traing do you think would actually improve your readiness to interact with culturally diverse patients?**
    c. **Who should be teaching this material?**
11. **What's the most important thing you've learned as a result of your training about cross-cultural medical encounters?**

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Role-Play Focus Group Questions

1. **How useful and relevant has your academic coursework been in terms of preparing you for clinical encounters with patients from different cultural backgrounds?**

2. **What has been the biggest deficiency of the cultural competence curriculum?**

3. **What have you learned about why self-awareness is important in working with patients from different cultural backgrounds?**

CULTURAL COMPETENCE CURRICULUM – SUMMARY OF FOCUS GROUP RESPONSES

1. **What constitutes the cultural competence curriculum"**

Students agreed that ethnic diversity is an important component of cultural competence training but emphasized that cultural competence is not limited to this narrow definition. They listed these topics as being part of cultural competence education:

1. Culture of poverty (socioeconomic).
2. Sexual orientation.
3. Culture of Medicine (institutional and global).
4. Health beliefs including CAM, religious and other personal beliefs held by patients.
5. Disability and chronic illness (seen as interchangeable).
6. Culture of language barrier.

They saw the informal curriculum learnt in clinics and on wards, during times when formal teaching (such as lectures or small group discussion) are not occurring, as being a key part of their cultural competence training. They agreed and remembered that formal training in the first two years occurred (gave examples: The Spirit book, skit on interpreters and self-reflection exercise). While an important foundation, they feel that these formal sessions do not 'stick' until they have to care for patients. Informal settings like work in a community setting gave students new insights and some students suggested that these experiences that focus on limited language proficiency patients should occur early to expose students to a need to learn about culture.

Ethics (in IM clerkship) sessions were identified as places where cultural issues and conflicts of values between doctor and patient are discussed in depth. Students saw this as part of the cultural competence curriculum.

Interestingly, nowhere were the basic sciences identified as a place where cultural competence education occurred.

2. **How useful and relevant was coursework in terms of preparing students for clinical encounters with patients from different cultural backgrounds?**

First year exposure should include patient care experiences that emphasize the relevance of understanding cultural differences, so students are oriented to this issue. They remember tagalong experiences in community clinics as an effective way to sensitize them to patient needs in this geographic area.

Students did want some categorical teaching on specific groups (examples were Middle Eastern or Indian patients, and a good example of this being taught in a useful way was Jehovah's witness's views) , even though they recognized that such an approach may promote stereotyping. They assured us that being diverse themselves and learning from

classmates of different backgrounds was an effective way to nurture a sensitive approach to patients.

There was a general sense (from examples given by individual students) that the opportunities for clinical teaching in the patient environment were underutilized. Clinical teachers could have done more to highlight the obstacles and solutions to effective care in a culturally diverse setting.

In the end they agreed that good communication, 'getting into a patient's shoes' in a general way rather than having detailed knowledge of specific groups, and understanding things from their perspective was the essential ingredient of cultural competency.

3. **What are curriculum's greatest strengths?**

    a. Exposure of students to diverse patients in every clerkship and clinical experience.
    b. Faculty role modeling (positive).
    c. Attention to the topic in the first two years. Use of the book 'The Spirit catches You…' was mentioned many times by many students as useful but could be covered in greater depth.
    d. Addressing issues of conflict in Ethics curriculum.
    e. SP interviews for interpreter module.

4. **What are the curriculum's greatest weaknesses?**

    a. Lost opportunities for teaching around patient encounters.
    b. Making the content directly relevant to patient care in the first two years (i.e. extending reflection to patient care).
    c. Not addressing poverty as a culture in itself.
    d. Not addressing health disparities that result from lack of cultural competence (this view was expressed by students who wanted to see more direct relevance of cultural exercises to actual patient care).
    e. Too many lectures in first year: suggestion was made to convert lectures to other strategies like films (examples were given of useful films addressing cultural issues), small group discussions, reading short stories, and patient stories.

5. **What have students learned about importance of self-awareness in working with patients from different cultural backgrounds?**

Students did not make a connection between caring for their patients and their own biases, even though they had done exercises in self reflection. The thread of the discussions did not include how students' own biases can result in or promote health disparities. No examples were given of this kind of outcome of 'poor' cultural competence.

6. **What is the biggest problem students encounter in taking care of patients from different cultural backgrounds?**

Language barrier, inadequate supply of trained interpreters, frustration resulting from poor communication. Students implied that given the opportunity for good communication, better patient care can result.

7. **What did students learn in their training that helped them address this problem?**

The PD interpreter module was remembered by the majority of students as being useful, with an impact on their attention to culture. They learnt from attendings who addressed culture in a sensitive way but commented on poor role models (such as one attending who gave more complete or 'better' care to patients of his own background).

8. **Specific examples of useful learning:**

    a. **Patient/family beliefs**
    From patients seen on wards and outpatient clinics. 'Patients are the best teachers'.
    b. **Stereotyping, bias, discrimination, assumptions**
    They like the self-reflection exercise but want faculty to include an example of how this potentially affects patient care.
    c. **How to work with an interpreter**
    The interpreter module in the PDS course was highly rated.
    d. **Specific communication skills (negotiating, problem-solving, strategies to increase compliance)**
    They felt that skills learnt in the PD course apply to cultural competence well. They would like more time in third year curriculum to discuss cultural issues

9. **How could curriculum be improved?**

1. Increase teaching just before the third year when students have to deal with the issue directly.
2. More on patient perspectives, e.g. patient panels. They stated that patients were the best teachers and they wanted to hear more from them and ask patients what would improve communication from a doctor.
3. Provide Spanish language classes to students esp. in year 2 and 3. This is an important aspect of communicating better.

10. **Specific recommendations:**

    a. **Where in curriculum should cross-cultural teaching be introduced?**
    Year 1, increasing in year 3. Of note, Basic Science was NOT mentioned as a place where this can occur.

Other clerkships emphasized (than FM, Peds and IM) were surgery (seen as an important place, esp where informed consent is sought) and Ob Gyn..

b. **What content should be taught?** How patient and physician beliefs impact healthcare outcomes, an evidence-based approach to health disparity (one example was to make at least one learning issues in the IM rotation on cultural differences or health disparities).
c. **Who should teach?** A. All the doctors who care for patients and with whom students interact. B. Experts in other disciplines like anthropology and from other campus departments like social sciences. C. Notably, students did not advocate for an expert approach to cultural competence training, i.e. they did not identify, nor did they suggest that any one person should be teaching about culture exclusively.

11. **What is the most important thing students learned about cross-cultural medical encounters?**

They make a difference to patient care.

Please note additional categories for comments that could not be included under the above headings

CULTURAL COMPETENCE CURRICULUM – SUMMARY OF FOCUS GROUP/INTERVIEW RESPONSES

1. What constitutes the cultural competence curriculum (CCC)?

Most students agreed the CCC consisted of both formal and informal elements. Formal elements most frequently mentioned included 1) Use of Spirit 2) Interpreter skit and module 3) PDS modules and SPs (standardized patients) in PD course. Lectures were also mentioned as part of the formal curriculum. Other aspects of the formal curriculum referred to were the alternative/complementary medicine selective; ethics assignments that incorporated cultural dimensions; and cultural components of the humanities selective. Tag-along experiences were variable, with some touching on cross-cultural issues, and others not. There was also disagreement about whether epidemiology presented relevant cross-cultural information, with some students remembering this content and others not.

The informal curriculum included the following components: 1) Learning from residents and attendings in clinical situations 2) Learning from patients in clinical situations 3) Learning from clinical situations generally 4) Learning from diversity of fellow students.

2. How useful and relevant was coursework in terms of preparing students for clinical encounters with patients from different cultural backgrounds?

Overall, most students evaluated both the informal and formal CCC as useful and relevant. The aspects of the formal curriculum that they remembered seemed fairly effective. They agreed that, in terms of the informal curriculum, there were both good and bad resident and attending role-models, but that in general they learned a lot about cultural competence in the clinical settings. Of note is that the two students interviewed separately were strikingly more negative about the CCC, and described in terms such as "superficial," "pretty poor," and "nothing new."

3. What are the curriculum's greatest strengths?

Strengths of the formal curriculum included:
1) The use of the Spirit book as a general introduction to get students thinking about cultural differences, although, as one student commented, "I know a lot of people didn't like it." Another student described the book as an experience of cultural immersion where "you sort of learn about these nuances."
2) The interpreter module and skit, about which students gave plenty of examples of specific learning that had occurred and generally evaluated as providing a good model of how to conduct an interpreted interview
3) The cultural dimensions of the PD and PDS SP cases
4) All skits and role-plays used throughout the curriculum
5) The information presented about Jehovah's Witnesses.

6) The information presented about alternative medicine (in the selective and ethics assignments).

There was disagreement as to whether the curriculum adequately covered gay and lesbian issues. One student commented, and others assented, that the "culture of medicine" was also covered very well.

Students also seemed to feel that the communication skills curriculum was very useful in cross-cultural interactions, and that generally speaking the skills taught to them translated well across cultures. They did recognize that some adaptation was necessary, but commented that they frequently drew on these skills. Related to this point, several students felt they had developed good empathic skills to get patients to express their feelings, good negotiating skills, and knew how to work to effectively with noncompliant patients from different cultural backgrounds. Students also used communication skills such as open-ended questions to elicit patient's perspective and to obtain feedback about their own performance. One student thought the communication skills taught were too basic.

Students believed that the first year was successful in conveying the idea that people hold very different perspectives.

Overall, the informal curriculum was considered superior to the formal curriculum because of its direct link between knowledge presentation and skill acquisition. Students felt they learned a great deal about specific cultures (i.e., Latino, Vietnamese, and others) through their clinical experiences, especially at clinics like Westminster, FHC-Santa Ana and Anaheim, and Long Beach; and that the quality of what they learned was generally good. Opinions did vary to some degree, with one student stating "Lots of informal teaching takes places taking into account cultural issues," while others said attendings rarely had time to talk about cultural issues. Students felt they learned best from positive physician role-models.

4. <u>What are the curriculum's greatest weaknesses?</u>

1) No information about culture of poverty, both from an empathic, sensitive perspective and a practical perspective (i.e., how to deal with insurance, resource limitations); several students agreed this was a pervasive problem in clinics that needed to be addressed
2) No information about mental retardation (1 student)
3) No information about gay, lesbian, transgender issues (several students believed this topic was already well-represented in the curriculum)
4) No information about Arab/Muslim cultures
5) Students need better preparation to understand the VA population as a "culture"

One student pointed out she never received feedback as to whether her interactions with patients during clerkships are culturally competent

5. **What have students learned about importance of self-awareness in working with patients from different cultural backgrounds?**

This question tended to be interpreted as asking about students' own biases. Some students felt this issue was addressed in the first year, others felt it was not attended to. One student mentioned an ethics assignment during third year which covered this topic nicely. Several students gave specific examples of how they had become aware of their own biases as a result of exposure to both the formal and informal curricula:

- Bias against drug-abusing patients
- Bias against painkiller-abusing patients
- Realization that just because medical student doesn't agree with patient doesn't mean patient is wrong
- General unawareness of cultural issues – had never thought about it and didn't really understand what it meant
- If hadn't been educated by CCC, "would have laughed" at some of patient's "nonscientific' beliefs

In the words of one student: "I think that that's been sort of a long process for me but something that PDS originally made me aware of, because that never would have occurred to me. I think that I'm an empathetic person and that I would go into every encounter with an open heart but as it turns out I really do have a harder time with certain patients."

In one of the three groups, there was general consensus that self-awareness was a useful component of CCC.

6. **What is the biggest problem students encounter in taking care of patients from different cultural backgrounds?**

Most students agreed the biggest problem was language differences. Other people mentioned the following:

- Stereotyping people from other ethnic groups
- Financial issues
- Explaining lifestyle changes (healthy eating, non-smoking)
- Hard to find common ground

7. **Specific examples of useful learning from the CCC:**

   a. **Patient/family beliefs** – Students were able to give several examples in response to this probe, such as Jehovah Witness beliefs about transfusion; VN patient beliefs, such as wind causing illness; Latina Catholic patient's views of birth control; Pakistani patient's view of returning to his country of origin to die. However, although they could identify these situations, they did not uniformly feel they were adequately prepared by their training

to *deal with* them. Students did feel they had been trained to ask about health beliefs as part of the curriculum.

b. <u>Stereotyping, bias, discrimination, assumptions</u>

Students commented that attendings and residents sometimes demonstrated stereotypic, denigrating attitudes toward patients of a specific ethnicity ("doing the Macarena" to refer to a Latina woman in labor; stereotyping drug abusers). "A lot are judgmental, a lot are stereotypical." Students varied in terms of whether they felt prepared to address these situations when they arose. One woman said she could not say anything because the attending was "intimidating." However, others reported that they often spoke up, but did so in a style that was not confrontational.

Students also commented that they felt some attendings showed favoritism toward patients of their own ethnicity, and were more dismissive and neglectful of patients from other ethnic backgrounds. This observation emerged from all three groups. Some students felt "shut out" when working with attendings and patients who shared an ethnicity different from their own; but others felt common ground was established , so that they had a "blast" and felt "enlightened" by the experience.

Students also pointed out that *patients* sometimes evinced bias, in terms of preferring a physician of the same ethnicity, and they did not seem to feel prepared to handle this issue. "I had a patient just today who told me that I couldn't understand his anger because I'm white and in the Korean population that's how they deal with conflict is they get angry/violent." This student said she did not know how to respond.

c. <u>How to work with an interpreter</u>

Students gave multiple examples of how an interpreted interview could affect the doctor-patient relationship, and were able to list numerous skills they had acquired, such as talking directly to the patient; not using too many open-ended questions; using the interpreter as a cultural intermediary; avoiding using family members as interpreters; making sure the interpreter translates everything the patient says; not allowing the interpreter to speak for the patient or take charge of the interview; paying attention to patient's body language; and developing a good relationship with the interpreter. This learning came mostly from the interpreter skit/module and but also from personal clinical experience.

One student commented she learned most about working with an interpreter when she had to serve as an interpreter herself.

d. **Specific communication skills (negotiating, problem-solving, strategies to increase compliance)**

Due to time constraints, this question was not asked in any of the groups, but in two of the groups, several students commented that they felt they had acquired adequate skills in these areas.

8. **Specific recommendations to improve the CCC:**

a. **Where in the curriculum should cross-cultural teaching be introduced?**

Most students felt some introductory information about cultural competence should be introduced in the first two years, but that the bulk of this content should be reserved for closer to third year, or in the third year itself. Students saw the first two years as laying a foundation of cultural awareness which could then be strongly built upon in the third year. The main point they felt should be stressed in the first two years was the idea that people can hold very different perspectives, that these perspectives can lead to conflict, and to become familiar with general principles and strategies for resolving such conflict. Another way of expressing this was to get across the idea that people can think differently about the same thing.

In terms of specific suggestions for the first two years, several students mentioned Clinica Carino as an important source of learning about culture during the first two years. One student recommended it be a required experience because "medical students respond to requirements." Another student wondered about giving tag-alongs a more consistent cross-cultural emphasis, so that they could reinforce other CC learning in year 1. A few students suggested that more cross-cultural information could be included in the epidemiology course, although others felt this material was already represented there. A small minority thought issues of cultural competence were not important in the first year because students were not seeing patients.

There was strong and widespread feeling that students would pay much closer attention to cross-cultural information when they were confronting patients of different cultural backgrounds on a daily basis, particularly in the case of students who did not have an internal motivation to learn about culture and diversity. Several students also agreed with the statement that they got so caught up in clinical medicine in the third year that they "forgot" whatever they'd learned about cultural differences in the first two years.

One specific recommendation was to set aside a week at the start of third year devoted to training cultural competence. Another suggestion was to use existing lecture/small group time on clerkships such as outpatient IM, and FM, to focus on cultural competence. One student received some support for

suggesting that the surgery clerkship pay more attention to cross-cultural dilemmas because of issues like informed consent. No one was in favor of more lectures or assignments, but many felt it would be possible to occasionally substitute a cultural emphasis for existing work. The idea of presenting a formal talk about each cultural background during third year seemed to meet with widespread support.

b. <u>What content should be taught?</u>

Many students wanted group-specific knowledge about as many different cultures as possible. In the words of one student, "I always feel like part of my knowledge is lacking... I know I should be sensitive to different things of their healthcare but I don't really know what they are..." This information should include beliefs and "misconceptions" patients from different cultural backgrounds held about illness and medicine; but was interpreted more broadly by some to cover religion and something about country of origin. By and large, students thought this type of teaching would be effective so long as there were reminders not to stereotype or make assumptions about any group. A small number of students felt lectures were *not* a good way of teaching about culture, and the curriculum should all be clinic-based informal teaching.

A couple of students wanted information that could be presented "scientifically," e.g., epidemiological information about diseases x ethnicity. On the other hand, a few students suggested humanities-based teaching approaches using short stories, poems, and movies.

A number of students mentioned being giving more information about how to navigate the insurance/coverage system, and how to access resources for indigent and uninsured patients.

There were several recommendations pertinent to language. A couple of students advocated a medical Spanish/conversational Spanish class in year 1, but most students said they would not have taken it. Other suggestions included a "cheat sheet" of commonly used phrases in a number of the languages commonly encountered in clinic. One student commented that she would like more guidance in how to convey empathy when there was a lack of a common language between herself and patient. All students agreed there was no time for such a class in third year. Regarding interpreters, one student wanted more information about what points should be covered when first meeting the interpreter, and how to use a family member if no interpreter is available.

A couple of students pointed out the importance of acknowledging diversity within as well as across groups, while one student wanted the curriculum to stress similarities as well as differences among groups.

c. **Who should teach?**

Many students mentioned the idea of using patients as teachers. This emerged both in talking about the formal curriculum (more use of SPs; more patient panels); and the informal curriculum (learning to ask patients for feedback in terms of what student was doing right or wrong). Several students mentioned that they had learned the necessary skills to learn from their patients. Patients as teachers were described "powerful" and "personal."

Another idea popular with the first two groups, which received a more mixed reception in the third group, was that students could learn about cultural diversity from each other, because of the diverse nature of the student body. Others felt that self-disclosure exercises were more of a way of getting to know each other, but not learning about different cultures. Overall, students felt that the process of utilizing the diversity of the students was best left as part of the informal curriculum, although one student suggested it be supplemented by formal lecture material that presented medically-relevant information.

An idea introduced in one group that got a lot of support was having campus experts in cultural studies present lectures to students. Others said that the best teaching was by attendings who have experience and expertise with cultural issues. "Medical students only listen to doctors."

A couple of students expressed the opinion that nutritional consults were not culturally sensitive and were frustrated by this deficiency.

9. What is the most important thing students learned about cross-cultural medical encounters?

Student body diversity (1111)
Use of Spirit
Showing respect and caring for patients
Realizing not everyone thinks the same
You can't teach cultural competence, you can only experience it
Best way is to learn from patients by asking them
Give patients benefit of the doubt, and appreciate their perspective

10. Please note additional categories for comments that could not be included under the above headings

All students had a fair degree of contact with patients from different cultural backgrounds.

All groups pointed out that diversity means more than culture, and includes sexual orientation, socioeconomic status, and disability.

While many students seemed eager for group-specific cultural knowledge relevant to healthcare, several students did express concern that such presentations might stereotype different ethnicities. These students called for a "balance" between acquiring appropriate cultural knowledge and approaching each patient as an individual. One student said only "Sometimes I think it's better when I go into a [n exam] room and figure the patient out for myself without any preconceived notions." Another student expressed similar reservations in the following manner: "Maybe the primary goal per se shouldn't be about teaching cultural differences as much as teaching that people think differently, you know."

There was difference of opinion about the openness of the student body to discuss sensitive issues of culture. On the one hand, some students' perception was that their peers felt comfortable "being themselves" and expressing their cultural and religious beliefs. However, other students felt that the whole discussion of culture was overlaid by a strong degree of political correctness, so that it was difficult for people to state their true opinions or feelings. "We're all taught to be so politically correct these days and no one wants to say how they really feel. Like it was hard for me to admit I had certain biases about certain cultures but I do..."

A few students worried about their decline in humanistic values: "When I go home I just don't think about patients, I think about their medical issues."

One student pointed out that "only students with opinions" would volunteer to participate in the focus groups, so they were not representative.