2009

THE NATURE AND MEANING OF CULTURE IN PRIMARY CARE MEDICINE: IMPLICATIONS FOR EDUCATION, CLINICAL PRACTICE, AND STEREOTYPES

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ABSTRACT OF DISSERTATION

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A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Education
at the University of Kentucky

By
Madison Lamar Gates

Lexington, Kentucky

Co-Directors: Dr. Kelly D. Bradley, Professor of Education
and Dr. Karen W. Tice, Professor of Education

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The medical profession in recent decades has made culture and cross-cultural competence an issue for patient – physician relationships. Many in the profession attribute the necessity of cross-cultural competence to increased diversity, globalization, and health disparities; however, a historical analysis of medicine indicates that culture's relevancy for health care and outcome is not new. The rise of clinics, which can be traced to 17th century France, the professionalization of physicians in 18th century U.S., and the civil rights movement of the 20th century illustrate that medicine, throughout its history, has grappled with culture and health. While medicine has a history of discussing cultural issues, the profession has not defined culture cogently.

Medicine's ambivalence in defining culture raises questions about how effectively medical educators prepare residents to be cross-culturally competent. Some medical educators have expressed that many didactic and experiential efforts result in stereotyping patients. Definitions of culture and their impact on stereotyping patients are the central problems of this study. Specifically, this study hypothesized that cultural beliefs impact ones willingness to accept stereotypes. Thus, this study sought to learn how faculty members and residents define culture. Faculty members also were compared to residents to glean the impact of cross-cultural education.

This study used an explanatory mixed method design where quantitative and qualitative methods work complementarily to examine a complex construct like culture. A valid and reliable survey provided quantitative data to compare the two groups, while open-ended questions and interviews with faculty members provided context. The statistical results reveal that faculty members and residents share a philosophy of culture; however, when the two groups' definitions are contextualized, they have many different beliefs. Differences also emerged with respect to predictability; cultural beliefs predict stereotyping among residents, but not faculty members. Faculty members attribute these differences to experiences, while residents believe that they do not learn about culture during their professional education.

In conclusion, this study found physicians define culture differently and that some definitions impact whether or not one is willing to stereotype. However, the profession has not made culture and cross-cultural education an important aspect of medical education.

KEYWORDS: cross-cultural competence, medical education, health disparities, professionalism, patient – physician relationship

Madison L. Gates

November 18, 2009

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DEDICATION

A doctoral program and dissertation for many of us is a long, challenging, and sometimes isolating process. While there are many whom I can look to and cite for support and encouragement, a few individuals have been my champions throughout this process and well before I started my program.

Veronica Walker, who encouraged and provided me rock solid support throughout this process, deserves and has earned my deepest appreciation and thanks. I dedicate this work and endeavors that grow out of this study to her steadfast loyalty, belief in me, and her patience.

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Trying to balance a professional work life and an academic one was often a source of stress; however, I would be remiss not to thank and acknowledge my friends and colleagues at the Kentucky Corrections Health Services Network at the University of Kentucky College of Medicine. Phillip W. Roeder, PhD, my supervisor and informal mentor, was always available for guidance and support, particularly with respect to a flexible work schedule. He was always available with keen insight as I navigated my program. I must acknowledge M. Jean Kennedy who was my initial sponsor and

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In closing, I offer this advice to forthcoming doctoral students and candidates. Always keep an open mind and welcome the diversity of advice and suggestions you will receive.

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Chapter 1: Introduction

Culture for many anthropologists, historians, philosophers, and educators is difficult to define and even more of a challenge to agree upon a broad definition beyond beliefs, values, and practices that group members share. While there is much discussion and debate in these fields about the definition and nature of culture, they often differ as much within their domains as they do across fields of study. During the past thirty years, medicine has begun to wrestle with the impact that culture has on health care and outcomes. However, the medical profession has not discussed how medicine defines culture. Medicine's definition of culture oftentimes must be gleaned from how the profession teaches physicians to interact with culturally diverse patients. Thus, the aim of this study is to learn how medicine defines culture and the impact their definition has on patient and physician encounters.

Medicine typically discusses culture in the context of the clinical encounter between patients and physicians. The focus on clinical encounters pertains to how differences in health beliefs between patients and physicians contribute to disparate diagnoses, treatment recommendations, and outcomes. The medical profession has termed differences in health outcomes and statuses across patient populations as health disparities and has identified culture as one of the explanatory factors for the phenomenon (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Betancourt & Maina, 2004; Boehnlein, Leung, & Kinzie, 2008; Engebretson, Mahoney, & Carlson, 2008; Fung, Andermann, Zaretsky, & Lo, 2008; Hobgood, Sawning, Bowen, & Savage, 2006; Kagawa-Singer & Kassim-Lakha, 2003; Shaya & Gbarayor, 2006; Tucker, et al., 2007). Medicine also refers to differences in diagnoses and treatment recommendations as health care disparities.

Overwhelmingly, medicine defines health care disparities as a phenomenon where physicians and health professionals, consciously or not, provide unequal diagnoses and treatment recommendations on the basis of race, ethnicity, gender, or other distinguishing patient characteristics (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Hobgood, et al., 2006; McGuire, Alegria, Cook, Wells, & Zaslavsky, 2006). However, medicine does not attribute the entirety of health and health care disparities to cultural differences between patients and physicians. The profession has identified other

contributors, such as access to care, quality of treatment, genetics, biology, and socioeconomic status (Anderson, et al.; Betancourt, et al., 2003; Betancourt & Maina, 2004; Kagawa-Singer & Kassim-Lakha, 2003; Kennedy, 2005; King, et al., 2008; Sarto, 2005; Shaya & Gbarayor, 2006; Tucker, et al., 2007; van Ryn & Burke, 2000). Yet, culture has become an increasingly salient way to contextualize health care disparities, particularly when they fall along the lines of race, ethnicity, gender, and social class.

The medical profession frequently cites the demographic shifts within the U.S. population as a reason to discuss and integrate culture into medicine, because physicians increasingly must address diverse health care needs of racial minorities and immigrants (Engebretson, et al., 2008; Macnaughton, 2000). Many medical professionals do not believe that the current health care infrastructure is capable of addressing the diverse medical needs of an increasingly pluralistic and global society (Kennedy, 2005; Martin, et al., 2004). For instance, the nonprofit Institute of Medicine (IOM), which the National Academy of Sciences founded in 1970 as an advisory body for medical and health professions, determined that the health care system at the start of the twenty-first century had not met diverse patients' needs and expectations (Betancourt, et al., 2003; Betancourt & Maina, 2004; Hobgood, et al., 2006). The IOM, which also advances public health issues, based this assessment on the persistence of health disparities found among minority racial and ethnic populations even when controlling for socioeconomic status and access to care (Betancourt, et al., 2003).

The IOM also found that the health care system had not adequately addressed disparities across patient populations, particularly when access to care is comparable (Betancourt, et al., 2003; Betancourt & Maina, 2004; Hobgood, et al., 2006). The finding that access to care is not a complete remedy to health disparities prodded the profession to recognize that other factors, such as culture, matter. Some members of the medical profession propose that culture is not only relevant to clinical encounters, but failure to address health disparities has a social impact, in that, a large segment of the population may receive similar care, but experience different outcomes (Martin, et al., 2004). The IOM proposed that health disparities in terms of race, ethnicity, and gender are not solely about the individual patient, but also have a public cost (Baquet, Carter-Pokras, &

Bengen-Seltzer, 2004; Betancourt, 2006b; Bloche, 2005), which may lead to increased poverty, disability, and mortality.

The IOM proposed that the impact of cultural differences on the social costs of health care will be exacerbated as the U.S. population becomes more multicultural, multiethnic, and multiracial (Betancourt, 2003; Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004; Godkin & Savageau, 2001; Juckett, 2005; Kripalani, Bussey-Jones, Katz, & Genao, 2006; Ladson, Lin, Flores, & Magrane, 2006; Park, et al., 2006; Tervalon & Murray-Garcia, 1998). Many medical professionals state that the demands to meet the needs of a large and diverse population will stress further a health care system that is bureaucratic, underfunded, and lethargically responsive (Anderson, et al., 2003; Betancourt, et al., 2003; Genao, Bussey-Jones, Brady, Branch, & Corbie-Smith, 2003). Politicians and health care professionals have proposed that an increasingly diverse society and a weak health care system that is unable to meet patients' needs likely will result in a poorer and sicker U.S. population; however, they state that understanding cultural differences will help remedy disparate outcomes across patient populations (Kennedy, 2005; Shaya & Gbarayor, 2006).

Some members of the medical profession further propose that cultural differences between patients and physicians have social, as well as individual health costs, especially when patients avoid encounters until their condition is severe and more expensive to treat in terms of human and capital resources (Baquet, et al., 2004; Fadiman, 1997). Additionally, patients are less likely to follow treatment recommendations diligently when their health beliefs are not compatible with what their physicians propose (Berger, 2008; Fadiman; Kleinman, 1980). The profession hypothesizes that when patients wait until their conditions become severe or do not follow treatment recommendations, care is more expensive, difficult, disruptive, and outcomes are less positive (Betancourt, 2006a). When this occurs, care becomes more expensive for everyone, since the health infrastructure distributes costs across all patients (Betancourt, 2006a).

While concerns about the sustainability of the health care system and the social costs of inappropriate diagnoses, recommendations, and outcomes are important explanatory aspects regarding why culture has become an issue in medicine, they are not exhaustive or complete in terms of the historical context for why many medical

professionals emphasize the importance of patients' beliefs, values, and practices. The history of the medical profession reveals that the basis for the current interest in culture is not new. Throughout the history of medicine, several significant social events provided the impetus for a discussion of culture, while other historical junctures have impeded discussions. However, despite the influence of history, the medical profession seldom contextualizes culture and medicine in a historical perspective.

The medical profession throughout much of its history has ebbed and flowed between descriptions of itself as being more of a science or an art (Jackson, 2002; Marcum, 2008; McCullough, 1999; Parker, 2005; Saunders, 2000; Solomon, 2008; Wailoo, 2004). The art and science debate does not preclude or reject the notion that medicine is an amalgamation of the two, but pertains to the extent that both influence medical practice. Many in medicine define the scientific aspect of their profession as empirical knowledge and evidence about diseases that are derived from natural and physical observations. A number of physicians also believe that scientific evidence is reproducible, replicable, and universally applicable (Helman, 2000; Marcum; McCullough; Saunders; Solomon). Consequently, many medical professionals perceive science as solely objective, value-neutral, and uninfluenced by social, political, and ideological factors (Helman; Kleinman, 1980; Rogers, 2004b; Saunders). Conversely, some medical professionals define the art of medicine as applications of science based on instinct, interpretations, experiences, and the uniqueness of clinical encounters (Marcum; Parker; Saunders; Solomon).

The tensions between art and science have roots in the early eighteenth century when the profession debated the importance and relevancy of patients' perspectives. The debate about patients' perspectives did not last, because social and political events shifted medicine's concerns about individuals to populations. The impact that science had on public health was an important factor to this shift. During the nineteenth century, many professionals within and outside the field of medicine attributed the rise of the medical profession and its authority over much of health care in the U.S. to advances in science and the public's acknowledgement that scientific discoveries positively impacted their lives (Geraghty & Wynia, 2000; Parker, 2005; Pescosolido, Tuch, & Martin, 2001; Starr, 1982). For example, the discovery that bacteria and poor sanitary conditions contribute

to the cause and spread of diseases led to public improvements to water supplies and waste management, which decreased the prevalence of epidemics (Geraghty & Wynia; Pescosolido, et al.; Starr). Physicians often heralded these discoveries and positioned themselves as the profession most capable of translating and implementing scientific advances on behalf of the lay public. Improvements in public health during the nineteenth century helped to solidify medicine's authority over much of health care. However, during the twentieth and twenty-first centuries, some professionals in medicine and other disciplines challenged, albeit not rejected, the dominance of science in the medical profession. Challenges to the dominance of science in the twentieth and twenty-first centuries occurred within broader social and political events that confronted inequalities and inappropriate uses of scientific advances.

The medical profession's history with respect to culture also is tied closely to patient activism and advocacy groups (Halpern, 2004; Pinn & Chunko, 1999; Rios & Simpson, 1998; Rogers, 2006; Ruzek & Becker, 1999; Wailoo, 2004). The Civil Rights Act of 1964 and the emergence of women's grassroots organizations in the 1970s that addressed health issues are two particularly relevant events and occurrences, which impacted medicine's history. The Feminist Women's Health Centers and the National Women's Health Network were founded in 1971 and 1975 respectively and were intended to advocate national policy makers on behalf of women. Women's grassroots organizations also were founded to provide women with education and health related resources (Ruzek & Becker). The grassroots and civil rights movements promoted inclusion of women and minorities in medical research, advanced the relevance of social and cultural factors, and advocated the need to understand these populations' health issues (Halpern; Pinn & Chunko; Ruzek & Becker). The civil rights and grassroots movements of the 1960s and 1970s directly raised the relevance of culture for medicine by promoting their groups' beliefs, values, and practices.

Defining Culture and Cross-cultural Competence

The medical profession primarily defines culture in terms of universality and essentialism, which is evidenced by the ways in which medicine discusses the issue (Dean, 2001; Gregg & Saha, 2006; Koehn & Swick, 2006; Tervalon & Murray-Garcia, 1998). While medicine seldom defines culture explicitly, this study inferred the

definition from how medical education integrates cultural beliefs and values into didactic and experiential efforts. The profession typically refers to this integration effort as cross-cultural education and terms the set of skills physicians should possess as cross-cultural competence (Betancourt, Green, Carrillo, & Park, 2005; Carrillo, Green, & Betancourt, 1999; Crosson, et al., 2004; Fox, 2005; Green, Betancourt, & Carrillo, 2002).

Medicine refers to the concept of cross-cultural competence as the ability of physicians to interact positively with individuals from another cultural group. Cross-cultural competence also proposes that one's culture influences clinical encounters and decisions and that not everyone shares the same health beliefs, values, and practices (Fadiman, 1997; Gregg & Saha, 2006; Kagawa-Singer & Kassim-Lakha, 2003; Koehn & Swick, 2006; Kripalani, et al., 2006; Lu & Primm, 2006; Turbes, Krebs, & Axtell, 2002). Although medicine has divergent views about cross-cultural competence, Gates and Bradley (2009) found that the profession largely categorizes the skill set into three domains: knowledge, attitudes, and skills.

The knowledge domain entails definitions about culture, such as shared traits and characteristics (Beach, et al., 2005; Dunn, 2002; Fung, et al., 2008), but not necessarily specifics about a particular group's beliefs, values, or practices (Morell, Sharp, & Crandall, 2002). However, some medical educators propose that cross-cultural competence means that physicians are knowledgeable about specific beliefs, values, and practices of groups they may serve (Anderson, et al., 2003; Beach, et al., 2005; Calamaro, 2008; Dunn; Fung, et al.; Horner, et al., 2004). Those advocating an attitudinal approach to cross-cultural education seek to teach medical professionals to be sensitive, appreciate the diversity of beliefs, values, and practices they will encounter, and recognize that cultural traits and characteristics influence patients' and, according to some, physicians' decisions about health practices and treatments (Anderson, et al.; Calamaro; Carrillo, et al., 1999; Crandall, George, Marion, & Davis, 2003; Dunn; Genao, et al., 2003; Green, et al., 2002; Horner, et al.).

The skill domain of cross-cultural competence pertains to efficient and effective communication with patients whose beliefs and values about health differ from those of their physicians (Anderson, et al., 2003; Beach, et al., 2005; Betancourt, et al., 2005; Dogra & Carter-Pokras, 2005; Dunn, 2002; Hasnain-Wynia, 2006; Juckett, 2005; Odom-

Forren, 2005; Rosen, et al., 2004; Shaya & Gbarayor, 2006; Taylor & Lurie, 2004). A common thread across all definitions of cross-cultural competence is the notion that culture is about shared beliefs, values, and practices. Furthermore, race, ethnicity, and to some extent, gender and socioeconomic status are the primary contexts in which many in medicine discuss shared beliefs, values, and practices (Betancourt, 2004, 2006a, 2006b). Although medicine has not defined culture cogently for the profession, the social sciences have grappled extensively with the meaning of cultural beliefs, values, and practices.

Some social scientists define culture in terms of a system where individuals share beliefs, values, customs, and practices that are passed from one generation to another as a way to deal with the world (J. A. Banks, 2006). Banks discussed other social scientists, who frame culture as a way of life for groups of people who unconsciously hold the same beliefs, values, practices, and symbols, which are imitated by successive generations. Some social scientists also define culture in terms of the role of communication and traditional ideas, which propose that group members coalesce primarily around shared patterns, symbols, texts, and linguistics that differentiate one group from another (J. A. Banks).

Billings (2007), a sociologist, framed beliefs and definitions of culture in terms of objective, performative, and institutional dimensions. The objective aspect pertains to the notion that culture has structure and form in texts, speech, and symbols, which provide meaning and identity (Billings). Billings' performative dimension of culture proposes that members act and behave within boundaries, as well as transform them. The institutional dimension of culture proposes that groups' beliefs, values, and practices are influenced and codified by power (Billings).

Medicine implicitly and primarily frames culture in terms of Billings' (2007) objective and performative dimensions. The objective and performative dimensions of culture also suggest that groups have essential traits and characteristics, and these definitions do not address issues of power that dominant and marginalized members engage in as they grapple over which beliefs, values, and practices should emerge as cultural. However, some in the medical profession find culture to be more complex than these two dimensions allow and propose that populations socially construct their beliefs, values, and practices and belong to more than one group (Betancourt, et al., 2003; Dunn,

2002; Engebretson, et al., 2008; Kagawa-Singer & Kassim-Lakha, 2003; Nunez, 2000). Those in medicine who believe culture to be complex also propose that group members, as well as non-members, influence and modify beliefs, values, and practices, which result in culture being dynamic.

These ways to define culture coincide with the philosophies of modernism and postmodernism. Modernism defines culture in functionalist and essentialist terms where beliefs, values, and practices are more or less inescapable, universal, and innate (A. Banks, Billings, & Tice, 1993; Narayan, 1997). Contrarily, postmodernism proposes that what we believe, value, practice, and how we institutionalize group characteristics are contextual, emergent, and socially constructed (A. Banks, et al.; Narayan). Many medical educators and social scientists define culture in terms of modernism, postmodernism, or somewhere between the two philosophies.

Kleinman (1980), a medical educator and leading voice in psychiatry and medical anthropology, proposed that culture is more nuanced and complicated than the essentialist perspective suggests. Kleinman (1980) posited that medicine is less scientific than it proclaims and is more artful than it admits. Betancourt, a physician, and Dogra, a psychiatrist, made more of a break with medicine's dominant and essentialist view of culture than Kleinman. For instance, Betancourt (2004, 2006a, 2006b) and Dogra (2001; 2007) explicitly challenged medicine not to define culture in essentialist and narrow ways where cultural beliefs, values, and practices are defined primarily by race and ethnicity. Others, such as Frisch (1990), an oral historian, and Payer (1996), a medical journalist, suggested that culture is more complicated than an essentialist and modernist perspective can explain and indicated that cultural beliefs, values, and practices can be defined more completely in terms of history, philosophy, and politics.

Several social scientists made more complete breaks with modernism and defined culture in postmodern ways. Narayan (1997), a philosopher, fundamentally deconstructed the notion of culture and rejected the essentialist perspective in lieu of factors like politics, power, resistance, and history. Similar to Narayan's way to frame culture, Banks, Billings, and Tice (1993) and Billings (2007) challenged the functionalism and essentialism of cultural beliefs, values, practices, and the inability of group members to escape shared beliefs, values, and practices.

These different perspectives reveal the complexity of culture and also provide departure points for medicine as it grapples with how to define and integrate cultural beliefs, values, and practices into the curriculum. Some in medicine are concerned that the profession defines culture too narrowly and too often in terms of race and ethnicity. They suggest that some definitions and efforts to integrate cultural beliefs and values into clinical encounters result in unintended consequences (Beagan, 2003; Betancourt, 2006a, 2006b; Gregg & Saha, 2006; Turbes, et al., 2002).

The arguments around how one defines culture, what it means to be cross-culturally competent, and what the term competence itself suggests culminated in the profession's concerns about stereotypes, which Chapter 2, *Medical Education, Culture, and Cross-cultural Competence*, examines in greater depth. Both critics and advocates of cross-cultural competence are concerned about the dangers of stereotypes. Critics cite stereotypes as a reason not to integrate cross-cultural skills into medical practice (Bloche, 2005). Advocates raise stereotypes as a concern in terms of how the profession defines and integrates culture into the medical curriculum (Betancourt, 2004, 2006a, 2006b; Dogra, Giordano, & France, 2007). The principal problem that this research investigated pertains to the concern about stereotypes and how the profession defines culture.

Problems with Culture and Stereotypes

Some members of the medical profession identify stereotypes as the most serious unintended outcome of cross-cultural education. Medicine defines stereotypes as generalizations about entire groups of people based on preconceived ideas and experiences (Berger, 2008; Betancourt, 2006a, 2006b). The unintended consequence of stereotypes is that communication does not improve during clinical encounters because some physicians believe it is unnecessary to ask some questions, and thus they fill in various information based on assumptions (Beagan, 2000, 2003). The profession attributes some problems of stereotypes to what and how medical education teaches about culture (Beagan, 2000, 2003).

In terms of education, many in the medical profession philosophically frame culture in terms of modernism where cultural beliefs and values are fixed and stable. However, others propose that culture is fluid and constantly emerging, similar to postmodernism. These different views about culture often are not included in how the

profession discusses the issue. The lack of in depth discussion suggests that culture does not need further explanation and that the profession collectively and universally shares the same definition. The absence of explicit focus on culture is a significant problem for medical education with respect to what the profession seeks to achieve and the pitfalls and traps that physicians want to avoid. This study seeks to examine more completely the relationship between medicine's understanding about culture and the likelihood that physicians stereotype some patients.

Framing Culture in terms of Social Identity Theory

Social identity theory provides the theoretical framework upon which this research examined the possible relationship between one's beliefs about culture (group identity) and their willingness to accept of stereotypes (group interactions). Tajfel and Turner, social psychologists, developed social identity theory and proposed that the categorization of individuals into groups, regardless of how arbitrary the membership, results in favoritism for one's own members and biases toward others. Stereotypes, discrimination, and prejudices figure prominently within the theory as possible outcomes of group identification (Bettencourt, Charlton, Dorr, & Hume, 2001; Billig & Tajfel, 1973; Sidanius, Van Laar, Levin, & Sinclair, 2004; Tajfel, Billig, Bundy, & Flament, 1971). With respect to this research, social identity theory helps to explain the dynamics between and within two groups: faculty members and medical residents. Social identity theory explains the possible reasons why these two groups do or do not make assumptions about patients who share or do not share their health beliefs and values.

The central components of social identity theory are group identity and interactions (Billig & Tajfel, 1973; Rubin & Hewstone, 2004; Tajfel, 1982; Tajfel, et al., 1971). The concept of cultural groups is the basis for individuals to differentiate themselves from others, as well as to identify with those they perceive as similar. The reasons for identification and differentiation pertain to power, status, pride, and resistance. Group justifications are aspects of the theory that help to explain intragroup and intergroup interactions, such as favoritism toward one's own members and the perception that others are more stereotypical than oneself (Bettencourt, et al., 2001; O'Flynn & Britten, 2006; Rubin & Hewstone; Verkuyten, 2005).

Social identity theory is appropriate for this study because the framework makes context important, which coincides with the ways in which this research discusses culture. However, as suitable as the theory is for this research, there are aspects of intragroup and intergroup interactions that the framework does not address explicitly. Social identity theory does not explain specific aspects of group identity and interactions, such as the role of history, politics, and resistance. Postmodernism explains much more completely the impact that history, politics, and resistance have on why individuals coalesce into groups and what motivates their interactions with others. Chapter 2, *Explaining the Arguments for Modernism and Postmodernism* expands upon this issue. Despite these limitations, social identity theory remains a tenable framework to conceptualize the dynamics of intragroup and intergroup relationships and the factors that influence them.

Research Study

This study focused on beliefs about culture instead of questions about what the skills are and how medical educators teach medical residents. Medicine often discusses culture in terms of subsets like race, ethnicity, gender, and social class; however, medical education seldom raises questions about the nature or meaning of the construct (Gates & Bradley, 2009). This research sought to understand philosophical perspectives of faculty members and medical residents as expressed through their personal epistemological beliefs about culture.

Personal epistemology with respect to what one believes about the nature and acquisition of knowledge provides a glimpse into the individual's philosophy. This insight into one's personal epistemology makes the framework tenable to approximate whether or not individuals' beliefs about culture are congruent with modernism or postmodernism. Furthermore, this research examined whether or not personal epistemological beliefs about culture impact the likelihood that one is willing to accept stereotypes. Additionally, this research examined what faculty members report that they formally and informally teach about the nature of culture and what medical residents learn about cultural beliefs, values, and practices during their medical education.

Research Questions

This study queried four phenomena: philosophical perspectives, agreement between groups, the relationship between beliefs about culture and willingness to accept stereotypes, and the impact of education. The specific research questions are

1. What are faculty members' and medical residents' beliefs about culture and their willingness to accept stereotypes?
    1.1. What do faculty members and medical residents understand about the nature of culture?
    1.2. What do faculty members and medical residents understand about intervening factors that influence what they believe to be cultural?
    1.3. What do faculty members and medical residents believe about stereotypes?
2. What is the philosophical agreement between faculty members and medical residents with respect to beliefs about culture and willingness to accept stereotypes?
    2.1. To what extent do faculty members and medical residents believe that medical education contributes to the way they understand culture?
3. What is the relationship between one's philosophical perspective regarding beliefs about culture and willingness to accept stereotypes?
4. What do faculty members report that they teach to medical residents about culture?

Significance

Cross-cultural competence and culture are a challenge to study. There are numerous departure points for both issues and each divergence is nearly limitless. This research examined culture in terms of what one understands about beliefs, values, and practices as conveyed through personal epistemology. Specifically, this study examined the relationship between what faculty members and medical residents philosophically understand about culture and their willingness to accept stereotypes. While the literature about what cross-cultural competence means and how medical schools integrate the skill set is extensive, there is a dearth of research about how physicians define culture. The

findings of this study have implications for how medicine should integrate culture into the curriculum in ways that minimize stereotypes.

The second component of this research examined what faculty members teach about the nature of culture and how congruently they and medical residents understand cultural beliefs and values, as they relate to health care and outcomes. This research examined what medical residents state they have learned about culture during their medical education. Congruence between the two groups provides evidence about the success of cross-cultural didactic and experiential efforts.

Summary

Medicine attributes some disparities in health outcomes to cultural differences between patients and physicians; however, the profession's understanding of culture is seldom part of the discussion. The medical literature frequently does not address how the profession frames culture; instead, medicine focuses almost exclusively on the skill set for cross-cultural competencies and how to teach them. However, the history of medicine provides insight into why the profession frames culture as it does. Chapter 2: Review of the Literature discusses the different ways in which medicine and the social sciences frame culture and how some definitions of the construct influence clinical encounters in unintended ways. The methods that this research used and the population of interest are discussed in Chapter 3: Research Design. Chapter 4: Results addresses each research question, analyzes the results, and explains the collected data. The study's summary, implications, and conclusions are presented in Chapter 5.

Chapter 2: Review of the Literature

Health disparities among different groups who received similar medical care is a primary factor that led medicine to consider the possibility that cultural beliefs, values, and practices are relevant to clinical encounters. Medicine began to document health disparities across patient populations as early as the 1970s (Wailoo, 2004; Williams & Rucker, 2000), primarily in terms of race and ethnicity. Many in the medical profession also attribute health disparities to explanatory factors like individuals' personal behaviors, environmental conditions, biology, and the patient – physician relationship. This study is interested primarily in the patient – physician relationship and the impact that culture has on clinical encounters when the two have different beliefs and values.

The ways that medicine understands culture are central to this study; however the medical literature is neither extensive nor explicit in how the profession frames cultural beliefs and values. Much of the medical literature about culture and cross-cultural education focuses on why medicine believes cultural beliefs and values are relevant, why the competencies are important, what it means to be competent, how schools teach the skills, and how education may contribute to unintended consequences. However, other disciplines like anthropology, sociology, philosophy, and history have defined and examined culture in detail. To understand and frame culture more completely, this study drew from a broad cross section of the literature to include medicine, medical anthropology, history, psychology, sociology, and philosophy.

This review clusters the literature around four concepts that explain the context and definition of culture: the art and science of medicine, medical education, philosophical perspectives, and group identity and behavior. Although the works that contribute to this research are grounded in their disciplines, the literature review discusses commonalities, as well as arguments across and within fields. The many ways in which social scientists and medical educators define culture and the implications that various definitions have on how physicians interact with patients whose health beliefs, values, and practices are different also are examined in this literature.

This literature review also reveals that culture is not an entirely new aspect of the patient – physician relationship, as some medical professionals suggest. The literature review starts with a history of the art and science of medicine, as a way to provide

context for why the profession is interested in culture. A description and analysis of the current lay of education follows the historical analysis and frames the different ways in which medicine defines culture. The literature review concludes with an analysis of how social scientists and medical educators frame culture in terms of modernism and postmodernism, how one's philosophy can be measured, and the theoretical framework which underlies the study.

The historical analysis indicates that medicine considered culture relevant for education and practice well before the 1970s. This analysis helps to contextualize and explain the variant meanings of culture in medicine. Frequently, the profession frames culture and practice in terms of the art and science of medicine. Although many in medicine described their practice as art and science well before the eighteenth century, this study's historical analysis begins with the eighteenth century, when many medical and lay professionals challenged medicine to integrate more aspects of art into practice. The historical analysis continues with the professionalization of medicine in the U.S. during the nineteenth century and concludes with the civil rights movement of the twentieth century.

Focusing on the Patient's Perspective in 18th Century France

The eighteenth century provides a starting point for how medicine has grappled with the art and science of practice. Communication between patients and physicians was a major concern during the eighteenth century. The concerns about communication largely entailed the notion that individuals' perspectives matter and that the physical examination is not the only important factor for clinical decisions (Foucault, 1973). The initial reasons some professionals inside and outside of medicine believed culture was relevant to the encounter pertained to the notion that objective observations and science are insufficient for clinical decision-making and that patients are more than objects from which to extract data.

Foucault, a historian and philosopher, was interested in the relationships among knowledge, power, and the individual (Pinar, 1998). These interests were not limited to medicine and eighteenth century France. During the 1970s, Foucault (1973) analyzed eighteenth century French medicine and discussed how knowledge and power differences between patients and physicians impacted the relationship between the two. Foucault

found that most physicians have more knowledge and power in the clinical encounter than most patients and that medical professionals used these differences to position themselves as the most important participant in the relationship. Foucault's discussion of knowledge, power, and how they impacted eighteenth century clinical encounters and practice can be framed in terms of art and science. The concept of medicine as art and science also provides context for how the profession grapples with culture and its relevance for the clinical encounter. Foucault's analysis illustrated that arguments about knowledge, power, and individuals were not only relevant for the twentieth century, but influenced relationships throughout history; the subtext of the discussion was that these issues are ongoing struggles.

During the French Revolution of 1789, some medical professionals argued that the art of medicine was important with respect to patients' perspectives of their illnesses (Foucault, 1973). This shift in what was important to the clinical encounter occurred during the political, social, and economic upheaval of the French Revolution; however, medicine in France was a well-established profession and had a number of exemplar schools and apprenticeships to prepare physicians (Foucault). The French Revolution was a tumultuous time where the middle class began to dismantle the political, social, and economic hegemony of the aristocracy along with institutions that suppressed or treated the different social classes inequitably. One of these institutions was medicine where quality care was typically accessible only to the aristocracy and privileged (Foucault).

Prior to the French Revolution, health care for the economically disadvantaged typically was provided in hospitals (Foucault, 1973). The conditions for care were overwhelmingly inferior and frequently contributed to the spread and exacerbation of diseases, in part, because hospitals were overcrowded, underfunded, and unsanitary (Foucault). Furthermore, hospitals oftentimes ignored the importance of individuals' perspectives, because physicians had too many patients for whom they had to provide care, attended to numerous and diverse diseases, and treated those who were in the poorest health (Foucault). These factors minimized the importance of patients' perspectives and had an overwhelmingly negative impact on the economically disadvantaged, who typically had no professional source of care other than hospitals (Foucault). The overcrowded condition of hospitals created encounters where patients'

medical history was about the extraction of information, reliance on observations, clinical knowledge, and skills (Foucault).

Foucault (1973) did not argue that observations, clinical knowledge, and skills are unimportant to the clinical encounter, but that hospitals did not balance the importance of patients' perspectives with these other factors. This approach also positioned physicians in almost complete control of patients' health where individuals had little power (Foucault). Patients were passive participants in their health care and management whereas physicians were active, knowledgeable, and understood science.

Hospital care suggested that science, almost to the exclusion of art, matter most and not patients' perspectives or how they understand their illness. Science was important for practical reasons like trying to treat as many patients as possible in the most efficient manner. Also, many physicians, during this period, believed that objective data matter more than patient provided information (Foucault, 1973). The small number of physicians and the large number of patients necessitated that encounters occur rapidly and efficiently, and many believed that empirical observations were the most efficient method to treat many individuals as quickly as possible (Foucault).

The economic situation of hospitals and the health outcomes for the economically disadvantaged population that physicians served were evidence for the revolutionists that the delivery of medicine was influenced by politics (Foucault, 1973). The sole focus on science and the near exclusion of patients' perspectives pertained more to maintaining the power of physicians in the relationship than what was necessary for diagnoses and treatment recommendations (Foucault). The factors that contributed to a class-based system for health pertained to who controlled and had access to knowledge, who entered the profession, and where care was provided (Foucault). The aristocracy and privileged classes often had advantages across all of these factors. According to some, science and reason were justifications for the status quo (Foucault).

For example, access to medical knowledge was reserved for the aristocracy and privileged classes who had resources either to pay for training or to secure an apprenticeship (Foucault, 1973). Science also consolidated power with physicians and led them to ignore or discount the importance of patients' perspectives and what they understood about their illnesses or diseases (Foucault). The objectification of patients

was greater for the economically disadvantaged classes, because the aristocracy received care at home or in small private clinics (Foucault). Regardless of where the aristocracy received care, they were in less competition for physicians' attention than the economically disadvantaged classes who sought care in hospitals.

The French Revolution had a number of impacts on medicine beyond the criticism of patient objectification and the inferior care provided in hospitals. Some historians attribute the rise of clinics to the French Revolution, which proposed that care was not based solely on science (Foucault, 1973). Clinics that grew out of the French Revolution sought to create affective environments where individuals felt safe and comfortable (Foucault). A number of medical professionals at the time believed that the affective environment of clinics improved health outcomes (Foucault). The French Revolution, which rebelled against the class hegemony of France, created conditions in which changes and challenges to the dominant model of medicine and medical care were possible; this tumultuous period also illustrated tensions between the art and science of practice.

The French Revolution and the conflict between the aristocracy and poor paralleled the arguments among the medical profession, the public, and the government over the influence that the art and science should have on medicine. The extent to which some in eighteenth century France perceived medicine as an art and science changed as a result of the French Revolution, class conflicts, social inequalities, economic disparities, political unrest, and not one event or set of conditions (Foucault, 1973). Socially and politically, medicine portrayed itself as almost solely scientific and objective where its techniques and practices were universally applicable in clinical encounters. Many in eighteenth century France argued that patients were important and should be active in clinical encounters (Foucault). Advocates for the recognition of patients' perspectives, embodied in the art of medicine, sought to counter the dominance of science and integrate the two into clinics where the aim was to improve health outcomes (Foucault).

Using Science to Professionalize Medicine during the 18th and 19th Centuries

In contrast to eighteenth century France, which questioned the dominance of science and the impact that it had on clinical encounters, some medical historians attribute the rise of American medicine to scientific advances and discoveries, such as the

introduction of the stethoscope in 1816 that allowed physicians to listen to internal bodily sounds (Geraghty & Wynia, 2000; Parker, 2005; Pescosolido, et al., 2001; Starr, 1982). While science contributed much to the growth of the medical profession in the U.S., this aspect of medicine alone does not explain why physicians became highly regarded and how they acquired high social and professional status. Many factors, such as power and politics along with science, contributed to changes in medical professionalism. As lay people began to understand the implications of science for health, many in government and medicine wanted physicians to incorporate the most current advances and discoveries into practice (Starr).

During the eighteenth and nineteenth centuries, the U.S. medical profession lacked the educational structure and prestige of European medicine, particularly in comparison to Germany and France (Bonner, 1998; Hodges, 2005; Starr, 1982). Medicine in the U.S. lacked strong and universal control over its profession, access to education and practice was open, the public often sought to treat itself, practitioners seldom worked fulltime, and there were few standards to define medical competence (Hodges; Mindrum, 2006; Pescosolido, et al., 2001; Starr). All of these factors were obstacles for medicine to become a highly regarded profession; however, some physicians who attended credible schools and apprenticeships, often in Europe, enjoyed high status and did not want the public to confuse or associate them with others in medicine who lacked their level of education or skills (Starr).

Many in medicine perceived professionalization as a way to improve physicians' status with the public, as well as become a more highly paid profession (Flexner, 1910; Starr, 1982); however, there was not always agreement about how best to achieve this goal. Some in medicine focused almost solely on control over who was eligible to practice, while others sought primarily to advance the profession along with science and technology in order to create a dependency relationship with the public (Starr). As medicine became more scientific and technical, lay people were less likely to attempt to treat themselves.

Some in medicine saw these proposed changes as an attempt to deny the larger public access to medical knowledge and providers (Starr, 1982). For instance, at the start of the nineteenth century, Samuel Thomson, a leader in botanist medicine, believed that

the general public had the capacity to understand much of the knowledge that the profession wanted to control (Starr). Although medicine continued to debate what professionalization entailed, many medical reformists settled on improvements to education, integration of scientific evidence and technology into practice, and the requirement of state licensure. In essence, the goals were intertwined, because control over access to education meant that the profession would determine the supply of physicians and who would practice medicine (Starr).

This effort started with the establishment of a strong politically active professional organization, the American Medical Association (AMA) (Starr, 1982). During the middle nineteenth century, the AMA lobbied state legislatures on behalf of the profession for control over education and the need for licensure. The association often pointed to the many newly developed tools and scientific discoveries, as well as the large number of physicians who were unprepared to use them, to make the case that medicine needed to professionalize (Starr).

During the early and middle nineteenth century, scientists began to understand that bacteria and poor sanitary conditions contributed to the cause and spread of diseases (Starr, 1982). These discoveries impacted social policies around disease prevention and demonstrated the value of science for medical education and the public good (Geraghty & Wynia, 2000; Pescosolido, et al., 2001; Starr). Endemic diseases like cholera were controlled largely as a result of science and the public understood the impact that these advances and discoveries had on public health (Starr). As the public accepted the importance of technological developments, medicine attached itself to science and used this connection to gain control over its profession largely through education. Control of education was central to professionalization, because the skills and competence of physicians were difficult to determine. Education largely consisted of apprenticeships, proprietary and for-profit schools, as well as colleges and schools of medicine (Hodges, 2005; Starr).

By the start of the 1920s, medicine gained some control over education, a result of legislative advocacy by the AMA that medical training needed to be scientific. Schools that were unable to provide a scientific education closed (Arky, 2007; Ebert, 1992; Harley, 2006; Hoover, 2005, 2006; Mindrum, 2006; Moseley, 2006; Regan-Smith, 1998).

Many attributed the closure of medical schools, particularly institutions that accepted women and blacks, to the Flexner report commissioned by the Carnegie Foundation (Harley; Hoover, 2005, 2006; Mindrum; Moseley). The purpose of the report was not to cause the closure of any schools, but to require schools to standardize medical education and provide scientifically based training. The Flexner report (1910) became the fundamental structure for medical education (Arky; Ebert; Fox, 1999; Harley; Hoover, 2005, 2006; Mindrum; Moseley). Twenty-first century medical education continues to be based on the Flexner structure.

Flexner (1910) proposed a four year medical curriculum where the first two years taught the basic sciences like chemistry, anatomy, physiology, pharmacology, and pathology and the last two dealt with clinical experiences where medical students honed their skills. Flexner also advocated that students' education needed to include laboratories for the basic sciences and hospitals for clinical experiences. Flexner suggested that physicians needed to be researchers and be prepared to evaluate scientific data in order to surmise when there was little or no evidence. While Flexner believed that a rigorous, scientific, and standardized education was critical for modern medicine, the report also proposed that physicians needed social skills to interact with patients and family. The physician as researcher and communicator suggested that science is important, but so are other aspects like art (Flexner).

The Flexner report (1910) sought to structure and standardize medical education to ensure minimal differences between physicians and to promote a greater reliance among professionals on objectivity, science, and evidence (Ebert, 1992; Mindrum, 2006). Many in the profession believe that physicians educated at one school should be comparable in practice to every other medically trained professional and that a scientific and standardized education is the best way to achieve the goal. However, medical education and the dominance of science in the curriculum were not the only efforts that medicine used to gain control over the profession (Starr, 1982).

The emergence and growth in political power of the AMA in the middle nineteenth century allowed the profession to lay the groundwork for changes in education and to advocate the requirement that a license was necessary to practice (Geraghty & Wynia, 2000; Starr, 1982). Successful implementation of these efforts meant that

medicine gained the ability to police itself. The AMA argued that local and state regulation was necessary, because the public was unable to rely on medical professionals to be competent (Geraghty & Wynia; Starr). The AMA based their position on the notion that the public needed protection from questionable practitioners and that patient outcomes suffered when there were no entry requirements for physicians to practice medicine (Starr). However, not everyone in medicine was enthusiastic about licensure requirements.

Many profit-oriented and corporate schools viewed licensure as an effort to marginalize or drive them from the profession, since licenses were tied to school accreditation (Starr, 1982). These schools understood that they likely did not meet accreditation standards. Elite and privileged physicians did not see the benefit of state licenses and thought the requirement would decrease their influence and status, if they were comparable to everyone else (Starr). Despite concerns of corporate schools and elite physicians, the professionalization of medicine resulted in two requirements prior to practice: matriculation from a legitimate and accredited program and successful completion of state examinations. Licensure was the final stamp of approval to indicate that physicians were competent and possessed minimal skills to practice. The AMA's advocacy for education and licensure was aided by the technological revolution of the middle nineteenth and early twentieth centuries, because these advances allowed the organization to argue that only physicians trained at legitimate schools were capable of using the new technologies. Technology was central to the argument that medicine needed to professionalize in terms of education and licensure.

In the middle nineteenth century, scientists had developed a number of diagnostic tools, such as stethoscopes, ophthalmoscopes, and laryngoscopes, to evaluate patients (Starr, 1982). Physicians previously learned this information from patients, but no longer had to rely on individuals' subjective data (Starr). These new diagnostic devices also increased the public's dependence on physicians who knew how to operate, read, and understand the findings (Starr). As technology grew in importance to the practice of medicine and physicians expanded their control over health care, scientific advances played a central role in the profession's ascendancy to the pinnacle of health care and the

subordination of other professionals like midwives, pathologists, radiologists, and nurses (Starr).

While the use of new technologies and diagnostic tools like x-rays required expertise and training, some health professionals during the time did not believe physicians were necessary to operate the devices or to analyze the results (Starr, 1982). However, as these new technologies and tools emerged, the AMA used educational and licensure requirements, along with their political power, which was greater than other professions, to argue that they were positioned best to control the expansion and growth of health care. While there were not enough physicians to operate all these new technologies, they lobbied hospitals to allow them to supervise others and to analyze the results (Starr).

Physicians relied upon the public's belief that increased specialization and skills were needed for medical practice (Starr, 1982). For instance, midwives lost their argument with obstetricians who proclaimed that tools like forceps and clamps made the delivery of babies too technical for non-specialists (Starr). Similar arguments occurred in other professions like nursing which was largely independent of medicine's supervision (Starr). By the early twentieth century, nurses were well-entrenched in the administration of anesthesia; however, physician anesthesiologists succeeded in their goal to wrest anesthesiology from nurses and to control the service (Starr). The anesthesiologists argued that the procedure was too specialized and technical for non-physician specialists (Starr). Starr, a historian, proposed through these examples that the professionalization of medicine pertained to power and politics as much as to science. Medicine sought to improve and secure its position and status within American society, and the profession perceived science, not art, as a way to achieve this goal.

As medicine subsumed midwives and nurses, other professions like social work, which were dominated by women, sought to become more like medicine and other high status scientific professions (Tice, 1998). The aim of social work was to become a more valued profession (Tice). Social work shared a number of similarities with medicine, such as diverse types of professionals who provided services, the diagnostic approach toward individuals, and the debate about how extensively practice should be influenced by art and science. However, the two were unlike in other ways, such as medicine's

dominance by men and the high status of some physicians. Many professionals in early social work believed that standardized case reports were the best way to inform the profession about how to help, control, and correct deviancy for certain groups assumed to be poor, mentally disabled, and morally corrupt (Tice). Standardized methods to investigate, practice, and manage charity work played an important role in the ascendancy of social work over charitable organizations, which eventually sought to replicate social work's focus on documentation (Tice). Tice, a social scientist, proposed that the diagnostic approach toward individuals was central to social work's desire to be recognized by others as being an objective and scientific profession.

However, some within the profession criticized these approaches as the sterilization of social and charitable works and the minimization of the art of practice, and others belittled the effort to become more objective (Tice, 1998). Tice found that social work's professionalization was complicated by the overwhelming prevalence of women, historic involvement with the poor, and attacks from male dominated fields like psychiatry and sociology. These factors were obstacles to social work's efforts to become a more respected profession and led others like psychiatrists and sociologists to view social workers in marginalized ways. However, many professionals believed that a more scientific and objective approach to discovery and case management, along with a professional vocabulary, would be instrumental in social work's recognition as a legitimate profession (Tice). For example, a number of organizations like the Salvation Army, which primarily was supposed to be about redemption and rehabilitation, succumbed to the perceived value of rigorous documentation (Tice). In a broader context, medicine and other professions, such as social work, understood the impact that science had on the public and how a growing number of lay individuals expected scientific advances and objective approaches to assessment to be integrated into professional practices (Starr, 1982).

The medical profession's focus on science and standardization in the U.S. during the nineteenth century was contrary to the eighteenth century French Revolutionists' efforts to highlight the importance of the art of medicine for practice. Tice (1998) also found that many social workers were concerned about their profession's objectification of individuals. There were many physicians in eighteenth century France and nineteenth

century U.S. who acknowledged that medicine was art and science. The focus on art or science during these two periods exemplified that factors outside of medicine influenced how medical education and practice evolved. Likewise, medicine impacted other professionals, such as psychologists, social workers, nurses, and laboratory technicians, and their efforts to become more like physicians, that is, more scientific, objective, and standardized.

For example, social work like medicine had a number of within field debates about how extensively art and science should influence the profession where some social workers wanted to standardize reports, others wanted to approach case work in a more narrative way, and a number of professionals sought to balance the art and science of their practice (Tice, 1998). In many respects, social work patterned the ways it recorded cases after more scientific professions like sociology and psychology (Tice). This was done for professional legitimacy and because social work had close relationships with scientific disciplines like psychology (Tice). Despite the different goals and approaches toward patients and individuals among professions like medicine, psychology, social work, and sociology, they all debate the extent to which their work is art and science. Their histories illustrate that some within their professions advocated a more scientific leaning whereas others proposed their work was a combination of art and science.

The art and science history of medicine reveals that context matter for how extensively the profession believes that it is an amalgamation of the two. For example the French Revolution led some French physicians to question their almost sole reliance on science and their lack of attention to patients' perspectives. This challenge to the one-sidedness of French medicine occurred during an economic, social, and class revolution; however, French medicine during the eighteenth century was a well established profession. Contrarily, the medical profession in the U.S. was more tenuous than its counterpart in France. Physicians in the U.S. during the eighteenth and nineteenth centuries sought to establish themselves as a highly regarded profession, and many professionals perceived science as a more likely vehicle to achieve this goal than art. The outcomes of the French Revolution on medicine and the factors that contributed to the rise of the medical profession in the U.S. illustrated the importance and relevance of context on how physicians viewed the role of art and science for practice. The U.S.

public and medical profession would not challenge the dominance of science that emerged during the professionalization of medicine in the eighteenth and nineteenth centuries in a major way until the rise of social movements during the 1960s.

Interpreting Social Movements and Scientific Advances in the 20th Century

The civil rights movement of the 1960s marked a major social and political event that influenced how the public and physicians interpreted the art and science of medicine and laid the most direct bases for culture's relevance for clinical encounters. The civil rights movement, largely identified with social justice and equality, had a direct impact on how medicine educated physicians. However, well before the civil rights movement of the 1960s, medicine had had an impact on how some blacks and women perceived the profession, and this provided context for why many called for changes in health care.

During slavery, some physicians and medical scientists used black bodies for experimentations, because they believed that blacks were mentally inferior and physically durable (Suite, La Bril, Primm, & Harrison-Ross, 2007). Black women and men frequently were involuntary subjects of medical experiments during the middle nineteenth century. One notable experiment sought to perfect a surgical procedure to repair vesicovaginal fistulas, an abnormality where urine discharges involuntarily and continuously into the vaginal vault (Suite, et al.). Dr. J. Marion Sims, often referred to as the father of modern gynecology, perfected the procedure after numerous painful operations on women slaves (Suite, et al.); these surgeries occurred prior to anesthesiology. Other experiments involved male slaves, such as Dr. Thomas Hamilton's trial to develop a medication for heat strokes (Suite, et al.). This trial studied the effects that different medications had on slaves whom he placed in pits for several days with their heads exposed to sun and heat (Suite, et al.).

Unauthorized and deceptive medical trials on blacks continued into the twentieth century with one of the most well known being the Tuskegee syphilis experiments which started in the 1930s in rural Alabama and concluded forty years later (Francis, 2001; Seto, 2001). Medical researchers conducted the study solely with black men and sought to understand the effects of syphilis on the body (Eiser & Ellis, 2007; Francis; Mindrum, 2006; Reverby, 2008). Initially, the trial was well intentioned, but once a vaccine for the disease was discovered, physician researchers withheld treatment to study the effects that

the disease would have on the body (Eiser & Ellis; Francis). The outcome for some of these men was death. These types of medical experiments often overused and misused blacks; yet, the provision of health care and access to providers were unequal, limited, and sometimes inferior compared to the larger population (Francis; Kai, Bridgewater, & Spencer, 2001; Williams & Rucker, 2000).

The experiences of women with the medical profession were different from those of blacks, but this population of patients was objectified too. During the eighteenth and nineteenth centuries, health issues about women largely focused on their bodies and reproduction (Hoffman, Magrane, & Donoghue, 2000). Until the rise of medicine as a profession, midwives had managed women's health and childbirth (Hoffman, et al.; Ruzek & Becker, 1999; Starr, 1982). After medicine grew into a highly regarded profession and provided the majority of health care, the largely male professionals replaced midwives as providers for women's health (Hoffman, et al.; Rogers, 2006; Ruzek & Becker).

Similar to pre-French Revolution medicine, U.S. physicians relied heavily upon science, which had the effect of silencing some women, since medical professionals considered observations and techniques more important to the clinical encounter than patients' subjective information. Some women advocacy groups and organizations found that their decreased numbers in the medical profession exacerbated the extent to which medicine silenced their population. For example, some patients did not raise issues outside of childbirth, because they did not believe that their health accounts would be respected or legitimated by their male physicians (Rogers, 2004a; Ruzek & Becker).

The experiences of blacks and women that culminated in the rise of the civil rights movement of the 1960s were different, but both illustrated the extent to which medicine relied on and misused science. Some blacks developed a strong distrust of physicians and scientists as a result of historic abuses (Francis, 2001; Kai, et al., 2001; Suite, et al., 2007; Williams & Rucker, 2000), and women did not believe that medicine attended in a real way to their concerns (Hoffman, et al., 2000; Rogers, 2006; Ruzek & Becker, 1999). The results of these experiences were that blacks and women sought many of the same outcomes from the civil rights movement to include improvements in trust and respect between patients and physicians and the legitimization of their

perspectives of health and illness (Eiser & Ellis, 2007; Halpern, 2004; Suite, et al.; Williams & Rucker). Many medical professionals proposed that increases in the number of minorities (Lim, Luo, Suo, & Hales, 2008; Suite, et al.; Williams & Rucker) and women (Ruzek & Becker) who practiced medicine were ways to address these issues.

As the medical histories of blacks and women illustrated, trust was an issue for some patients who were reticent to provide a complete account of their conditions. This was particularly true for blacks who believed that physicians sought to experiment on them (Eiser & Ellis, 2007; King, et al., 2008; Mindrum, 2006). Women also had trust issues with the largely male population of physicians who sometimes framed their health concerns outside of reproductive care as hysteria (Pinn & Chunko, 1999; Rogers, 2006; Ruzek & Becker, 1999). Some medical professionals have suggested that an increase in racial, ethnic, and gender diversity is one remedy for the lack of trust that blacks and women had with some physicians. The diversity proposal for some medical professionals meant that health disparities can be reduced if black and women physicians were available for black and women patients, which medicine refers to as patient – physician concordance.

Medical professionals who have examined patient – physician concordance propose that patients more openly and more completely provide information about their conditions when they share ethnicity, race, or gender with their physicians. Patients also are more likely to follow treatment recommendations when they are in ethnic, racial, or gender concordant relationships (Berger, 2008; Cooper, et al., 2003; Eiser & Ellis, 2007; R. L. Street, O'Malley, Cooper, & Haidet, 2008). However, findings from patient – physician agreement studies are mixed with respect to the impact that similar race, ethnicity, or gender have on clinical encounters. Some studies suggested that patient satisfaction improves when ethnic, racial, or gender relationships are concordant, while others did not find improvements.

One concordance study suggested that patient – physician concordance did not improve the relationship or communication between the two; however, the study found that physicians are more patient-centered with individuals they find to be more active in their care (R. L. Street, Jr., Gordon, & Haidet, 2007). In another concordance study, Cooper, Beach, Johnson, and Inui (2003) found that patient – physician race concordance

resulted in improved patient satisfaction and a more positive perception of the communication process.

Konrad, Howard, Edwards, Ivanova, and Carey (2005) found that patient – physician concordance was contextual and likely depended on factors other than race. Their study investigated the impact that race had on the management of hypertension to include detection of the disease and medication regimens (Konrad, et al.). Konrad et al proposed that continuity of care seemed to be the most important factor for patients and the management of their hypertension. However, black patients who had to use public clinics fared better in the management of their hypertension when they were in concordant relationships (Konrad, et al.). This finding may pertain as much to social class as race, since patients who use public clinics may not have comparable continuity of care compared to those in private clinics (Willems, De Maesschalck, Deveugele, Derese, & De Maeseneer, 2005). The Konrad et al study did not explicitly consider the impact of social class.

Blanchard, Nayar, and Lurie (2007) sought to understand the relationship between race and ethnicity concordance and patients' perceptions that they were not respected during encounters with physicians and office staff. They found that black and Latino concordance matters for their relationship with staff, but not physicians. However, Asian patients were more comfortable and believed they were respected more in concordant relationships with physicians whereas Latinos indicated they were disrespected more during encounters with ethnically similar medical providers (Blanchard, et al.). Although, the concordant studies discussed here address different issues of the patient – physician relationship, such as satisfaction, communication, clinical care, and respect, none of the studies provided evidence that patient outcomes improved when individuals and medical providers share the same race, ethnicity, or gender. However, a limitation of some of the studies is that they discuss too few patient characteristics and the interactions that race, ethnicity, gender, and social class may have on concordant relationships.

The suggestion by some medical professionals that patients should seek health care from members of their respective racial, ethnic, or gender group is unrealistic and problematic (Betancourt, 2006b; Betancourt & Maina, 2004; Eiser & Ellis, 2007; Rios & Simpson, 1998). The implementation of patient – physician concordance would have the

effect of requiring racial, ethnic, and gender quotas for medical schools, which would result in the re-segregation of the provision of care. Patient – physician concordance also suggests that group members have essential traits and characteristics that do not vary. A central shortcoming of patient – physician concordance is that the concept does not recognize the interactions of race, ethnicity, gender, and social class. For example, race concordance suggests that members of a particular group do not vary in terms of gender or social class. A departure from the essentialism embedded in the implementation of patient – physician concordance, many in medicine advocate that their profession needs to diversify the ranks of faculty, staff, residents, and students.

A number of medical professionals propose that the impact of racial, ethnic, and gender diversity extend beyond issues of trust and the patient – physician relationship. They suggest that diversity's impact more broadly affects cross-cultural education in terms of peer interactions and policy development (Betancourt, 2006b; Betancourt, et al., 2003; Kripalani, et al., 2006; Shaya & Gbarayor, 2006). Some medical educators propose that a diverse workforce provides opportunities for faculty members, medical residents, and students to learn about diverse beliefs, values and practices from each other (Kripalani, et al.; Shaya & Gbarayor). Interactions with diverse cultural groups can foster and allow faculty members and medical residents to model appropriate cross-cultural behaviors that they will need with patients. Some medical educators also find that diverse beliefs, values, and practices among physicians and medical residents facilitate recruitment and retention. A more diverse leadership likely will facilitate the profession to understand and respect diversity as different ideas about research, professionalism, and health emerge. Diversity within medicine's leadership also likely means that decisions and the evolution of the profession will be more inclusive and representative of the broader population (Betancourt, 2006b; Betancourt, et al., 2003; Shaya & Gbarayor).

Medicine has succeeded in diversifying the profession in terms of gender; however, the diversity of underrepresented racial and ethnic minorities has been relatively static. The diversification of specialties also has been mixed, in that, some are much more diverse than others. The medical profession, since 2002, has increased continuously the percentage of all women who graduate from medical school ("Facts: Applicants, Matriculants, Graduates, and Residency Applicants," n.d.). In 2008, 49.3%

of all medical graduates were women compared to 45.3% in 2002 ("Facts: Applicants, Matriculants, Graduates, and Residency Applicants," n.d.), as shown in Figure 2.1.

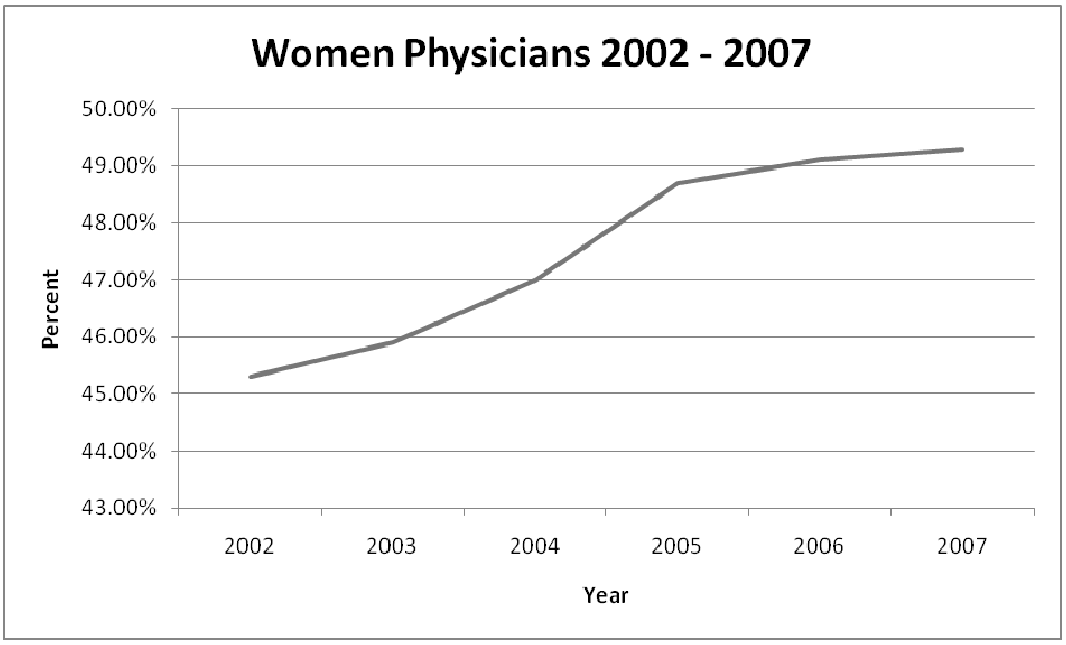

Figure 2.1, Women Physician Trend 2002 – 2007

The progress in terms of gender is contextualized further when one realizes that the percent of all women graduates from medical school in 1961 was 5.5% ("Facts: Applicants, Matriculants, Graduates, and Residency Applicants," n.d.). The trend data for racial and ethnic minorities are less positive than that of women. The percentages of medical graduates who are black, Latino, and American Indian appear to be static and small, as shown in Figure 2.2. Blacks, Latinos, and American Indians respectively comprised 6.86%, 7.32%, and1.16% of all medical graduates in 2008 ("Facts: Applicants, Matriculants, Graduates, and Residency Applicants," n.d.).

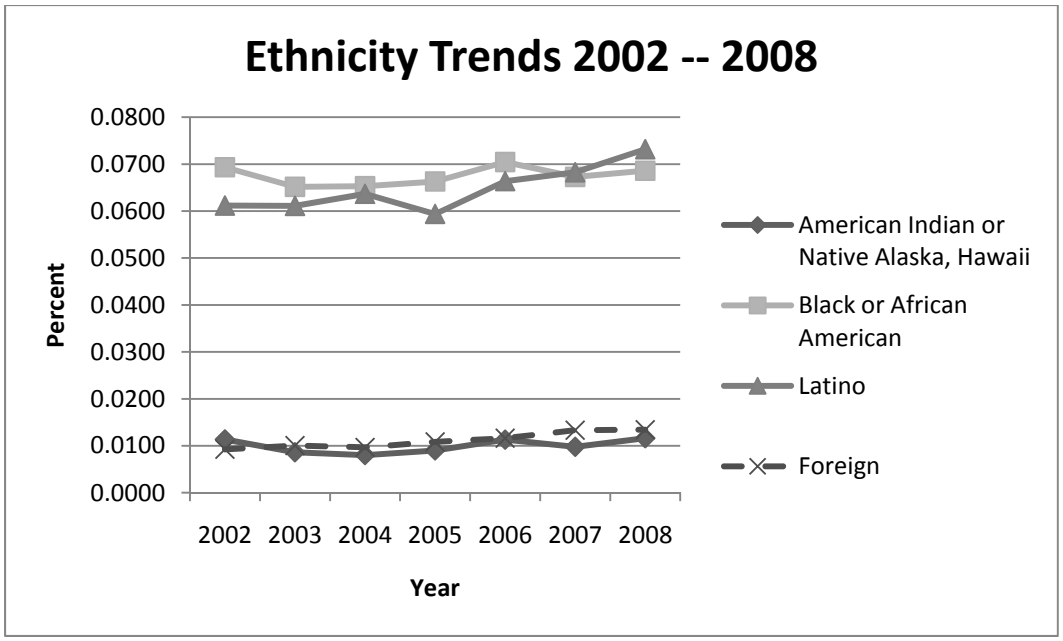

Figure 2.2, Race and Ethnicity Trend 2002 – 2008

Caucasian and Asian medical graduates, during 2002 – 2008, also have remained somewhat constant at an average 63.76% and 20.13% respectively ("Facts: Applicants, Matriculants, Graduates, and Residency Applicants," n.d.).

While gender differences between men and women overall seem to have improved over the past 6 years, especially when compared to race and ethnicity, the diversification of specialties has not been uniformed. Brotherton, Rockey, and Etzel (2004), who surveyed medical residents in 2003, found there are a number of medical specialties, such as orthopedics, otolaryngology, radiology, and general surgery, which are overwhelmingly dominated by men, who comprise 92.6%, 80.5%, 76.3%, and 76.2% of specialists respectively. Conversely, there are a few specialties, such as obstetrics and gynecology, pediatrics, and dermatology, dominated by women residents, who comprise 70.8%, 65.1%, and 57.0% of the specialists respectively (Brotherton, et al.).

The gender stratification among primary care shows that men and women are evenly represented in family medicine at 50.1% and 49.1% respectively (Brotherton, et al.). Women dominate obstetrics and gynecology and pediatrics, as discussed above. Men are dominant in general internal medicine and internal medicine pediatrics at 60.8% and 56.2% respectively (Brotherton, et al.). These data suggest an upward trend for the diversity of medicine with respect to gender; however, race and ethnic diversity has not

made the same progress. It is also important to note that much of these data are self reported and that the profession has not attended to its middle and upper social class status, which differentiate many physicians from the patients they see.

Unlike diversity efforts which have positive effects, ethnic, racial, and gender concordance between patients and physicians is troublesome with respect to what the concept suggests. Some studies have found patient – physician agreement matters whereas others indicated that concordance does not impact the relationship. Contrarily, the medical profession has identified a number of positive effects from faculty, staff, resident, and student diversity with respect to cross-cultural education. While concordance and diversity have not been shown to improve disparities in health outcomes directly, agreement studies indicate the importance of patients' cultural beliefs to their relationship with their physicians. Goals to diversify medical education also show that the profession has approached disparities in health care and outcomes without much diversity within its rank. The persistence of health disparities among ethnic, racial, and gender populations leads advocacy groups, governmental agencies, and the medical profession to explore other ways to minimize disparities (Betancourt, 2006b; Betancourt & Maina, 2004; Eiser & Ellis, 2007; Rios & Simpson, 1998). A number of these subsequent efforts were based heavily on science.

As found in the section, *Using Science to Professionalize Medicine during the 18th and 19th Centuries*, science was a major factor in how medicine codified the profession's cultural beliefs, values, and practices, which influence how physicians interact with and provide care for patients. During the 1960s, medicine strongly leaned toward science, and many argued that randomized controlled trials and scientific evidence are the gold standards for care and are the answers to health disparities (Jackson, 2002; Jenicek, 2006; Rogers, 2004b; Saunders, 2000). Randomized controlled trials are guided by a systematic and replicable approach to discovery where large numbers of individuals are recruited randomly to approximate the population of interest (Marcum, 2008; Parker, 2005; Rogers, 2004a, 2004b; Saunders).

Many in the profession believe that when physicians base treatment recommendations almost solely on evidence, they minimize their subjectivity and biases, as well as the impact of subjective data from patients (Marcum, 2008; Parker, 2005;

Rogers, 2004a, 2004b; Saunders, 2000). While randomized controlled trials ascended in importance during the late twentieth century, advocacy groups simultaneously believed that medicine minimized the importance of issues like trust and health beliefs. Advocacy groups do not reject the importance of science, but believe that individuals have an active role to play in their health care and management (Pinn & Chunko, 1999; Ruzek & Becker, 1999). The ascendancy of randomized controlled trials and patients' as active participants and managers culminated in the emergence of bioethics.

Bioethics emerged between the 1960s and 1970s and grew out of early advocacy work that sought to balance the value of art and science. Bioethics, one of the first efforts in medicine to combine biology and ethics, is based on the premise that physicians are the experts, patients need to be nurtured, and ethical and humanistic behaviors are as important as science and biology (Loewy, 2003). However, bioethics focuses mostly on physicians' scientific skills and behavior as caring and respectful professionals, but patients still are constructed as passive objects. Despite efforts to humanize the profession, health care continues to be guided almost solely by objective findings, diagnostic tests, and evidence and minimally, if at all, by what patients report or believe about their illness or disease (Jackson, 2002; Jenicek, 2006; Rogers, 2004a, 2004b; Saunders, 2000).

Bioethics, which seeks to improve the delivery of care as a way to improve health outcomes, had a minimal impact on the reduction of health disparities. The effort also did not improve health outcomes across patient populations. Critics of bioethics attribute the minimal impact on health disparities to what some in the field describe as the "rich man's ethics," which raise issues of social class (Loewy, 2003). The "rich man's ethics" refer to the upper social class status of some physicians who do not understand fully some of the larger social issues like access to care and the diversity of health beliefs, values, and practices of some patients (Loewy). Although efforts, such as bioethics, did not raise concerns about culture explicitly, the concept provided context for cultural issues to emerge. Bioethics, in the 1960s, suggested the importance of patients' cultural beliefs and values about health.

Medical Education, Culture, and Cross-cultural Competence

The civil rights movement of the 1960s and the social activism that followed in the 1970s spurred medical organizations and the federal government to recognize, collect data about, and investigate disparities in health care and outcomes (Baquet, et al., 2004; Byrd & Clayton, 1992, 2001). In addition to collecting data regarding health disparities, a number of federal agencies, such as the Office for Civil Rights in the Department of Health, Education, and Welfare, were created in the late 1960s to eliminate discrimination and disparities (Trubek & Das, 2003). Critics of the Office for Civil Rights believed that the agency was slow to respond to complaints of discrimination and was overall ineffective (Trubek & Das). Perhaps due to concerns about the ability of the Office of Civil Rights to address health disparities, other agencies, such as the Office of Research on Women's Health at the National Institutes of Health and the Task Force on Minority Health at the Department of Health and Human Services, emerged during the 1980s and 1990s (Seto, 2001). These agencies were established to advance women's and minorities' health concerns, which culture had become increasingly important to discussions about disparities (Seto). In addition to promoting health concerns of women and minorities, these agencies were important in documenting the existence of health disparities, which most directly influenced medicine with respect to the importance of culture to health care and outcomes.

The U.S. Department of Health and Human Services and its predecessor the Department of Health, Education, and Welfare is the nation's leading federal agency for health research and statistics. Since the middle 1970s, the Department has documented the nation's health status. The Department's 1976 – 1977 report identified several health disparities between whites and blacks, socioeconomic statuses, and gender (National Center for Health Statistics, 1977). The data indicated that whites live longer and are healthier than blacks, while women overall have the best health status (National Center for Health Statistics, 1977). Lower socioeconomic status resulted in lower health status compared to those with greater wealth (National Center for Health Statistics, 1977). This report did not highlight disease prevalence or specific outcome differences among racial, ethnic, and gender groups, but it illustrated that health disparities existed even when access to care was controlled.

Reports about health disparities like those created by the National Center for Health Statistics had an influence on medical education, which began to explicitly integrate cultural content into the curriculum during the 1970s (Crandall, et al., 2003; Lum & Korenman, 1994; Wyatt, Bass, & Powell, 1978). Wyatt, Bass, and Powell conducted a survey study of 113 medical schools in the U.S., of which 72 responded, and found that 44 deans reported that their curriculum included cross-cultural education. Twenty-eight schools did not integrate culture into their curriculum (Crandall, et al.; Lum & Korenman; Wyatt, et al.). While Wyatt, Bass, and Powell did not discuss the extent to which medical schools integrated culture into the curriculum or whether or not students were required to take these types of courses, their findings indicated that medical schools considered culture relevant for education and health care. Others like Tervalon (2003) also stated that medicine actively sought to provide cross-cultural education during the 1980s.

However, Lum and Korenman (1994) suggested the integration of culture during the 1980s and 1990s was not widespread and the efficacy of cross-cultural education was not effective. Lum and Korenman conducted a survey study in 1991 and 1992 of all 126 medical schools with a 72% response rate. The survey indicated that 13 schools out of 98 provided independent courses regarding culture and only 1 program required cross-cultural content (Lum & Korenman). Lum and Korenman indicated that 33 additional schools in the study planned to provide cross-cultural courses. However, Lum's and Korenman's analysis of cross-cultural competence in the early 1990 was not favorable.

The integration of culture between the 1970s and 1990s illustrated how diffusely medical schools integrated cultural content and how differently researchers and educators interpreted early efforts. Early efforts by medical schools to integrate culture into the curriculum were voluntary and predated cross-cultural accreditation standards. However, there are a number of factors that propelled the profession to include culture as a required competence for medical residents. These factors include the growing documentation of health and disease specific disparities across populations, such as the 1985 National Center for Health Statistics' report, which specifically discussed group differences in terms of heart disease and hypertension. This report indicated women had better health statuses than men, and blacks faired much worse than white patients in terms of

prevalence and death from heart disease and hypertension (National Center for Health Statistics, 1985).

As the case for cross-cultural education grew, medicine could no longer ignore the impact of health disparities and the role that it could play to reduce them. However, prior to standards developed by the Accreditation Council for Graduate Medical Education (ACGME), cross-cultural education in medicine was disjointed where one school's efforts may be widely different from another. ACGME was established in 1981 to improve health care and accredit all U.S. residency programs ("ACGME at a Glance.," n.d.). The private, nonprofit ACGME is the collaborative work of five organizations, the AMA, American Board of Medical Specialties, American Hospital Association, Association of American Medical Colleges, and the Council of Medical Specialty Societies ("ACGME at a Glance.; Britt, 2007; Morris, 1993). The five organizations are also ACGME board members.

A central part of the mission of ACGME is to improve residency education, which the organization sought to do when it defined a set of six competencies for medical residents in 2000. ACGME, in 2000, required that all medical residents should possess cross-cultural skills (Brotherton, et al., 2004; Joyner, 2004; Lattore & Lumb, 2005). ACGME integrated cross-cultural skills into the professionalism competency and proposed that medical residents should be sensitive, responsive, and respectful of the cultural beliefs, values, and practices of their patients. The competency specifically states that diversity is not limited to race, which is how much of the medical education literature discusses the issue (Gates & Bradley, 2009).

Although ACGME requires cross-cultural competence for medical residents, critics have questioned the effectiveness and impact of accreditation on education with respect to the integration of content and the preparedness of residents. Critics of accreditation are concerned largely about ACGME's independence and the broadness of requirements. Morris (1993) found ACGME is not sufficiently independent of specialty and subspecialty organizations, which comprise some of the accreditation body's decision-making board members. Thus, when ACGME develops and enforces competencies or policies, the organization needs the support of specialty and subspecialty board members, who will be affected. Contrarily, ACGME has no influence on specialty

and subspecialty organizations like the Advisory Board of Medical Specialties (Morris). Through ACGME, specialty and subspecialty boards play an important role in what their professions teach and the skill requirements of their physicians, which raises questions about the accreditation body's independence. The troublesomeness of ACGME's independence is compounded by questions regarding what the accreditation body requires as evidence that programs have met standards.

Joyner (2004), who favorably viewed ACGME's competency approach to residency, questioned the vagueness of the competencies and what constitutes evidence that residents can demonstrate required skills. The six competencies ACGME requires encompass both clinical and non-cognitive behavioral skills and were designed broadly so that programs can be compliant and meet accreditation requirements, but also flexibly so that specialties can include content-specific skills (Joyner). ACGME recognized that documentation of compliance was weak (Joyner). Joyner indicated ACGME has improved documentation requirements for accreditation by asking close-ended questions of programs and requiring resident portfolios as examples of their work. While ACGME has validated the questionnaire and found the instrument to be reliable, improving the documentation of accreditation is an ongoing process (Joyner). However, ACGME has not validated or evaluated the reliability of what should comprise resident portfolios, which remain largely undefined (Joyner).

Some critics have questioned ACGME's independence from specialty and subspecialty boards and the vagueness of the competencies; however, they acknowledge that accreditation overall has a positive impact on residents' education and preparedness to practice (Britt, 2007; Brotherton, et al., 2004; Joyner, 2004; Lattore & Lumb, 2005; Morris, 1993). Residency programs, ACGME, and member organizations like the Advisory Board for Medical Specialties have vested interests to prepare competent physicians and maintain their credibility with the public, who has entrusted them with authority and control over graduate medical education. As important as the integration of cross-cultural skills into residency programs is with respect to addressing the health care needs of a diverse society, accreditation has not fostered a discussion to determine the meaning and nature of culture or the impact that cultural beliefs, values, and practices

have on clinical encounters. Like other accreditation requirements, ACGME describes cross-cultural competence very broadly.

The Office of Minority Health in the U.S. Department of Health and Human Services is much more specific than ACGME regarding the cross-cultural competencies of health care professionals and began identifying a set of standards in 1997 (Office of Minority Health., 2001). The necessity for the standards largely emerged in response to demographic changes in the U.S. population and the documentation of disparities in health care among different patient groups. The standards represent the collaborative work of health care professionals, organizations, accrediting agencies, as well as patients, unions, and federal and state agencies. In 2001, the Office of Minority Health codified fourteen standards that health care organizations, who receive federal funds, are required to follow (Office of Minority Health.). The standards are grouped around three concepts: cross-cultural skills among health care professionals, linguistic services, and ongoing organizational goals regarding culture (Office of Minority Health.). The complete list of standards is provided in Appendix A. National Standards on Culturally and Linguistically Appropriate Services (CLAS). While medicine has guidance on what constitutes a cross-culturally competent person, neither ACGME nor the Office of Minority Health is specific about how they define culture.

The meaning of culture often must be gleaned from how the profession implements cross-cultural education. Cross-cultural education is medicine's approach to teach medical students, residents, and physicians how they should interact with patients who have beliefs, values, and practices differ from the biomedical model. Cross-cultural education often frames culture in the context of health disparities, specifically across race, gender, religion, language, and to some extent social class lines. The profession often cites increased diversity and the globalization of the population, as if these factors alone are reasons why culture is relevant to clinical encounters and health disparities. In many ways, this perspective decontextualizes culture and medicine from other important influences like history and politics. For instance, cross-cultural education suggests that culture is a relatively recent issue that the profession needs to address, despite medicine's history with cultural issues like who to treat and how to listen to and understand patients.

This limited way to contextualize culture provides insight into what the profession understands about cultural beliefs, values, and practices.

The profession broadly defines cross-cultural competence as the ability to bridge cultural differences between patients and physicians with the recognition that not everyone shares the same beliefs, values, and practices and that culture influences health practices and decisions (Fadiman, 1997; Gregg & Saha, 2006; Kagawa-Singer & Kassim-Lakha, 2003; Koehn & Swick, 2006; Kripalani, et al., 2006; Lu & Primm, 2006; Turbes, et al., 2002). Furthermore, some medical professionals propose that cross-cultural competence prepares physicians to provide better care and improves health outcomes largely through improvements to communications and the patient – physician relationship (Anderson, et al., 2003; Beach, et al., 2005; Betancourt, et al., 2005; Dogra & Carter-Pokras, 2005; Dunn, 2002; Hasnain-Wynia, 2006; Juckett, 2005; Odom-Forren, 2005; Rosen, et al., 2004; Shaya & Gbarayor, 2006; Taylor & Lurie, 2004). Medicine overall frames cross-cultural competence as a skill that is objective and definable (Dean, 2001; Nunez, 2000; Tervalon, 2003), as well as one that relies on intuition and personal relationships (Engebretson, et al., 2008; Kagawa-Singer & Kassim-Lakha; Nunez).

Medicine typically teaches cross-cultural competencies in terms of three broad domains: knowledge, attitudes, and skills (Gates & Bradley, 2009; Kripalani, et al., 2006; Ladson, et al., 2006; Lie, Boker, & Cleveland, 2006; Park, et al., 2005). While these domains help to frame cross-cultural competence, they also provide insight into what the profession understands about culture. The knowledge domain pertains to definitions and information about culture that physicians use to understand what patients believe, value, and practice (Kripalani, et al.; Ladson, et al.; Lie, et al.; Park, et al., 2005). Definitions about culture often pertain to specific characteristics about groups' beliefs, values, and practices (Beach, et al., 2005; Kripalani, et al.).

Some medical professionals include epidemiologic data, based on randomized controlled trials, as an aspect of cultural knowledge. Those who consider epidemiology as relevant to culture do so because these types of data describe and explain disease prevalence for specific populations (Campinha-Bacote & Campinha-Bacote, 1999). The intent of epidemiology and other population based data is to provide physicians with knowledge they need in order to make health related judgments and predictions about

group members (Campinha-Bacote & Campinha-Bacote; Chin & Humikowski, 2002; Helman, 2000; House, 2002).

This type of population specific knowledge becomes a guide for some physicians with respect to the questions they ask and leads others to draw conclusions with incomplete information. In effect, epidemiology allows physicians to minimize patients' perspectives and to rely on large population studies (Jenicek, 2006; Saunders, 2000). Furthermore, some medical professionals believe that epidemiologic data also minimize patients' perspectives because it eliminates within group differences. The profession sees knowledge as fundamental to understanding the relevance of culture for medicine. Many in medicine also perceive the knowledge domain for culture to be well-defined and structured and seek primarily to integrate information in a scientific and objective manner (Dean, 2001; Tervalon & Murray-Garcia, 1998).

Related efforts to cross-cultural education, such as the biopsychosocial model and evidence-based medicine, frame and describe culture in narrow and delineable senses. The biopsychosocial model proposes that biology, psychology, social settings, and environments influence patients' health beliefs, practices, and decisions (Alonso, 2004; Astin, Sierpina, Forys, & Clarridge, 2008; Borrell-Carrio, Suchman, & Epstein, 2004; Butler, Evans, Greaves, & Simpson, 2004; Checkland, et al., 2008; Fava & Sonino, 2008; McLaren, 1998; Suls & Rothman, 2004). Conversely, evidence-based medicine relies heavily on scientific findings and randomized controlled trials (Jenicek, 2006; Parker, 2005; Rogers, 2004a). However, evidence-based medicine also acknowledges that groups, defined by race, ethnicity, and gender, have different needs (Chin & Humikowski, 2002; Engebretson, et al., 2008; Hasnain-Wynia, 2006; Parker).

While the biopsychosocial model and evidence-based medicine approaches to clinical encounters differ, both assume a degree of certainty and universality across patient populations. The two approaches readily and explicitly acknowledge that individuals are unique and different; yet, they implicitly propose that group members are more or less alike. In many ways, these approaches to medical practice minimize individuality and the unique perspectives of patients in lieu of population based data.

Some medical educators believe that the profession's goal should be to train physicians to be culture free or neutral (Beagan, 2000; Berger, 2008). This notion has led

some medical educators to believe that patient differences, to the extent that they exist, do not matter and that everyone should be treated the same (Beagan, 2000; Betancourt, 2006b; Betancourt & Maina, 2004; Groopman, 2007). The belief that physicians can be culturally neutral implicitly suggests that there are no group differences and impartial applications of science and technology have the same effect regardless of patients' cultural beliefs, values, and practices. Furthermore, the notion of culturally neutral physicians implies that patients are passive, always adherent, and universally the same. However, the ways in which medicine approaches attitudinal training suggest that culture is much more contextual, complex, and less universal than described by the knowledge domain (Dogra, 2001; Dogra, 2007; Dogra & Wass, 2006; Weissman, et al., 2005).

The attitudinal domain proposes that culture is tenuous, personal, and difficult to teach and learn (Dogra, 2001; Dogra, 2007; Dogra & Wass, 2006; Weissman, et al., 2005). Attitudes pertain to affective education where faculty members and medical residents learn to be sensitive to, aware of, and to appreciate that some patients have health beliefs, values, and practices that differ from the profession's perspectives (Carrillo, et al., 1999; Crandall, et al., 2003; Dogra, 2001; Dogra, 2007; Leininger, 2001; Weissman, et al.). The attitudinal domain focuses to an extent on patients' perspectives and how individuals understand diseases and illnesses, which is similar to many of the profession's historical efforts to highlight the importance of the art of medicine (Dogra, 2001; Dogra, 2004; Dogra & Carter-Pokras, 2005; Dogra & Karnik, 2003; Weissman, et al.). Attitudes, as a way to improve trust and communication between patients and physicians, grew in importance during the civil rights movement of the 1960s (Halpern, 2004). A number of attitudinal efforts to teach about culture culminated in the profession's patient-centered care model.

The patient-centered care model, while not the same as cross-cultural education, emerged most directly from patient advocacy and the work of medical ethicists who sought to improve the patient – physician relationship and communication. The model espouses that patients and physicians are full partners and managers during the clinical encounter and suggests that the perspectives of both are equal (Engebretson, et al., 2008; Koehn & Swick, 2006; Martin, et al., 2004; Ponte, et al., 2003). Although physicians are the medical experts and recommend treatments, the patient-centered care model proposes

that clinical encounters should entail negotiations with patients, who ultimately decide whether or not to follow their providers' advice. The patient-centered care model also explicitly proposes that individuals' beliefs and values about health are important and that patients are unique (Beach, Rosner, Cooper, Duggan, & Shatzer, 2007; Lamiani, et al., 2008; O'Flynn & Britten, 2006; Ponte, et al.). According to the patient-centered care model, the factors that influence clinical encounters include race, ethnicity, gender, social class, location, and disease state (Beach, et al., 2007; Borrell-Carrio, et al., 2004; Carrillo, et al., 1999; Engebretson, et al.). Furthermore, the patient centric nature of the attitudinal domain cautions against stereotypes (Carrillo, et al.; Dogra, 2004; Dogra, et al., 2007; Dogra & Karnik, 2003), which indicates that some medical professionals realize that a focus on culture may result unintentionally in assumptions and generalizations. Many of these medical professionals do not want to simplify culture or essentialize beliefs and practices.

The skills domain to teach and learn about culture seeks to integrate the art and science of medicine and melds knowledge and attitudes into application and practice, an acknowledgement that both are important and relevant for cross-cultural education and competence (Beach, et al., 2005; Campinha-Bacote & Campinha-Bacote, 1999; Hasnain-Wynia, 2006; Leininger, 2001; Park, et al., 2005). The skills domain focuses primarily on improving clinical encounters and the patient – physician relationship largely through communication. Communication and trust are vital aspects of the skills domain and the goal to minimize health disparities and improve outcomes through increased patient adherence to medical treatment (Beach, et al., 2005; Campinha-Bacote & Campinha-Bacote; Fadiman, 1997; Hasnain-Wynia; Helman, 2000; Kleinman, 1980; Leininger; Park, et al., 2005). In many ways, the skills domain is based on objective, defined, and stable evidence, as well as affects like personal rapport and intuition. Despite the integration of knowledge and attitudes into one domain and the suggestion that art is important, the profession predominantly approaches skills as if cross-cultural education results in certain and predictable health outcomes (Fadiman; Helman; Kleinman, 1980).

During the 1970s and 1980s, Kleinman (1980), a psychiatrist and anthropologist, proposed a specific approach to communication that involve negotiations and translations where physicians seek to understand patients' perspectives of their illness, as well as

ensure that patients understand biomedical explanations and treatment recommendations for their disease. The key aspect of Kleinman's approach to clinical encounters is physicians' ability to communicate illnesses and recommendations to patients in a culturally relevant and appropriate way (Fadiman, 1997; Helman, 2000; Kleinman, 1980). However, Kleinman (1980) suggested that the onus rests with physicians to negotiate and translate cultural differences during clinical encounters.

The skills domain, despite efforts to integrate aspects of knowledge and attitudes, frames culture as shared beliefs, values, and practices that are more or less essential and universal across group membership (Betancourt, 2003; Eiser & Ellis, 2007; Koehn & Swick, 2006; Ladson, et al., 2006; Park, et al., 2005; Park, et al., 2006). Even when communication seeks to bridge and negotiate differences in beliefs and values and when medicine recognizes that members of a group differ, physicians often practice the skill set as if culture has universal and essential precepts that bind people together (Koehn & Swick; Ladson, et al.; Park, et al., 2005; Park, et al., 2006). The notion that culture is well-defined is consistent with medicine's scientific and evidence-based approach to education about diseases. Furthermore, the skills domain of cross-cultural education often positions physicians in almost sole control and management of patients' health, in contrast to the patient-centered care model's notion of shared power during clinical encounters.

The patient-centered care model, across the knowledge, attitudinal, and skills domains, most closely captures what the profession seeks to achieve with cross-cultural education. Both cross-cultural education and the patient-centered care model seek to teach medical students, residents, and physicians how to interact with patients in a respectful and active way that positively impacts the clinical encounter. The two approaches to clinical encounters highlight the individuality of patients and the importance their perspectives of diseases and illnesses have on health outcomes. However, the patient-centered care model's focus on individuality does not delve specifically into what or why patients may be similar or not or why clinical encounters may need to be different depending on the person.

Cross-cultural education differs from the patient-centered care model with respect to explaining explicitly why the patient – physician relationship may differ from

encounter to encounter. The absence of culture as an explicit explanatory factor and the focus on individuality may work counter productively to understanding that cultural beliefs, values, and practices influence patients' and physicians' health care decisions. Individuality, for some medical professionals, may suggest that they do not need to attend to issues of culture, because patients vary so much that group beliefs, values, and practices more or less are irrelevant or not important. Cross-cultural education contrarily proposes that cultural beliefs, values, and practices influence patients, physicians, their relationship, and health outcomes. Furthermore, cross-cultural education problematizes the patient – physician relationship especially when health care professionals ignore culture. Cross-cultural education posits that clinical encounters are more positive and achieve better outcomes when individuals and medical professionals explicitly acknowledge and bridge cultural differences.

Despite the overall tenets of cross-cultural education, some medical educators are critical of the profession's strategies to teach about culture and believe that medicine integrates cultural beliefs and values into the curriculum too definitively and as a tool to make predictions. These critics suggest that when medicine teaches about culture, particularly via case study, physicians are likely to objectify or stereotype some patients. Case studies, across all three domains, are the most prevalent strategy that medicine uses to integrate and teach cultural content (Azad, Power, Dollin, & Chery, 2002; Donner & Bickley, 1993; Kenny & Beagan, 2004). The goal of case studies is to provide realistic examples to demonstrate the role culture plays in clinical encounters (Beagan, 2003; Carrillo, et al., 1999; Crandall, et al., 2003; Kripalani, et al., 2006; Rabinowitz, Melzer-Geva, & Ber, 2002; Rosen, et al., 2004).

Critics of case studies state that this strategy contributes to stereotypes where members of cultural groups are presented as being more or less the same (Beagan, 2003; Gregg & Saha, 2006; Turbes, et al., 2002). Additionally, cases present culture too simplistically or incompletely (Beagan, 2003; Gregg & Saha; Turbes, et al.). For some medical students, case studies suggest that all encounters are attributable to culture when they and patients have different frames of references regarding health (Gregg & Saha). Sometimes, physicians' initial exposure to individuals who have different beliefs than they do come from case studies (Beagan, 2003). Medical educators are concerned these

single representations will be instructive for medical students and residents with respect to how they interact with others and whether or not they are willing to accept stereotypes (Beagan, 2003; Gregg & Saha; Turbes, et al.).

For example, Groopman (2007), a physician, used case studies to discuss the impact communication, the patient – physician relationship, and medical professionalism have on medical care and health disparities. Groopman, through cases, criticized the limited, structured, and scientific ways in which medical schools almost solely teach physicians to conduct clinical encounters. Groopman found the profession's approach to teach physicians about medicine to be an obstacle to the patient – physician relationship. Implicitly, Groopman suggested that medical schools train physicians not to recognize patients' perspectives. However, the cases that Groopman discussed overwhelmingly made communication and health disparities an issue when patients and physicians were of a different race, ethnicity, or religion. Gender was also expressly mentioned when patients were women. Subtly, this way of discussing health disparities conveys the idea that some groups are inherently different from physicians.

Groopman (2007) also proposed that patients should question their physicians about health care and treatment decisions. Although Groopman did not raise the issue explicitly, his case discussions also pertained to social class. Middle and upper class patients whom Groopman described were comfortable with the patient – physician relationship and questioned not only communication styles, but also clinical decisions. Groopman did not discuss that some patients see physicians as the medical authority in the relationship and as someone not to question. Summarily, Groopman's cases suggested that clinical encounters improved when physicians know patients' cultural background and when patients take an active role in their health care. While the cases that Groopman presented suggest that cultural knowledge and skills positively impact clinical encounters, they also may be interpreted to mean culture is the sole remedy for health disparities.

Tice (1998) criticized the early uses of cases in charity and social work because they were less about individuals and more about pathologies, symptoms, and professionalism. The early middle class social workers whom Tice described heard rich narratives from individuals, but, in their effort to become more scientific and

professional, they often read and described stories sterilely. Similar to Foucault's (1973) analysis of eighteenth century French medicine where physicians often objectified their patients during clinical encounters and relied more on technical and observational data than what patients provided, Tice found that charity work during the nineteenth century did much the same to individuals in the U.S., particularly women and the poor. Middle class social workers and others often used cases, in a manner similar to medicine, to construct evidence of pathologies (Tice).

As the field of social work grew and cases became more important, many interpreted these reports as evidence of what was wrong with individuals or why people needed protection (Tice). Tice also indicated that social workers often sought to portray themselves as impartial observers. However, social workers' cases, which dwelled on impartiality and objectivity, were similar to those used in medicine and the cultural ambassadors that Narayan (1997) described. The cases often were incomplete, but many professionals used the data like clinical findings to withhold resources and educate their members, as well as the public (Tice). Tice did not propose that social work should abandon cases, but suggested that professionals need to balance the art and science approach to documentation and to recognize that class, politics, power, and professional ambitions matter and are part of their work.

Narayan (1997) also criticized reductionist views of cultural beliefs, values, and practices and proposed a more complex way to use cases. While Narayan used the term cultural ambassadors instead of cases, she proposed a framework to present and discuss people in a contextual and realistic way. Narayan proposed that powerful and dominant groups often project essential beliefs, values, and practices upon marginalized groups for political advantage or because they misread the history of others. Cultural ambassadors illustrate the essentialist views and predestined roles that some westerners define for third-world individuals. Many westerners often base these roles on their expectations of third-world persons, whom they perceive as culturally different; however, some third-world individuals impose these roles upon themselves (Narayan). Narayan identified three cultural ambassadors: emissaries, mirrors, and authentic insiders.

Emissaries typically portray their culture positively, primarily comprised of traits and characteristics from privileged groups (Narayan, 1997). This role often presents one

group's or subgroup's beliefs and values as universal (Narayan). Emissaries also suggest that groups have essential properties and that within group differences or conflicts do not exist (Narayan). The focus on positives aspects of one's culture is largely a response to colonialism and seeks to highlight cultural separateness between native people and colonizers (Narayan). This role fails to discuss how dominant cultures marginalize less powerful groups or how some factions resist others (Narayan). While cultural emissaries focus on promoting the positives of their culture, the mirror role conversely discusses the negative impact of colonialism on non-western cultures.

The mirror role describes colonizers as victimizers and the colonized as victims and faults the west for most of the third-world's ills. As with emissaries, the mirror role obfuscates the complexities of culture and detaches beliefs, values, and practices from their historical contexts (Narayan, 1997). Many of these ambassadors portray third-world cultures as monolithic, because they focus on the colonizers and not the internal debates that occur within groups (Narayan). Narayan proposed that this role positioned the west as central and the third-world as peripheral to the narrative. Aspects of the mirror role sometimes emerge in medical cases, especially when physicians minimize patients' concerns and perceive their perspectives somewhat peripheral to clinical encounters. In a number of medical cases, the role and actions of physicians to resolve health issues are the sole focus; patients and their relationship with medical professionals are excluded as relevant and primary to clinical encounters.

Authentic insiders, unlike the emissary and mirror roles, discuss positives and critical aspects of their culture (Narayan, 1997). These cultural ambassadors describe the legacy of colonization and the debates about beliefs, values, and practices that individuals have within their respective groups (Narayan). The role also treats third-world individuals as active narrators of how their cultural beliefs, values, and practices form and change (Narayan). Narayan proposed that the authentic insider role overcomes some of the shortcomings of the emissary and mirror roles, such as, the static portrayal of culture; however, the role also shares some of the problems of the others. Many westerners expect authentic insiders to be members of the respective group they represent, and for some this mean these individuals are the prototype for their entire cultural group (Narayan). Sometimes outsiders' perceptions of culture mute within group

differences based on the intersection of race, ethnicity, gender, and social class (Narayan). Across the criticisms, many professionals within and outside of medicine use case studies as a strategy to teach content; however, this instructional approach has the potential to lead some to stereotype.

Critics like Beagan (2000), a medical sociologist, Narayan (1997), and Tice (1998) did not propose to abandon cases, but to use them cautiously and to complicate them when possible. Cases, to an extent, inherently objectify individuals from the perspective of the author and tend to portray people incompletely. Often the subjects of cases are de-centered, since they seldom provide their own narratives. For example, physicians and others in medicine frequently write cases describing racial, ethnic, or working class groups through their middle and upper class perspectives. Cases also have the effect of essentializing groups of people, as they frequently are used to educate or describe pathologies. Cases seldom complicate or acknowledge how different domains of culture, such as race, ethnicity, gender, and social class, intersect and interact with one another. Cases tend to be very specific about a particular issue. In medicine, cases are about diseases and illnesses, not the myriad of events or circumstances that may impact individuals and their health. Many of the issues described above grew out of professions' need and desire to be more scientific and legitimate.

The divergent ways medicine and other professions use cases to teach about culture suggest that cultural knowledge is not a high consensus construct. Many social scientists and medical educators acknowledge that culture has different meanings across and within many disciplines and fields (Gregg & Saha, 2006; Nunez, 2000; Rosen, et al., 2004; Yali & Revenson, 2004); however, medical educators teach and convey cultural knowledge as if content is more or less stable and universal across groups (Koehn & Swick, 2006). While much of medicine leans toward one way to define culture, the broader literature was instructive with respect to definitions from other professions. These other definitions also indicate how varied and complexly many disciplines and fields understand culture.

Framing Culture along a Continuum of Perspectives

Atkinson (2004), an applied linguist, proposed that culture is one of the most difficult constructs to define in the social sciences, because there is little agreement or

consensus over the meaning of the term. Culture sprang from the works of anthropologists who studied and sought to describe and explain the beliefs, values, and practices of non-western people (Boggs, 2004). Much of the early anthropological work in culture viewed groups somewhat monolithically; however, context became important as single patterns and explanations were not tenable across all individuals (Atkinson; Brumann, 1999; Poddar, 2003). Anthropologists and sociologists have provided many departure points for different definitions of culture. Depending on the source, anthropologists and sociologists have identified dimensions of culture as ways to explain shared beliefs, values, and practices (Billings, 2007; Boggs; Brumann, 2002; Fischer, 1999).

This study drew from the works of anthropologists and sociologists who identified dimensions of culture, as objective, performative, and institutional. Not all social scientists framed culture according to the dimensions Billings (2007), a sociologist, proposed. However, the ways that Billings framed culture coincide with the contextual and explanatory ways in which this study sought to examine cultural beliefs, values, and practices. A dimensions based approach provides a more complete and explanatory way to frame culture than one based almost entirely on descriptions of a group's beliefs, values, and practices. For instance, Billings' dimensions help to explain the origins of our beliefs, the meaning and reasons for our values, and the motivations for our behaviors and practices. These are only a few of the questions that a more in depth definition of culture elucidates. Culture, when explained primarily in terms of descriptions of beliefs, values, and practices, lacks depth and suggests to some that these factors alone provide a complete picture of a group (A. Banks, et al., 1993; Engebretson, et al., 2008; Gregg & Saha, 2006; Koehn & Swick, 2006).

The objective dimension proposes that culture derives meaning and identity from texts, speech, language, and symbols that groups use to communicate internally, as well as with others (Billings, 2007). While not necessarily universal, group members understand textual, spoken, and symbolic modes of communication. Moreover, members understand and recognize cultural patterns, whether or not they adhere to their group's modes of communication (Billings). In a sense, texts, speech, language, and symbols are the bases for group membership, but only to the extent that they are well-known and

widely used by members (Billings). The objective dimension defines beliefs and values, but the performative aspect of culture explains more completely their manifestations.

The performative dimension defines culture in terms of how group members behave and what they practice (Billings, 2007). This aspect of culture frames the boundaries around which members perform and act, as well as how individuals transform these limitations (Billings). While not all members have the same practices, they recognize when they and others act outside their group's norms (Billings). In some respects, the performative dimension is a limitation in that there are boundaries for how individuals behave, but in other ways, this dimension frames how members transform their groups (Billings). Billings proposed that transformations of expected behaviors not only are possible, but are part of the evolution of culture; members influence those outside their group, while outsiders also have an impact on them.

The institutionalization of cultural beliefs, values, and practices reveals why and how different traits emerge over others, as well as how groups transform them (Billings, 2007). Billings proposed that power, authority, and politics, internal and external, are aspects of the institutional dimension of culture and influence what others perceive as cultural. The institutionalization of traits and characteristics explains culture in a more complex way than the idea that a majority of members define and adhere to their groups' beliefs, values, and practices. The institutional dimension proposes that power, authority, and politics influence objective and performative aspects of culture (Billings). According to the institutionalization of culture, beliefs, values, and practices are not necessarily monolithic or universal, since members contest among themselves what their groups believe, value, and practice. These internal contestations often entail groups who use power and politics to situate their specific traits as primary and dominant while others resist the essentialism and universality of these projections (Fischer, 1999; Narayan, 1997). The impact of power is that those with and without status or privilege debate what is and is not cultural (Fischer; Narayan).

Medical educators and social scientists understand beliefs, values, and practices in a much more complex, contextual, and multifaceted way, when all three dimensions comprise the definition of culture. When social scientists and medical educators examine beliefs, values, and practices in terms of the objective or performative dimensions, they

often view culture as well-defined and delineated with a degree of certainty (Engebretson, et al., 2008; Gregg & Saha, 2006; Koehn & Swick, 2006). The notion of culture as contextual or certain is more akin to endpoints along a continuum than a bifurcation of people's beliefs. These endpoints represent the many ways in which social scientists and medical educators understand and explain groups' beliefs, values, and practices.

Some social scientists have critiqued cultural beliefs, values, and practices framed in terms of essentialism where culture describes how one unconsciously views and interprets the world (Atkinson, 2004; A. Banks, et al., 1993; J. A. Banks, 2006; Brumann, 1999; Feinberg, 2007; Narayan, 1997). According to this essentialist definition, members adhere to cultural traits in unavoidable ways across generations, which suggest that beliefs, values, and practices are longstanding, historic, and innate. The suggestion that traits and characteristics are inherent and that members cannot explain why they believe and value what they do implies that groups are static; individuals are universally the same; and members do not contest among themselves what is cultural (J. A. Banks; Boggs, 2004). Like other variants of essentialism, this way to explain culture portrays shared beliefs, values, and practices as easily identifiable, stable, and largely inescapable, since they seldom change (Engebretson, et al., 2008; Gregg & Saha, 2006; Koehn & Swick, 2006).

Others, who have examined essentialist definitions of culture, propose that shared beliefs, values, and practices comprise a system that is passed from one generation to the next (Atkinson, 2004; J. A. Banks, 2006; Brumann, 1999; Varey, 1996). This essentialist definition describes culture as a system, because members base decisions and interactions with others, as well as those in their group, on shared beliefs, values, and practices (J. A. Banks; Brumann, 1999; Fischer, 1999; Varey). This view of culture suggests that ingroups' and outgroups' interactions may be somewhat deterministic, since beliefs, values, and practices are stable and universally shared to the extent that they can be referred to as a system. This definition proposes that culture provides boundaries and limits for members' beliefs, values, and practices and their interactions with others (Fischer; Narayan, 1997; Varey).

Some social scientists who define culture as a system recognize that groups are not monolithic and that members differ from one another. However, some social scientists believe that culture as a system has boundaries that limit the extent to which individuals can differ and still be considered tenable members of the group (Varey, 1996). If variance occurs in a stable system, differences must be minimal and minor. Unlike the essentialist definition that proposes that culture is inherent, this view of shared beliefs, values, and practices highlights the importance of socialization among members (J. A. Banks, 2006; Betancourt, et al., 2003; Dunn, 2002; Engebretson, et al., 2008; Kagawa-Singer & Kassim-Lakha, 2003; Nunez, 2000). However, some social scientists believe the extent to which individuals learn and abide by these traits are often as unavoidable as if they were innate.

Some social scientists and medical professionals complicate the definition of culture and propose that group membership is not delineated neatly into race, ethnicity, gender, or social class. However, they believe that shared beliefs, values, and practices are consciously or unconsciously transmitted from one generation to another, (Atkinson, 2004; Borneman, 2002; Feinberg, 2007; Gregg & Saha, 2006; Helman, 2000; Kleinman, 2004; Sullivan, 2006). This more complicated definition of culture rejects the idea that groups do not influence each other. This view of culture proposes that group identifiers like race, ethnicity, gender, and social class influence and interact with each other (Beagan, 2003; Benkert, Peters, Clark, & Keves-Foster, 2006). Despite discussions about the intersection of groups, this perspective, oftentimes, defines individuals in somewhat stable and deterministic terms (Brumann, 1999; Carroll, 2001).

Social scientists also complicate the definition of culture in terms of power and authority and propose that these factors influence what some members portray as universal beliefs, values, and practices (A. Banks, et al., 1993; Billings, 2007; Brumann, 1999; Fischer, 1999; Narayan, 1997). This view of culture suggests that those with power, authority, or political capital institutionalize groups' beliefs, values, and practices; however, resistance also influences what members consider as cultural (A. Banks, et al.; Billings; Brumann, 1999; Fischer; Narayan). This way to define culture relies heavily upon the institutional dimension of culture. While this perspective complicates the meaning of culture, some social scientists criticize this viewpoint for the suggestion that

beliefs, values, and practices are inescapable, since power and authority ensure that cultural transformations are beyond the control of most group members (A. Banks, et al.).

More complex notions of culture challenge the universality and legitimacy of group traits, but do not dismiss necessarily the notion that individuals share beliefs, values, and practices (A. Banks, et al., 1993; Brumann, 1999; Fischer, 1999; Narayan, 1997). These more complicated definitions of culture propose that traits and characteristics emerge from the intersections and interactions of different group memberships, such as race, ethnicity, gender, and social class. The impact of group intersections and interactions is that beliefs, values, and practices emerge in expected and unforeseeable ways (Atkinson, 2004; A. Banks, et al.; Brumann, 1999; Feinberg, 2007; Fischer; Narayan).

The intersections of factors like race, ethnicity, gender, and social class shift and change what individuals and groups perceive as cultural (Atkinson, 2004; A. Banks, et al., 1993; Brumann, 1999; Feinberg, 2007; Fischer, 1999; Narayan, 1997). Power and political authority complicate culture in that these factors impact, not necessarily determine, what emerges as shared beliefs, values, and practices for a particular group (A. Banks, et al.; Boggs, 2004; Fischer; Narayan; Poddar, 2003). In contrast to the essentialist and universalist definitions of culture, this more complicated notion proposes that shared beliefs, values, and practices are contextual, emergent, and dependent upon group interactions (Atkinson; A. Banks, et al.; Brumann, 1999; Fischer; Narayan). The dynamics between and among groups with power and authority and those who resist the hegemony of others are central aspects of this definition of culture where members argue and debate what they perceive as universal beliefs, values, and practices (A. Banks, et al.; Fischer; Narayan). This definition suggests that cultural beliefs, values, and practices emerge after internal contestation among members.

While these definitions of culture are not exhaustive of how social scientists and medical educators frame culture, they provide major points of departure along the continuum of an essentialist and universalist perspective to an emergent and contextual way to understand group characteristics. The many ways in which these disciplines define culture suggest that there is not a universal way to understand cultural beliefs and values or why some traits and characteristics emerge as dominant compared to others.

The primary differences across these definitions pertain to how completely social scientists and others understand culture.

The different ways in which social scientists define culture coincide with two philosophical perspectives, modernism and postmodernism. The essentialist definition of culture is consistent with modernism, while the more emergent definition aligns with postmodernism (A. Banks, et al., 1993; Brumann, 1999; Fischer, 1999). Modernism and postmodernism are important to this study with respect to whether or not one's philosophical perspective influences communication, the relationship between patients and physicians, and the extent to which medical providers do not stereotype others.

Explaining the Arguments for Modernism and Postmodernism

Discussions of modernism and postmodernism explain how medicine and other disciplines frame culture and how these philosophies impact the ways we interact with and perceive the world. While there is no single unified definition for modernism, Banks, Billings, and Tice (1993) framed the philosophy as rooted in objectivism, predictability, and rationalism where many define knowledge in terms of essentialism and universality. Modernism posits that knowledge and facts are largely self-evident and independent of human construction, that is, truth merely awaits to be discovered (Boggs, 2004). This definition of culture leads many to believe that beliefs, values, and practices are fixed and decontextualized and that race, ethnicity, gender, and social class define the boundaries for group characteristics (A. Banks, et al.; Brumann, 1999; Fischer, 1999).

Modernism implies certainty and stability even though the philosophy acknowledges that other factors like history and politics influence what some people perceive as culture (A. Banks, et al., 1993; Brumann, 1999; Fischer, 1999; Narayan, 1997). A number of social scientists and medical educators understand culture in modernist ways, because the philosophy provides a way to describe and predict particular group members' beliefs and values. This view of culture reinforces and strengthens group identity, legitimacy, stability, and certainty (Billig & Tajfel, 1973; Tajfel, et al., 1971). For instance, many physicians rely on predictability during clinical encounters and believe that a modernist definition of culture makes the construct a more useful tool and guide for patient interactions. In summary, modernism provides order to the way we

understand the world and supplies a structure to explain phenomena in a scientific, objective, and rational manner.

Modernism does not reject outright the notion of context; however, the philosophy limits the extent to which factors other than objectivity influence knowledge and facts (A. Banks, et al., 1993). Modernism recognizes that beliefs, values, knowledge, and facts change, but only in limited ways (A. Banks, et al.). For instance, Banks, Billings, and Tice (1993) and Billings (2007) discussed the many ways in which academics and activists essentialized Appalachia as one region where inhabitants of the area possess more or less the same traits and characteristics. Some researchers describe Appalachians as fatalistic people, which fuel the perception that they are uneducated, isolated, and exploited by the "outside world" (A. Banks, et al.). Other essentialisms of Appalachia include descriptions of the region as economically and politically hapless compared to its industrial surroundings (A. Banks, et al.; Billings).

These narratives often portray Appalachians as passive victims. However, as Banks, Billings, and Tice (1993) found, resistance is also a part of Appalachia's history where the region's inhabitants are not solely fatalistic or exploited by outsiders. Banks, Billings, and Tice also discussed how Appalachia was not defined wholly by white working class people. An account of Appalachia and the people is incomplete without an acknowledgement that gender, race, class, history, oppression, as well as resistance, intersect and shape the region (A. Banks, et al.).

Modernism is a well entrenched and a difficult philosophy from which to break; however, many in medicine and the social sciences have disrupted and challenged the perspective in ways that are limited, as well as fundamental and transformative. Payer (1996), a medical journalist, conducted a comparative study among similar cultures and found many differences across nations that supposedly share common beliefs and values. Payer investigated the influence of culture on medical decision-making and treatment recommendations in France, Germany, Great Britain, and the U.S. and found that patients, depending upon the country, described overall similar problems and physicians consistently made the same diagnosis. For instance, patients in Great Britain often complained as a group about the bowels. Unrelated to bowels, British physicians did not believe the death of patients negatively reflected upon their medical skills (Payer).

Payer (1996) attributed the differences and divergences to the prevailing philosophy of the country. For example, French physicians frequently base their diagnoses on logic and reason, even when contradictory evidence is available (Payer). Romanticism explains why German physicians are preoccupied with heart and circulation problems and why they frequently make low blood pressure diagnoses (Payer). British physicians, influenced by the empirical works of Locke, Berkley, and Hume, rely more on observations than randomized controlled trials. Payer attributed the aggressiveness of American medicine to the belief that treatment should be vigorous and fast acting, the frontier spirit of the west, and the idea that Americans are explorers who always overcome obstacles.

Payer (1996) rejected to an extent the modernist definition of culture and proposed that factors like politics and philosophy influence what people believe and value. However, Payer did not examine other factors like the role of race, ethnicity, gender, and social class. Payer believed that groups' beliefs, values, and practices are stable and valuable as a predictive tool. Through many examples, Payer made broad generalizations about patients and physicians in four countries, as she sought to broaden aspects of culture beyond shared belief, values, and practices to include politics and philosophy.

Frisch (1990), an oral historian, complicated the definition of culture and asserted that a nation's history was incomplete without narratives from a broad cross section of the population. Oral history appeals to many researchers, because the method does not mediate individuals' narratives and groups that typically are not included in historical accounts are (Frisch; Ritchie, 2003). A purpose of untold stories is to contribute to the larger body of knowledge and to provide narratives that the public has not heard (Ritchie). Oral history also can be a way to demonstrate there are within group differences and that members debate and contest historical accounts.

Frisch (1990) explicitly raised social class as an influential factor in how we frame and discuss history and challenged the accuracy and completeness of historical accounts when historians discounted the contribution of one group over another. Frisch illustrated this concept when he described the differences that the New York Times had with researchers over how to package an article about unemployment in Buffalo. The

researchers wanted to present narratives from a diverse group of working, middle, and upper class residents about their reflections and experiences regarding unemployment; however, the New York Times sought a working class article that discussed this group's personal experiences (Frisch).

The New York Times was motivated to publish an article that their readers expected, which suggested that unemployment only impacted the working class (Frisch, 1990). Frisch suggested that politics was involved, since, the New York Times wanted to highlight the dire conditions of Buffalo and its residents. This illustration reveals how politics can influence research and present incomplete narratives. This limited way to frame unemployment was similar to what Banks, Billings, and Tice (1993) found with the ways that some researchers inaccurately and incompletely described Appalachians as uneducated working class whites.

Kleinman (1980) conducted his explanatory work with culture in Taiwan and identified universal and essential characteristics that spanned across all cultural groups in the country. While Kleinman (1980) held many beliefs about culture that are similar to modernism, he also broadened how we should understand shared beliefs, values, and practices to include the acknowledgement that there are within group differences, such as gender and social class. For example, Kleinman (1980) found that western-style physicians in Taiwan often explain health and medical issues differently based on patients' social class. Upper class patients frequently receive the most detailed explanations for their conditions, while physicians' limit the depth to which they discuss clinical findings with working class patients (Kleinman, 1980). Kleinman (1980) also proposed that power impact patient and physician encounters and found that physicians typically have the most influence in clinical encounters. However, Kleinman (1980) stressed that patients are not universally the same. Some patients with high status alter the paternal role that physicians often play (Helman, 2000; Kleinman, 1980).

In many respects, Kleinman (1980) framed culture as knowledge that is universal and stable enough for physicians to make predictions and to use as a guide for interactions with patients. For example, Kleinman (1980) found that the Taiwanese culturally stigmatize psychological problems, such as depression, regardless of gender or social class. Patients often express these problems as psychosomatic symptoms and

expect their medical providers to treat the symptoms as physiological instead of psychologically. While Kleinman (1980) recognized that Taiwanese culture is not monolithic and that cultural differences exist within families and social classes, he observed that patients have expectations of care that are culturally biased and proposed that medical providers should deliver care based on individuals' cultural frame of reference.

Kleinman (1980) illustrated this issue in the case of a forty year old Taiwanese man, who suffered palpitations, dizziness, and sweating. The patient visited a western style internal medicine physician, who conducted an extensive examination to include tests and labs, but found no physiological problems (Kleinman, 1980). The physician suggested to the patient that his problems were probably psychological (Kleinman, 1980). Since Taiwanese frown upon psychological diagnoses and recommendations, the patient did not follow the physician's advice to visit a psychiatrist, despite the internist's suspicion that the individual suffered from anxiety after his marriage to a woman who is fourteen years younger (Kleinman, 1980). This clinical encounter illustrates what happens when physicians do not consider patients' cultural beliefs and when providers propose recommendations that patients will not follow.

Kleinman (1980) proposed that providers, who treat individuals in culturally appropriate ways, increase patients' adherence to treatment recommendations. He suggested that medical providers who do not share the same culture as their patients are the ones who need most to engage in negotiations and translations, since they do not understand the hidden meanings and the nuances of groups' beliefs, values, and practices. The idea that non-group members need to attend to cultural differences more than group members suggests that individuals do not contest beliefs, values, and practices and that everyone more or less shares the same traits and characteristics.

Kleinman (1980) illustrated this concept in an example about marriage counseling where a patient visited a shaman because she was upset about her husband's affair. The shaman suggested that the woman should have another child, which many western psychiatrists would find as a counterintuitive recommendation, but the result was that the husband ended his affair. Explicitly, the shaman advised the client to have a baby, but, in effect, suggested to the wife to be more intimate with her husband. Kleinman (1980)

used this case to illustrate that treatment recommendations need to recognize the importance of patients' perspectives and coincide with their beliefs and value system. In this illustration, the shaman did not need to engage in negotiations and translations with his patient, since the two are from the same cultural group.

Some social scientists and medical educators express concern about these partial breaks. However, other social scientists and medical educators frame cultural beliefs, values, and practices as predictable and definable sets of traits and characteristics. Although factors other than objectivity and innateness influence traits and characteristics, partial breaks assume that group members largely accept and adhere to the same beliefs, values, and practices. Kleinman (1980), Payer (1996), and Frisch (1990) departed from a modernist definition of culture in as many respects as they adhered to the philosophy.

Postmodernism explains culture in a more complex way than modernism (Atkinson, 2004; A. Banks, et al., 1993; Boggs, 2004; Brumann, 1999; Fischer, 1999; Narayan, 1997), which grew out of the eighteenth century enlightenment (A. Banks, et al.; Boggs). Postmodernism rejects the idea that science and evidence are objective, neutral, and independent of historical and social influences; the philosophy proposes that truth is cultural, individually constructed, emergent, and incomplete (A. Banks, et al.; Boggs; Fischer). According to this philosophy, culture is not fixed and compartmentalized into isolated and discreet facts that do not intersect and influence one another (Atkinson; A. Banks, et al.; Narayan). Postmodernism explains culture as emergent, multifaceted, and influenced by social, political, and historical factors (A. Banks, et al.; Dean, 2001; Fischer; Gregg & Saha, 2006; Narayan).

In many ways, postmodernism contests the idea that the world is neatly ordered, ahistorical, and that knowledge and facts have universal acceptance (A. Banks, et al., 1993; Fischer, 1999; Narayan, 1997). Postmodernism questions the idea that cultural beliefs, values, and practices are always longstanding ways in which groups interpret and interact with the world (A. Banks, et al.; Fischer; Narayan; Poddar, 2003). Furthermore, the philosophy proposes that power and privilege influence peoples' beliefs and values (A. Banks, et al.; Fischer; Narayan; Poddar).

Postmodernism exposes how limited and incompletely we understand knowledge and facts when we do not consider the impact that power, politics, and history have on

what we know (A. Banks, et al., 1993; Narayan, 1997). This philosophy proposes that individuals who support and resist certain beliefs, values, and practices influence traits and characteristics that emerge as cultural (A. Banks, et al.; Fischer, 1999; Narayan; Poddar, 2003). Resistance, an aspect of culture that is inseparable from power, is central to Narayan's discussion of how some groups in India reacted to the British who often perceived cultural beliefs, values, and practices of native groups in modernist ways. There were some Indian groups who resisted these projections, but others embraced the cultural beliefs, values, and practices projected upon them. A number of social scientists propose that power and resistance explain more accurately and completely how beliefs, values, and practices emerge and why some traits and characteristics are portrayed as cultural whereas others are not (A. Banks, et al.; Fischer; Narayan; Poddar).

Narayan (1997) illustrated the impact that power and resistance have on culture and the ways some western researchers examined India from pre-colonial through modern times. Some western researchers inaccurately attribute a number of beliefs, values, and practices to the entire native population of India that really are traits and characteristics of only a few, such as sati. Narayan described sati as a practice that some researchers and feminists attribute to all of India. Sati was practiced by some upper caste Indian women where the wife, in a state of grief, threw herself onto her husband's funeral pyre (Narayan). Perhaps well-intended, some western feminists took up sati as an issue and campaigned against the practice, but they often talked about the act from the point of view of a westerner and sometimes without historical context (Narayan). For example, Daly, a western feminist, discussed sati as if the practice was without history, widespread, and not contested within India (Narayan).

During colonialism, the British were careful not to disrupt all native traditions and identified sati as an Indian religious practice (Narayan, 1997). However, Narayan indicated that sati was not widely practiced, limited to upper caste Hindus in specific regions of the country, and challenged by many within India (Narayan). The arguments within India about sati pertained to when the practice was acceptable, committed voluntarily by the widow, and when it was not, coercion or manipulation (Narayan). Others in India believed that there were no acceptable practices of sati, which indicated that indigenous people contested the issue (Narayan). Hindus were a privileged group in

pre-colonial India and sought to portray their culture as authentic, historic, and universal (Narayan). Their high status, in part, explains why the British and others recognized sati as a universal practice across groups (Narayan).

Other western feminists mistakenly connected dowry-murder to sati and characterized both practices as cultural (Narayan, 1997). Unlike sati, which has roots among some upper caste Hindus, dowry-murder, the killing of a wife for her assets, is not cultural or unique to any group (Narayan). Some western researchers associate dowry-murder to sati, in part, because they examine culture and India in an uncritical and ahistorical way (Narayan). Western feminists, such as Daly, detached sati and dowry-murders from their historical contexts and linked the two, despite their different locations in time and the fact that sati was once customary whereas dowry-murder was not acceptable (Narayan). Dowry-murders within an appropriate historical context reveals that the act is not related to sati (Narayan). Narayan proposed that the act pertains to violence, greed, economics, and not culture.

Narayan's examples illustrate how both internal and external groups incorrectly describe some beliefs, values, and practices as cultural. When individuals examine cultural beliefs, values, and practices in terms of power, resistance, and history, a number of traits and characteristics that members and non-members perceive as shared appear not to be so. However, some cultural groups want to combine with others under the aegis of a unified population, despite historically different beliefs, values, and practices. Some of these groups are motivated by the desire for political power, while others want to resist outside forces (A. Banks, et al., 1993; Narayan, 1997; Poddar, 2003). As Banks, Billings, and Tice (1993) found among some Appalachia group members, a modernist read of culture has advantages in that coalitions are easier to forge. Narayan (1997) and Poddar (2003), a professor of postcolonial studies, found that some outsiders and indigenous groups characterized culture in essentialist terms, even though native populations had distinct beliefs, values, and practices from one another prior to the arrival of the British. During periods in their history, Appalachians and Indians adopted a modernist perspective of culture to resist outsiders and believed that universal beliefs, values, and practices were the best counter to those who threatened their ways of life.

The Appalachian and Indian illustrations of Banks, Billings, and Tice (1993) and Narayan (1997) respectively suggest that modernism ignores the role of motivations in terms of what appears as cultural whereas postmodernism includes this explanatory aspect. Narayan illustrated the role of group motivations and challenged the modernist notion that cultural beliefs, values, and practices have essential, universal, and stable characteristics that are longstanding and shared by all group members. For example, many Indian nationalists sought to position their traditions and practices as universal and cultural where the aim was to maintain power and status over women and other groups, resist the colonial British, and perpetuate their way of life (Narayan).

Colonialism, in some ways, provided the motivation for many Indians to unify diverse native groups in order to resist and differentiate themselves from the British (Narayan, 1997). During and post colonialism, nationalism became a movement to gain self rule where privileged members in India defined traditions and practices favorable or unique to their particular group (Narayan). Narayan described how some nationalists criticized the country's feminists who rejected their beliefs, values, and practices. These nationalists described Indian feminists as products of westernization and a threat to traditional cultural beliefs, values, and practices, particularly with respect to women (Narayan). The traditional role in which these nationalists placed women were incomplete, since Indian women have a diverse history in terms of education and social class (Narayan).

Narayan (1997) used a personal account of her home life to illustrate the complex role that women played in India. She described her observations as a child where her mother and other women family members contested culture and conveyed messages of conformity and resistance (Narayan). While Narayan's women family members often described the challenges of Indian womanhood, they frequently instructed their daughters to follow tradition, which was an implicit suggestion to adhere to cultural practices and norms. Narayan also found that many of the views shared by Indian women were not dissimilar from the views of western feminists. Nationalists argued that feminisms changed traditional Indian women, but Narayan explained that women have a history where they contested the roles that some men projected upon them.

Other non-western cultural groups also grapple with politicizations and essentialized perceptions of their beliefs, values, and practices. Similar to Indians, some native populations resist these perceptions of their cultural beliefs, values, and practices, while others embrace essential traits and characteristics, often for political power or legitimacy. Fischer (1999), an anthropologist who examined Mayan culture in Guatemala, found that western researchers and social scientists increasingly frame ethnic populations, their politics, and their identities in terms of postmodernism instead of modernism. However, Fischer explained why a number of Mayan nationalists reject postmodern ways to understand their cultural beliefs and values. These Mayan nationalists propose that these contextual and emergent ways to frame their traditions are efforts by westerners to deemphasize the longstanding and historic nature of their traits and characteristics. Many of these Mayan nationalists want to portray their traditions as historic, and they often use religion and language to essentialize the many indigenous groups in the area into a larger Pan-Mayan culture (Fischer).

Some Mayan nationalists, who frame indigenous Guatemalan groups as one, often describe sacrifices to the gods as a universal aspects of all groups' culture (Fischer, 1999). Fischer indicated that these nationalists seek to unify language and identity under a single dialect and location respectively. These efforts were conducted under the assumption that native populations needed to awaken longstanding and historic practices that were repressed during colonialism (Fischer). Fischer proposed that Guatemalan nationalists seek to essentialize indigenous groups to argue the innateness of their beliefs, supplant indigenous rivalries or loyalties to other cities and cultures, and achieve political legitimacy. While the context and specific beliefs and values of the Pan-Mayans nationalists who emerged during the 1990s and the Indians that Narayan (1997) described differ, their goals are similar because both groups seek to universalize their beliefs and values for political legitimacy and power. Narayan's and Fischer's examination of Indian and Mayan cultures, respectively, illustrate that politics, power, history, and group members' contestations often complicate beliefs, values, and practices that emerge as cultural.

Throughout the literature, many social scientists and medical educators discuss culture in terms of shared beliefs, values, and practices around which individuals

coalesce. Frequently, social scientists and medical educators discuss what unites us, but they also indicate that some modernist definitions of culture do not explain fully how shared beliefs, values, and practices emerge. For example, Kleinman (1980), Payer (1996), Fadiman (1997), an English professor, and Frisch (1990) identified common characteristics that unify individuals into groups. Frisch saw history as one of the sources that unite us as a nation, while Kleinman (1980), Payer, and Fadiman focused on physical, mental, and emotional characteristics. Kleinman (1980), Fadiman, and Frisch focused on national cultures and identities, and Payer extended the discussion across four western cultures. Frisch and Payer provided the only explicit markers for what they meant by culture, which is shared beliefs, values, and practices that guide rather than limit how individuals interact and interpret the world. This definition contrasts with the postmodern perspective of Narayan (1997) and Banks, Billings, and Tice (1993), who chipped away at what culture is and the supposed uncontested collectiveness of the construct.

This study framed social scientists' and medical educators' definition of culture along a continuum of modernism and postmodernism. As the literature suggests, culture is difficult to define and even more of a challenge to measure, particularly with respect to whether or not a modernist philosophy of culture results in a greater willingness to accept stereotypes than the postmodern perspective. In many respects, this study is interested in what one believes about the nature of culture. Epistemology, the study of knowledge, provides a means to glean what one believes about culture.

Approximating philosophical beliefs about culture

While there are other ways to conceptualize epistemology, this research found Schommer's variant of personal epistemology, which measures beliefs about knowledge and learning to be most appropriate. This version of epistemology depends upon situations and content domains (Clarebout, Elen, Luyten, & Bamps, 2001; Duell & Schommer-Aikins, 2001; Hofer, 2001; Schommer, 1994). Personal epistemology, as a way to understand knowledge and learning, also coincides with the philosophical perspectives of modernism and postmodernism (Hofer, 2006; Muis, Bendixen, & Haerle, 2006; Schommer, 1994). Personal epistemology, as framed by Schommer, proposes that

we understand knowledge and learning in naive and certain terms like modernism or complex and fluid ways like postmodernism.

Models of personal epistemology that social scientists and psychologists developed prior to Schommer are unidimensional and pertain to stages of development where one's perspective of knowledge progresses from simple and absolute to complex and relative (Buehl & Alexander, 2001; Chan & Elliott, 2000, 2004; Duell & Schommer-Aikins, 2001; Hofer, 2001, 2006; Schommer-Aikins, 2004; Schommer-Aikins & Easte, 2006; Schommer-Aikins & Hutter, 2002; Schommer, 1990a). Unlike earlier unidimensional models, Schommer's personal epistemology is multidimensional where absolute endpoints seldom identify where one solely resides (Clarebout, et al., 2001; Duell & Schommer-Aikins; Hofer, 2001; Schommer, 1994). This concept of personal epistemology is similar to the ways in which individuals lean toward one philosophy, but do not hold every aspect of a belief system as absolute (Clarebout, et al.; Duell & Schommer-Aikins; Hofer, 2001). Schommer (2004; 1990a, 1990b, 1994) identified five dimensions to an individual's epistemological beliefs:

- structure of knowledge
- stability of knowledge
- source of knowledge
- speed of learning
- ability to learn

The dimensions of structure, stability, and source pertain to how we understand knowledge, while speed and ability address our perspectives of learning (Schommer-Aikins, 2004; Schommer, 1990a, 1990b, 1994). The structure of knowledge is concerned with how concepts relate to each other, such as whether or not information is complex and relational or simple and isolated (Schommer-Aikins; Schommer, 1990a, 1990b, 1994). The idea that knowledge is emergent and fluid or fixed and certain pertains to the stability of knowledge (Schommer-Aikins; Schommer, 1990a, 1990b, 1994). The source of knowledge asks whether or not concepts are constructed or exist independently of discovery (Schommer-Aikins; Schommer, 1990a, 1990b, 1994). The extent to which we learn occurs either quickly or gradually, and our ability to learn is determined innately or experientially (Schommer-Aikins; Schommer, 1990a, 1990b, 1994).

According to Schommer (1990a, 1990b, 1994), at one end of the continuum, personal epistemology is constructed, interrelated, complex, and gradually acquired through experience, which is consistent with postmodernism. At the other end of the personal epistemology continuum, individuals learn concepts from experts and domains exist independently from one another (Chan & Elliott, 2000, 2004; Duell & Schommer-Aikins, 2001; Hofer, 2001; Schommer-Aikins, 2004; Schommer-Aikins & Easte, 2006; Schommer-Aikins & Hutter, 2002; Schommer, 1990a, 1990b, 1994), which coincides with modernism. One's personal epistemology also leans toward modernism when one believes that innate ability largely determines individuals' capacity to learn and acquire knowledge. A central tenet of personal epistemology is that one's understanding about knowledge and learning in one domain does not mean an individual has the same beliefs in another (Clarebout, et al., 2001; Duell & Schommer-Aikins; Schommer-Aikins). Therefore, a postmodernist view of knowledge in one content domain like culture does not indicate a worldview.

Social Identity Theory as Theoretical Framework

Social identity theory is the framework that ties together the definition that one has about culture, the philosophical perspective that one adopts, and the measurement of one's beliefs. The central thesis of this study is that one's beliefs about culture are relevant to how one views or behaves toward members outside their cultural group. While there are other ways to understand group identity and interactions, social identity theory provides a tenable framework to explain the relationship between faculty members and medical residents, their beliefs about culture, and their willingness to accept stereotypes.

Tajfel and Turner developed social identity theory out of the field of social psychology and sought to explain how individuals behave toward group members and non-group members (Bartsch & Judd, 1993; Bettencourt, et al., 2001; Billig & Tajfel, 1973; Ethier & Deaux, 1994; Jetten, Spears, & Postmes, 2004; Rabbie, Schot, & Visser, 1989; Tajfel, 1982; Tajfel, et al., 1971). The social psychologists initially conceptualized the theory to explain social behaviors between dominant and subordinate groups; the need for individuals to maintain positive social identity; and, behaviors in which members engage to maintain or enhance self-esteem (Brown, 2000; Lalonde &

Silverman, 1994; Rubin & Hewstone, 2004; Tajfel; Verkuyten, 2005). In addition to being explanatory for social groups and their interactions, social identity theory contributes to how we understand group bias, status inequality, homogeneity, stereotypes, and attitudinal changes (Brown; Ethier & Deaux; O'Flynn & Britten, 2006; Tajfel).

Social identity theory recognizes the following facets of group identity, behavior, and intergroup interactions (Brown, 2000; Jetten, et al., 2004; Rubin & Hewstone, 2004):

- Traits and behaviors are contested within groups.
- Members belong to multiple groups simultaneously.
- Intergroup and intragroup dynamics change.
- Factors such as, status, legitimacy, competition, and common fate, influence group interactions.
- Groups form and behave as they do for many reasons, to include self-esteem and collective pursuits of rewards.

Context, such as situation and saliency, underlines facets of group identity, behavior, and intergroup interactions, and rejects the notion that groups are static and fixed (Brown; Jetten, et al.; Rubin & Hewstone).

Along with context, social identity theory provides a framework to understand culture in terms of collectiveness and cohesion. The theory posits four requirements for group collectiveness and cohesion: awareness among individuals that they belong to a group; agreement and support for a group's values; a desire to want to belong to a group; and, recognition by non-members (Lalonde & Silverman, 1994; Tajfel, 1982). Recognition by others is perhaps the most necessary criterion for groups to exist, which implies there are always ingroups and outgroups (Billig & Tajfel, 1973; Lalonde & Silverman; Tajfel; Tajfel, et al., 1971).

Social identity theory also provides a framework to discuss cross-cultural competence in a way that explains why strong group identity sometimes may heighten group differentiations from one another. The concept of group differences is particularly relevant in the case of faculty members and medical residents, who may have dissimilar health beliefs, values, and practices from their patients. The framework proposes that a focus on differences encourages stronger belongingness to a group where assumptions and expectations can lead some to see others as outsiders; in essence, this focal point may

enhance unintentional stereotypes (Huddy, 2004; O'Flynn & Britten, 2006). Social identity theory proposes that when we highlight differences the result is likely to be an increase in biases and stereotypes toward others.

Variability, which is closely related to stereotypes, is another aspect of social identity theory. Social identity theory defines variability as the extent to which intragroup members differ from one another or the distance that members are from some central tendency (Bartsch & Judd, 1993). Unlike variability, which pertains to distance, stereotypes are common characteristics and behaviors that distinguish one group from another (Brown, 2000; Carter, Hall, Carney, & Rosip, 2006). Variability pertains to within group differences, while stereotypes are about traits and characteristics that distinguish groups from one another.

Social identity theory proposes that the extent to which groups see themselves and others as similar or varied depends on several factors: size of the ingroup and the comparative outgroup, order in which comparisons are made, ways that groups perceive and identify themselves, and the magnitude of the stereotypes (Bartsch & Judd, 1993). Although the extent to which groups perceive stereotypical behaviors and variability depends on four factors, ingroup members seldom see themselves more stereotypical than they perceive outgroup members (Bartsch & Judd). Conversely, ingroups sometimes perceive themselves as less variant than outgroups members, who in turn, occasionally see themselves as less dispersed than their comparative groups (Bartsch & Judd). As with other aspects of social identity theory, perceptions of stereotypes and variability are contextual and dependent upon multiple factors (Bartsch & Judd). However, the theory hypothesizes that stereotypes and discrimination are reduced when individuals share goals, interact with culturally diverse individuals, or belong to multiple groups with others (Tajfel, 1982). A decrease in competition also minimizes the motivation for members to engage in discrimination against those outside their group (Tajfel).

While social identity theory does not discuss culture explicitly, the framework implicitly explains how groups' beliefs, values, and practices impact intragroup and intergroup interactions (Hewstone, Rubin, & Willis, 2002; Huddy, 2004; Reicher, 2004; Rubin & Hewstone, 2004). In some respects, the theory frames culture as complex; yet, in other ways, the framework does not provide a complete way to examine intragroup and

intergroup relationships. For instance, unlike postmodernism, social identity theory does not explain the intersections between and among group identifiers, such as race, gender, ethnicity, and social class. However, social identity theory complicates the idea of group identity and proposes that individuals share memberships in multiple groups (Brown, 2000; Tajfel, 1982), which is consistent with postmodernism's supposition that groups are not isolated and disconnected from one another (A. Banks, et al., 1993; Narayan, 1997).

While there are others theories in which to investigate group identity and behaviors, this study viewed social identity theory as a tenable framework to examine intragroup and intergroup interactions and to explain the relationship between beliefs about culture and willingness to accept stereotypes. However, the theory is limited with respects to groups' motivations to adopt specific beliefs, values, and practices; members' identification with their respective groups; and, reasons why ingroups view others as outsiders. Social identity theory primarily relies on issues of self-esteem, power, and behavioral factors like rewards to explain group identification (Bettencourt, et al., 2001; Billig & Tajfel, 1973; Rubin & Hewstone, 2004; Sidanius, et al., 2004; Tajfel, et al., 1971; Verkuyten, 2005).

This study proposed that factors other than self-esteem and behaviors explain belongingness and that history, politics, and resistance, along with power, influence why groups coalesce and how cultural beliefs, values, and practices emerge. Frameworks like postmodernism provide a more in depth explanation than social identity theory, particularly, with respect to individuals' motivations to identify with specific groups and their interactions with others. Although social identity theory does not explore these important explanatory aspects of group identity, the framework is important with respect to group interactions. Despite the different motivations for group identity, there oftentimes are still ingroups and outgroups, and here, social identity theory is explanatory.

Summary

This study framed culture along a philosophical continuum where one's beliefs lean toward modernism, postmodernism, or somewhere between the two. The literature across several disciplines illustrates the difficulty that medical educators and social

scientists have to define culture. Although culture is difficult to define, there are many different definitions that social scientists and medical educators use to explain cultural beliefs, values, and practices. Some social scientists propose that one's philosophical perspective can lead to stereotypes. Stereotypes, as the central research problem, pertain to groups' perceptions and interactions, which social identity theory provides a framework to explain. The following chapter, Research Design, describes the methods and population and explains the process by which the study examined the relationship between one's beliefs about culture and willingness to accept stereotypes.

Chapter 3: Research Design

This research sought to explain what faculty members and medical residents understand about culture, what impact their philosophy of cultural beliefs and values has on stereotypes, and what influence didactics have on why the two groups agree or disagree about cross-cultural communications with patients. This study was guided by four research questions:

1. What are faculty members' and medical residents' beliefs about culture and their willingness to accept stereotypes?
2. What is the philosophical agreement between faculty members and medical residents with respect to beliefs about culture and willingness to accept stereotypes?
3. What is the relationship between one's philosophical perspective regarding beliefs about culture and willingness to accept stereotypes?
4. What do faculty members report that they teach to medical residents about culture?

This research hypothesized that a postmodern perspective of culture, instead of a modernist view, decreases the likelihood that faculty members and medical residents will stereotype patients. Conversely, the null hypothesis was that one's philosophical perspective of culture makes no difference in terms of the extent to which individuals accept or reject stereotypes.

Methodology

This study is an explanatory mixed method research design where qualitative data explain quantitative findings. Betancourt (2003) and Dogra and Wass (2006), leading researchers in the arena of cross-cultural education, proposed that mixed method studies are the most appropriate and instructive approach for this *type of* inquiry. They proposed that qualitative methods can provide richness to quantitative studies, which are more generalizable and replicable (Betancourt, 2003; Dogra & Wass). Furthermore, culture is contextual and interpretational, which lends itself to mixed method studies where populations can be described quantitatively and findings can be contextualized qualitatively. This explanatory mixed method study *first* collected and analyzed close-ended survey data and used open-ended and semi-structured interviews to explain the

quantitative findings. The purpose of this design was to quantify beliefs about culture and willingness to accept stereotypes and qualitatively discuss findings that emerged from the quantitative component. The quantitative and qualitative methods work together to accentuate components that the approaches alone do not address.

Sample

The population of interest for this study is primary care physicians. While there are other definitions of primary care, this study defined the specialty as comprehensive and continuous health management provided by family and community medicine, internal medicine, obstetrics and gynecology, and pediatrics (Moore & Showstack, 2003). Comprehensive care refers to the scope of services across all ages, and continuous care describes the typically long-term relationship these specialists have with their patients (Moore & Showstack; Safran, 2003). While some in the medical profession do not consider obstetrics and gynecology and pediatrics as specialties that have long-term relationships with patients, many women use the same obstetrician to delivery all their children. Other patients prefer gynecologists for their primary care, because they specialize in women's health. Pediatricians also tend to provide care for many families' children from birth through adolescence. Overall, these specialties can have long-term relationships with patients.

This study identified Academic Health Centers where residency education primarily occurs as the source for the sample. In 2009, there were 131 accredited medical schools. The sampling frame for this study came from one Academic Health Center, the University of Kentucky; thus, findings are not generalizable to primary care. The University of Kentucky was selected purposively because they meet the criteria for the population of interest; they are familiar to the researcher; and, culture is a complex and sensitive construct to discuss and investigate. Furthermore, a familiar population likely would provide richer data than an unfamiliar group given the comfort and trust that could be established with participants. In addition to familiarity with the population, the small number of participants was manageable for an initial study about culture in a field driven by science and structure. Primary care departments at the University of Kentucky provided the actual sampling frame, which were lists for faculty members and medical

residents. These lists provided individuals' name, degree, specialty, status, and email address.

The specific primary care population that this study targeted was family and community medicine, internal medicine, obstetrics and gynecology, and pediatrics. These primary care specialties are appropriate for this study, because there are oftentimes many occasions and opportunities where they and their patients may hold different health beliefs, values, and practices, which necessitate cross-cultural skills. Summarily, primary care likely has richer, more numerous, and more diverse cross-cultural experiences than other specialties. The specialties also highlight the importance of communication between themselves and patients; the relevance of biological, as well as psychological and social factors to health; and, the impact that health disparities have on some patient populations. These factors are all central issues for this study with respect to how physicians communicate with patients, whether or not they effectively understand culture, and their willingness to stereotype.

Since the target population for this study is small, a census sample was conducted where all faculty members with didactic responsibilities and all medical residents in the Departments of Family and Community Medicine, Internal Medicine, Obstetrics and Gynecology, and Pediatrics were recruited to participate in the survey component of the study. This study, which is interested in similarities and differences between educators and learners, selected medical residents as a comparison group to faculty members who teach. Although medical students are an appropriate comparative group to faculty members, residents are more suitable, because they have completed medical school where the majority of cross-cultural education occurs and they see patients in a significantly more independent way than medical students. Medical residents are also an appropriate population, because they have decided on a specialty whereas students may not have made this decision and have not been matched to a particular specialty. The interview sample, comprised only of faculty members, was purposive in terms of gender, ethnicity, social class, beliefs about culture, and willingness to accept stereotypes. The inclusion requirement for the interview sample entailed completion of the study's close-ended survey.

The purposive sampling frame and population size for this study preclude the generalizability of findings; however, this study may have utility and provide guidance for other schools and colleges of medicine. While medical schools proclaim to have unique programs, accreditation requirements mandate, to an extent, a degree of similarity. Many in medicine also posit that physicians trained at an accredited university received more or less the same core curriculum, which includes cross-cultural education. Thus, the University of Kentucky's cross-cultural education efforts may be instructive for others in medicine in terms of what is effective and problematic.

Instrumentation

This study sought to address the research questions using two instruments: a close-ended survey and open-ended interviews. The close-ended survey was modified from an existing valid and reliable questionnaire, and the interview guide was designed to be flexible to accommodate the likely emergent nature of the data. The close-ended instrument consisted of three types of variables: philosophical beliefs about culture, demographics, and willingness to accept stereotypes. See Table 3.1 for the list of variables and how they were operationalized and measured.

Table 3.1, List of Variables

Variables	Operationalization	Measurement
Independent		
Beliefs about culture	Average of close-ended items	Ratio
Gender	Open-ended	Nominal
Ethnicity	Open-ended	Nominal
Citizenship (natural or naturalized)	Close-ended	Nominal
Status in department	Close-ended	Ordinal
Parent's social class	4 close-ended items	Ordinal
Medical specialty	Close-ended	Nominal
Parent's education	Close-ended	Ordinal
Year in residency	Close-ended	Ordinal
Number of years living in U.S.	Open-ended	Ratio
Dependent		
Willingness to Accept Stereotypes	Average of close-ended items	Ratio

The beliefs about culture variable was based on Schommer's Epistemological Questionnaire, which is a valid and reliable instrument to learn about one's personal epistemology (Duell & Schommer-Aikins, 2001). In terms of content validity, the Epistemological Questionnaire covers the field of educational psychology. The instrument also has predictive validity in that each dimension of epistemology has foretelling strength for some dependent variable (Duell & Schommer-Aikins). In terms of reliability, the instrument has a .74 test-retest correlation and a range of .63 to .85 inter-item correlation for the dimensions (Duell & Schommer-Aikins). Schommer's tool is an appropriate measure for the beliefs about culture variable, because the instrument measures what one understands about the nature and acquisition of knowledge, such as, whether or not one believes culture is fixed and innate or fluid and experiential.

The original beliefs about culture variable was comprised of forty-one items from the Epistemological Questionnaire and represented the dimensions of structure, stability, and ability to learn. This study did not consider the source of knowledge and speed of learning as critical for studying the epistemological perspective of faculty members and medical residents. The source of knowledge overlapped components of the structure and stability of knowledge, as well as ability to learn. Several studies found that the speed of learning was not a significant dimension or should be combined with ability to learn to form a new dimension (Buehl & Alexander, 2001; Chan & Elliott, 2004; Clarebout, et al., 2001; Hofer, 2001; Muis, et al., 2006). Along with beliefs about culture, the original instrument asked demographic questions, which are consistent with how other researchers studied either the population or the topic (Crosson, et al., 2004; Dogra & Karnik, 2003; Godkin & Savageau, 2001; Ladson, et al., 2006; Lee & Coulehan, 2006; Lempp & Seale, 2006; Park, et al., 2006; Tang, Fantone, Bozynski, & Adams, 2002; Weissman, et al., 2005).

Social class was the most difficult demographic variable to ascertain, as there are several different definitions, interpretations, and categories for the term (Krieger, Williams, & Moss, 1997). This study used Wright's topology of social class to estimate this variable and did not rely on participants to classify themselves, which likely would have resulted in large variances, since social class has different definitions for many people. The typology defines one's social position based on educational attainment,

whether or not individuals own or control assets, the extent to which one has the ability to make decisions within an organization, the number of subordinates, and the extent of supervision over others (Borrell, Muntaner, Benach, & Artazcoz, 2004; Krieger, et al.; Muntaner, Borrell, Benach, Pasarin, & Fernandez, 2003). Thus, wealth or education alone is not sufficient to estimate social class. Individuals were classified either as upper, middle, or working class. There are other measures of social class, such as economic status, educational attainment, occupational position, and neighborhood location (Krieger, et al.). However, these other measures of social class are unidimensional and do not consider a broad range of factors like Wright's topology.

Beliefs about culture and demographic variables are predictors for willingness to accept stereotypes. This research used Carter's, Hall's, Carney's, and Rosip's (2006) twelve-item instrument to measure willingness to accept stereotypes. Carter, et al, psychologists, developed and tested their Acceptance of Stereotyping Questionnaire for validity and reliability. Cross-validation was used to validate the items across two sets of studies where the findings were practically the same (Carter, et al.). Carter et al. found the instrument to have internal consistency and a test-retest correlation of .70. This study administered the instrument as developed, except the words social, stereotyping, and their variations were changed to less emotional and politically sensitive terms. Prior to the administration of the close-ended instrument, this study obtained the advice of content experts in cross-cultural education about the instruments' appropriateness, completeness, and congruence with the research questions. The content experts represent the disciplines of medical anthropology, medicine, and education, and were sought based on their research in their disciplines and the depth to which they studied the issue. Based on feedback from the content experts, the close-ended instrument was piloted (See Appendix B. Original Beliefs about Culture Instrument).

Pilot of Close-ended Instrument.

The purpose of the pilot was to identify changes in content and design; test the validity and reliability of the beliefs about culture and willingness to accept stereotypes measures; and, eliminate items for beliefs about culture that are not explanatory. The goal to eliminate non explanatory items was important, because survey researchers like VanGeest, Johnson, and Welch (2007) found that fewer items result in higher response

rates. A number of faculty members in the target population also indicated that a long survey would decrease participation.

The instrument was piloted with ninety-seven physician assistant students at the University of Kentucky in the College of Health Sciences, Department of Clinical Sciences. The pilot population was appropriate, because they are similar to faculty members and medical residents, in that, they conduct medical interviews and make treatment recommendations to patients. Like medicine, the discipline of physician assistant studies has integrated cross-cultural education into their curriculum. The pilot population also was selected because the risk of contamination to faculty members and medical residents was minimal, since the two professions are in different colleges, do not take the same coursework, and do not attend the same academic or professional meetings. Although physician assistants are comparable to faculty members and medical residents, they are limited in terms of how extensively they assess patients and make treatment recommendations. The physician assistant curriculum also differs from medicine, in that, the program is a two year and six month master's degree instead of the typical four years to earn a medical doctorate and the three to four years to complete a residency program in primary care. Despite these differences, medicine and physician assistant studies are similar enough to infer pilot findings.

Revisions to Close-ended Instrument.

SPSS 17.0 was used to evaluate the close-ended instrument statistically, while users' comments were examined to identify items that were confusing or poorly constructed, as well as problems with format and design. Descriptive statistics were conducted on all close-ended items to identify patterns for unanswered questions. The descriptive analysis did not reveal any patterns for unanswered questions, and participants did not identify design flaws with the instrument. The primary statistical measures that were examined were Cronbach's alpha, a factor analysis, and multiple linear regressions. Cronbach's alpha, a measure for reliability, was .648 for beliefs about culture and .573 for willingness to accept stereotypes. The reliability findings are similar to what Duell and Schommer (2001) found for beliefs about culture (.63); however, the reliability for willingness to accept stereotypes was less than the .70 finding of Carter, et al (2006).

The study conducted a factor analysis to evaluate how valid the beliefs about culture and willingness to accept stereotypes measures are. In addition, the factor analysis provided guidance for which items of the beliefs about culture measure are not explanatory and can be eliminated. The factor analysis was based on principal component analysis; the Eigenvalue minimum, a measure of explanatory importance for the factor analysis was set at 1.0; and, correlation coefficients for items had to be greater than or equal to absolute .70. Correlation coefficients at .70 and greater explain more variance and suggest that an item most likely resides on the factor upon which it loads (Creswell, 2005; Nardi, 2006). This study also used a rotation solution because this method loads variables on the highest correlated factor and on fewer dimensions (Ramsay & Silverman, 2005). This study extracted factors using the varimax method, which assumes that items are independent (Ramsay & Silverman). The varimax method coincides with Schommer's (2004; 1990a, 1990b, 1994) assertion that personal epistemology is multidimensional and content domains are independent. The original forty-one items beliefs about culture measure accounted for 70.726% of the variance, while 57.756% of the variance was explained for willingness to accept stereotypes, which consisted of twelve questions.

The original beliefs about culture measure was identified as part of the instrument that could be reduced. Based on the factor analysis, fourteen items had a correlation coefficient of .70 and greater on only one factor. These items were selected to create a revised measure for beliefs about culture. A multiple linear regression equation was computed for the original forty-one items and the revised fourteen-item measures for beliefs about culture to determine if the two differed with respect to their predictability for willingness to accept stereotypes.

The stepwise method for the regression analysis revealed that either the forty-one or fourteen item measures for beliefs about culture are significant predictors for willingness to accept stereotypes, as presented in Table 3.2.

Table 3.2, Regression Equations for Beliefs about Culture (Pilot Study)

Variable	*B*	*SE B*	β
Original Beliefs about culture	.699	.201	.368*
Revised Beliefs about culture	.534	.165	.346*

*$p<.01$.

The stepwise method was appropriate for this regression analysis, because this research had no theoretical basis to propose an order to enter beliefs about culture or demographic variables. Since both measures for beliefs about culture significantly predicted willingness to accept stereotypes, the fourteen item measure was administered to the sample population. Along with eliminating questions that are not explanatory, the direction of items for beliefs about culture and willingness to accept stereotypes was mixed to address response bias. Some statements were worded to elicit agreement, and others were written to draw disagreement, because survey administration studies have found that some respondents answer intensity measured statements in one way, such as all agree or disagree (Nardi, 2006). This study used a four point intensity scale from strongly agree to strongly disagree. The four point scale required participants to choose a position of agreement instead of a neutral stance.

In addition to close-ended items regarding one's beliefs about culture, the pilot also included open-ended questions. A thematic approach was used to analyze the open-ended questions where the most important aspects of each response were recorded (Glesne, 1999). The responses were read several times for patterns, broad concepts, and themes that were expected, as well as those unexpected. This method revealed that many of the responses to the open-ended questions were consistent with how the pilot population responded to the close-ended items. The least compelling open-ended question asked participants about their sense of belongingness to their cultural groups. Although the responses were appropriate for the question, they were almost identical to how participants defined culture. This question did not contribute to or explain what participants understand about culture, cross-cultural education, or stereotypes and was eliminated from the revised instrument.

Unlike the question about belongingness, responses to what influenced one's definition of culture were unique from other responses and provided explanatory

information. While the question about what influenced participants' definition of culture was informative with respect to how they formed their views, this research is interested specifically in how professional education shapes one's beliefs, which participants explicitly were asked. The more general question about influences was eliminated. This study found the question about professional education to be limited, since the item only asked about the most important factors participants had learned. The responses were likely incomplete, since the question only solicited the most significant factors. This question was revised where the words, most important, were eliminated.

The pilot tested the survey with a similar population, evaluated the reliability and validity of the questionnaire, and eliminated items that were not explanatory or predictive. The revisions to the instrument resulted in a more pointed and condensed survey that likely increased participation (See Appendix C. Revised Beliefs about Culture Instrument). In addition to the close-ended survey, this study also conducted interviews with faculty members to learn in depth what they report that they teach medical residents about culture.

Interview Guide.

The interview guide and data collection for this study borrowed from grounded theory, a research method where collected data explain inductively some phenomenon, that is, researchers use specifics to develop general explanatory statements about the world (Creswell, 2005; Glesne, 1999; Hatch, 2002). Glaser and Strauss, sociologists, developed grounded theory in the 1960s as a qualitative method which proposes the following: definitive truth exists; we approximate reality at best; and, individuals' narratives and representations are instructive for generalizations (Hatch). As a qualitative method, grounded theory is concerned with validity and reliability in ways similar to quantitative research, in that, sometimes researchers use descriptive statistics as further evidence for their findings. While there are several variations of grounded theory, the one that influenced the development of the interview guide recognizes that data are emergent and instruments must change to accommodate new information (Creswell). Although grounded theory influenced the interview guide, this research is not a grounded theory study.

The interview guide was based on four factors: the purpose of the study, the domain of culture, the literature, and knowledge about the population, which Glesne (1999) and Hatch (2002) proposed. The guide began with general questions and moved to more specific ones as the interview continued (Glesne; Hatch). Faculty members were asked three types of questions, which Hatch described as descriptive, structural, and contrast. Descriptive questions are those that prompt participants to discuss specifics that they have direct or intimate knowledge of, such as their responsibilities. Structural questions focus more on how participants reflect and make connections. Contrast questions delve into how one defines concepts, constructs, and situations.

Descriptive questions asked faculty members to describe how medicine integrates culture into the curriculum; what they teach about diverse beliefs, values, and practices; and, what skills they believe medical residents should learn. Structural questions pertained to concerns faculty members have about teaching cross-cultural skills; whether or not cultural content can be learned didactically; and, what evidence existed that culture matters for clinical encounters. The interview guide primarily consisted of contrast questions, which sought to understand differences between faculty members and medical residents. Contrast questions asked why the two groups differed in their perceptions of culture and cross-cultural education and why there were so few differences within and between groups (See Appendix D. Preliminary Interview Guide). While these questions provided the basis for conducting interviews, the guide was flexible and dependent upon what participants said.

Data Collection

Prior to the collection of data, the Institutional Review Board (IRB), whom the University of Kentucky has authorized to monitor research that involves human and animal subjects, approved this study. However, at the University of Kentucky, any research with medical residents, referred to as house staff, also has to be approved by the Graduate Medical Education office. The review committee for the Graduate Medical Education office is comprised of residency directors across all the clinical departments in the College of Medicine. After IRB authorization, Graduate Medical Education approved this study. There was no additional approval beyond IRB for faculty members.

This study identified several ways to recruit participants for this study to include the use of departmental mail, attendance at regularly scheduled educational conferences, which accreditation mandates, faculty meetings, or email. Recruitment at an educational conference or faculty meeting was preferable; however, departments plan and schedule these events well in advance, sometimes up to a semester or year prior to the meeting. While departmental mail was a tenable option, there were logistical shortcomings, such as access to mailboxes for recruitment and follow-up, timely management of who had completed the instrument, and lack of security with respect to who has access to the survey. Several web-based surveys were tested to overcome these limitations and SurveyMonkey was selected to administer the instruments. This web-based tool supports both close-ended and open-ended responses, email invitations and reminders, downloads of responses to include who responded, as well as whether or not participants completed the instrument.

The chairs, residency directors, or a staff member provided the names and email addresses for faculty members and medical residents. The sample population received email invitations that invited them to participate in the study. The email message included a description of the study, relevance to their profession, and importance of their contribution, along with a link to the web-based instrument and consent form. Participants were informed of a deadline and those who did not respond received a reminder message one week later. A subsequent follow-up message was sent to participants who had not responded by the end of the second week and two days prior to the date that the survey closed.

Faculty members, who completed the close-ended survey, were invited to participate in an interview. The purposive sample of faculty members was based on their means for beliefs about culture and willingness to accept stereotypes, richness of responses to open-ended questions, and demographics. The study sought to learn from a diverse group with different beliefs. Chairs and residency directors for family and community medicine, internal medicine, obstetrics and gynecology, and pediatrics stated that thirty minutes was the maximum time that the majority of the faculty members in their departments would set aside for an interview; however, the time limit was extended for participants who wanted to discuss the issue further. The interviews were conducted

in person at the faculty member's office and were audio recorded. Prior to the interviews, faculty members received an account of the significant similarities and differences between themselves and medical residents with respect to how they defined culture, the implications for clinical encounters, the role and impact of didactics, and willingness to accept stereotypes (See Appendix E. Summary of Beliefs about Culture Findings).

Data Analysis

SPSS 17.0 was used to analyze the close-ended survey data. Instruments were defined as incomplete if 50% or more items were coded as missing or "Not sure". This study did not include any incomplete instruments in the data analysis. Participants' scores for the beliefs about culture and the willingness to accept stereotypes variables were computed as averages. Beliefs about culture and willingness to accept stereotypes variables consisted of fourteen and twelve items, respectively, which ranged in value from one to four. "Not sure" responses were treated as missing data, and these items did not figure into participants' scores. For example, if a participant answered nine out of twelve items, the individual's score was based on the sum of the item's value divided by nine to determine the average.

This study computed descriptive statistics for beliefs about culture and willingness to accept stereotypes and treated the two as interval variables, because the degree of agreement and disagreement between items is equal (Creswell, 2005; Nardi, 2006). Beliefs about culture and willingness to accept stereotypes were described in terms of frequency, mean, and standard deviation. Demographic data are comprised of nominal and ordinal variables. The nominal variables are gender, ethnicity, citizenship, parents' education, and social class. These variables are nominal, because there is no order or numerical significance inherent to them (Creswell; Nardi). Status in department is an ordinal variable, because faculty members are considered higher in status than third year medical residents, who are considered higher than second years, who are higher than first years. Number of years living in the U.S. also is an ordinal variable. Nominal and ordinal variables were recoded into numeric values in order to evaluate these items statistically.

In addition to descriptive statistics, this research computed Cronbach's alpha and a factor analysis to evaluate respectively the close-ended instrument's reliability and validity. The following multivariate statistics also were computed to understand the relationship between and among variables: multivariate ANOVA, correlation, and multiple linear regression analysis. The multivariate ANOVA tested whether or not medical residents and faculty members differed with respect to their beliefs about culture and willingness to accept stereotypes in terms of gender, citizenship, specialty, status in department, and parents' education and social class.

Correlations provided data about relationships, and multiple linear regression analysis determined the predictive value of the independent variables for the dependent one. A multiple linear regression was performed to determine how explanatory beliefs about culture, specialty, status within department, year in residency, gender, citizenship, parents' social class and educational attainment, and number of years living in the U.S were for willingness to accept stereotypes.

This study used the listwise method for missing values because this approach only considers complete cases. Conversely, the pairwise approach only deletes missing cases for the particular variable under analysis, which results in different numbers of observations for different variables. The pairwise method mixes cases, which impacts the representativeness of the data, especially if missing items are not random. While there are other methods to address missing values like mean substitution, expectation maximization, and other iterative approaches, this study used the listwise method, since a number of missing data belong to dichotomous and nominal variables which are not appropriate for statistical estimations.

This study used the stepwise method, instead of the enter option, to add variables to the regression equations. Some researchers use the enter method to add variables when there is a theoretical foundation in which to order or rank their explanatory value. This study had no basis upon which to order variables, and thus used the stepwise method, which adds variables one at a time in different combinations to the equation according to correlation strength. Along with descriptive and multivariate statistics, this study analyzed open-ended and interview data thematically.

A draft of categories and codes were developed for the open-ended interview data, which were based on expected findings for beliefs about culture, cross-cultural education, and stereotypes. Expectations were based on themes found throughout the literature; the researcher's familiarity with the population and their approach to cross-cultural education; and, related concepts like the biopsychosocial model, evidence-based medicine, and patient-centeredness. The initial categories were art, science, instruction, curriculum, patient health beliefs, professionalism, health disparities, and diversity.

The interview data were coded based on the approach Glesne (1999) described where specific codes and small bits of data are identified for patterns, grouped into broader concepts, and analyzed for themes and relationships. The transcribed interviews were read as a whole and then for key phrases and ideas with respect to the draft codes. Based on key phrases and ideas that emerged from the initial read of the interviews, the code list was revised and interviews were read several times for similarities and differences, which became the basics for a new set of codes and categories. Once the transcripts were marked with the final codes and examined for patterns, the newly emerged data became the basis to develop concepts and to refine themes. Themes were evaluated in terms of patterns within, between, and across groups.

This study like others that collect data via interviews was susceptible to biases and perceptions that interviewer and participants may have had of each other whereby interviewees may provide data they believe are desirable and the interviewer may change the nature and structure of interviews. There are a number of reasons why interview biases emerge, such as the identity of the interviewer, misperceptions made about the study, and participants' lack of understanding of the issue. This study sought to minimize the impact of interview bias by providing summary data to participants (See Appendix E. Summary of Beliefs about Culture Findings), asking faculty members to make comparisons between themselves and medical residents, and not inquiring into whether or not they believe cross-cultural education is relevant to health care and outcomes. Oral history is instructive on how to address interview bias when participants provide information they believe the interviewer wants. While the data may not reflect what the person actually believes, this information indicates what participants believe is the "right answer" to a question. This study also relies on grounded theory as a reason to change

the interview structure, as emergent data may necessitate changes to learn additional information.

Summary

This research sought overall to learn from faculty members and medical residents whether or not a modern philosophy of culture increases one's willingness to accept stereotypes more than a postmodern one. While philosophical perspectives are a challenge to identify, this research approximated what faculty members and medical residents understand about culture via a close-ended survey that inquired about their epistemological beliefs. This study analyzed differences between faculty members and medical residents in terms of their beliefs about culture, willingness to accept stereotypes, and the relationships among the variables that influence their cultural philosophy. Open-ended interviews with faculty members sought to learn in greater detail what they understand about culture and to explain the extent to which they believe that they teach medical residents about cultural content.

The quantitative and qualitative data and analyses work together to more completely understand the research inquiry. Quantitative analyses lend themselves to determining central tendencies, making group comparisons and assumptions about populations, and determining relationships. Qualitative analyses are used often to reveal in depth descriptions about participants, what the nuances are, why individuals or groups are similar or different, and the particulars of patterns and themes that emerge or do not. The two approaches to data analysis together complement each other and provide data that neither approach alone would reveal. This study used the two approaches to make quantitative statements about a population, as well as contextualize qualitatively what the statistical methods reveal, as well as findings that do not emerge. The following chapter provides the results of the data analysis.

Chapter 4: Results

This study sought to learn what faculty members and medical residents in primary care medicine understand about culture and their willingness to accept stereotypes about patients. The inquiry was guided by four research questions:

1. What are faculty members' and medical residents' beliefs about culture and their willingness to accept stereotypes?
2. What is the philosophical agreement between faculty members and medical residents with respect to beliefs about culture and willingness to accept stereotypes?
3. What is the relationship between one's philosophical perspective regarding beliefs about culture and willingness to accept stereotypes?
4. What do faculty members report that they teach to medical residents about culture?

The results to each research question are presented in this chapter. Prior to the results for the research question, the sample population is described.

Description of Validity, Reliability, and the Population

Other researchers have evaluated the beliefs about culture and willingness to accept stereotypes components of the close-ended instrument for validity and reliability; however, this study consulted experts in the fields of medicine, medical anthropology, and education to obtain further content validity for the survey. The study also used a factor analysis to evaluate construct validity for beliefs about culture and willingness to accept stereotypes. The method was based on the principal components analysis and the Eigenvalue minimum was set at 1.0. Factors were extracted using the varimax method, because this study posited that the items that comprised the beliefs about culture and willingness to accept stereotypes variables are independent. The analysis excluded missing values based on the listwise method. Based on these criteria, six components with Eigenvalues greater than 1.0 emerged for beliefs about culture and accounted for 66.509% of the variance. Four components with Eigenvalues greater than 1.0 emerged and explained 59.714% of the variance for willingness to accept stereotypes.

The study used Cronbach's Alpha to test reliability. The alpha coefficient for beliefs about culture and willingness to accept stereotypes was .551 and .722

respectively. The validity and reliability findings for beliefs about culture were consistent with Duell's and Schommer-Aikins' (2001) findings, and willingness to accept stereotypes was consistent with what Carter, et al (2006) found. This study combined faculty members and medical residents to evaluate the validity and reliability of the beliefs about culture and willingness to accept stereotypes measures.

The aggregate population for faculty members and medical residents across all four specialties was 298, of which 121 responded to the survey for an overall response rate of 40.6%. Filtering out partial responses, the response rate for completed surveys was 38.3%. Faculty members' overall response rate of 42.0% was higher than medical residents', who responded at 35.8%. However, the opposite was true for Obstetrics and Gynecology where medical residents had a higher response rate than faculty members. See Appendix F. Response Rate by Group and by Specialty for a more in depth description of the two groups. In addition to differences in response rates between faculty members and medical residents, the participants differed across specialties as well. Family and Community Medicine (47.9%) and Obstetrics and Gynecology (42.9%) responded in greater percentages than Internal Medicine (30.9%) and Pediatrics (34.7%). See Appendix G. Response Rate by Completed and No Response for a complete description of the differences in participation.

The response rates across the sample population suggest that the specialties had different interests in culture and cross-cultural education. Based on response rates, obstetrics and gynecology and family and community medicine expressed greater interest in the study than the other specialties. This study expected greater interest from family and community medicine, because the specialty's philosophy talks extensively about patients, their health beliefs, and factors that impact individuals' health (Martin, et al., 2004). However, the interest in culture from obstetrics and gynecology was not expected. This specialty's interest, at least at the University of Kentucky, may be explained, in part, by a large and active Latino clinic for high risk pregnancies.

In addition to medical specialty and status as faculty member or medical resident, this study also collected gender, ethnicity, citizenship, number of years living in the U.S., year in residency, and parents' education and social class. The overall distribution of women and men participants was 45.2% and 51.3% respectively, while 3.5% did not

provide their gender. The majority (67.0%) of participants identified themselves as Caucasian, while 8.7% described themselves as Latino and 7.8% as Asian. See Appendix H. Distribution by Ethnicity and Parents' Education for a complete description of the sample population. A majority (76.5%) of faculty members and medical residents were born in the U.S., but those, who were not, have lived in the U.S. a mean of 13.14 years with a standard deviation of 9.80. Respectively, 65.8% and 62.2% of all participants' fathers and mothers had obtained an undergraduate degree or higher. See Appendix H. Distribution by Ethnicity and Parents' Education for a more in depth description of faculty members and medical residents. Cumulatively, 89.6% of all participants lived in middle (48.7%) or upper (40.9%) class homes, while a minority of 6.1% of medical residents and faculty members had working class parents.

Statistical and thematic data in this chapter are organized in terms of the four research questions where the scores for beliefs about culture and willingness to accept stereotypes are described, along with intervening variables like gender and social class. Correlations and thematic analyses of open-ended responses further explain the meaning of the scores. After the description of the population's beliefs about culture and willingness to accept stereotypes, the study compared their agreement on these two constructs. The final statistical analysis examined the predictive and explanatory value of the independent variables for the dependent one. The study analyzed cross-cultural education thematically via in depth interviews with faculty members.

Describing Beliefs about Culture and Willingness to Accept Stereotypes

This study computed scores for beliefs about culture and willingness to accept stereotypes. See Chapter 3, *Data Analysis* for a description of how this study calculated participants' scores. The scores for beliefs about culture have a range from 1.00, which represents the most contextual way to understand culture, to 4.00, the most essentialist and concrete perspective. The scale to measure willingness to accept stereotypes also ranges between 1.00 and 4.00. Scores of 1.00 indicate that participants are likely to reject stereotypes, whereas scores of 4.00 signify a willingness to accept generalizations. Beliefs about culture scores ranged between 1.62 – 2.64 for faculty members and 1.86 – 2.79 for medical residents. Faculty members had an overall mean of 2.245 ($N = 51$, $SD =$

.192) and medical residents had an average score of 2.323 (N = 64, SD = .205) for the beliefs about culture variable, as shown in Table 4.1.

Table 4.1, Beliefs about Culture Scores – Faculty Members and Medical Residents

	Faculty			Medical Residents		
	N	M	SD	N	M	SD
Specialty						
IM	7	2.265	.221	23	2.278	.196
OB/GYN	14	2.276	.180	11	2.256	.173
FCM	22	2.195	.211	13	2.366	.184
PEDS	8	2.313	.115	17	2.397	.233
Total	51	2.245	.192	64	2.323	.205

In addition to specialty and status, this study asked medical residents to provide their PGY status, which is unique to this group. Residency for primary care specialties typically requires three to four years and specialties refer to years in residency as PGY where first year residents are junior to third and fourth years. This study sought to understand the effect of PGY status on beliefs about culture and willingness to accept stereotypes to determine whether or not perceptions or attitudes change over time during residency. This study collected four PGY statuses, first, second, third, and fourth, and the means were 2.361 (N = 19, SD = .237), 2.312 (N = 14, SD = .165), 2.312 (N = 22, SD = .211), 2.223 (N = 6, SD = .166), respectively. See Appendix I. Culture Score for Faculty Members and Medical Residents for means across all variables.

Along with beliefs about culture, this study measured participants' willingness to accept stereotypes, which ranged between 1.75 – 3.08 for faculty members and 1.67 – 3.25 for medical residents. Faculty members' and medical residents' means for willingness to accept stereotypes were 2.494 (N = 49, SD = .294) and 2.512 (N = 63, SD = .339) respectively, as shown in Table 4.2.

Table 4.2, Willingness to Accept Stereotypes Scores – Faculty Members and Medical Residents

	Faculty			Residents		
	N	M	SD	N	M	SD
Specialty						
IM	6	2.708	.283	23	2.583	.331
OB/GYN	13	2.472	.227	10	2.418	.430
FCM	22	2.441	.328	13	2.484	.225
PEDS	8	2.516	.275	17	2.494	.372
Total	49	2.494	.294	63	2.512	.339

The means for first, second, third, and fourth year medical residents' willingness to accept stereotypes were 2.550 (N = 19, SD = .263), 2.502 (N = 14, SD = .410), 2.478 (N = 22, SD = .316), 2.482 (N = 6, SD = .480) respectively. The means for willingness to accept stereotypes are granulated further for both groups in terms of demographic variables like gender and social class, which are provided in Appendix J. Stereotypes Score for Faculty Members and Medical Residents. Across all intervening variables, faculty members' and medical residents' scores for beliefs about culture leaned toward modernism. Additionally, the scores for faculty members and medical residents indicated that both groups are more willing to accept stereotypes than they are to reject them. Faculty members' and medical residents' responses to the open-ended questions regarding how they define culture and how they identify themselves culturally helps to explain the close-ended findings, which indicate that the two groups hold modernists views and are willing to accept stereotypes.

Faculty members and medical residents overwhelmingly defined culture as shared beliefs, values, and practices that influence and impact how one views others and interacts with the world. For example, one faculty member defined culture as "a group of people with similar backgrounds or experiences, such as those who watched Sesame Street and Mr. Rogers, doctors, Wall Street, or religion." A resident framed culture as a "set of beliefs and attitudes that are based on ethnicity, religion, or a certain geographic area."

Faculty members and medical residents often defined culture in terms of race, ethnicity, and religion, which is consistent with what Betancourt (2004, 2006a, 2006b) and Dogra, Giordano, and France (2007) found in their research. These identifiers for many participants defined culture and delimited boundaries for how individuals interact with and interpret the world. Conversely, there were a few faculty members and medical residents who expressly stated that culture is not defined by identifiers, such as the following comment by a medical resident, "Culture is a set of beliefs and mores that influence one's behaviors and attitudes toward life. It is in no way equivalent to race or ethnicity, but relates to the circumstances in which one was raised, including religion and value systems." This medical resident rejected race and ethnicity as primary identifiers, but proposed that religion is a way to define culture. There were many faculty members and medical residents who defined culture in narrow ways; however, there were others who rejected these limited definitions. Furthermore, the two groups seldom mentioned language, gender, and social class as ways to define culture; yet, when participants raised gender, it was often done so by women.

However, faculty members and medical residents differed in how complexly they perceived culture. A faculty member recounted how he realized that he did not know as much about a cultural group as he thought to illustrate the complexity of culture.

> Although I was born in Lexington, I moved to London when I was ten and consider it more home than here, but when I moved back to London [Kentucky] after serving in the army and completing medical school I realized how much I didn't know about farmers. Even though my relatives were all farmers, I didn't really know much about farm life. As I began to get farmers as patients, I began to see things that I didn't know about their beliefs and practices. So, we may think we know something about a culture, but a lot of times we don't know as much as we think.

The following comment from a medical resident captured how many in this group perceived the complexity of culture.

> Culture itself isn't complicated as long as people within the group all agree about what their commonalities are. The bigger the group is, the harder it is to define the commonalities. For instance, in the black population, there is more diversity than I can comprehend. But, if you make groups smaller, for example, northeastern white lesbians, you'll likely find fewer complications. What makes culture complicated is that we don't live in bubbles and cultures are in constant movement with and around each other.

Although this definition of culture included nuances and the emergent nature of groups' traits and characteristics, many medical residents stated or indicated, on some level, shared beliefs, value, and practices are not difficult to define. Geographic location also emerged as a way many medical residents defined culture. Geographic location often pertained to countries and regions of the world and included specific states like Kentucky and areas like Appalachia.

When faculty members defined culture, they included phrases like "difficult to define," "blended boundaries," and "intervening factors" in their definitions. One faculty member described culture as follows

> Culture is very complex and very subtle. There's always more to it than the way that you define it. It really is such a complex issue, and I don't think people have a good enough understanding of it to define it well. One way people can talk about culture is like how they talk about art. For example, how do you define art? You know it when you see it, but you can't really define what makes it art. It's hard to capture all the nuances of culture.

Explicitly, this faculty member related culture to art and implicitly suggested that cross-cultural skills are difficult to teach, if teachable at all. These types of statements were prevalent among faculty members who found culture to be complex.

A number of faculty members and medical residents stated that cross-cultural competence is difficult to practice, because oftentimes physicians do not know the groups to which individuals belong, since one seldom is a member of only one group. Both groups overwhelmingly defined cultural identity as the confluence of multiple memberships and as a factor that complicates culture and their responsibility to provide care. For example, a faculty member stated that

> Culture is all around us like the air we breathe. It's not something we define every day. I don't wake up and say, 'This is how I'm going to behave today, because I'm a white person' or 'I'm Roman Catholic, so this is how I'm going to behave today.' It's just something you don't think about. As we grow, we recognize we're a mosaic of cultures. There are very few of us who are strictly just Roman Catholic and nothing else.

A medical resident framed cultural identity as follows

> Learning and feeling other's culture will help us to consider people's feelings and emotions. However, it must not be used to make decisions. Cultural and ethnic groups are heterogeneous. Understanding culture is just like knowing the traffic rules. You cannot drive without knowing them, but it does not define where you go.

While the faculty member and medical resident above found identity to be a complicating factor for medical practice, the resident suggested that physicians can define shared beliefs, values, and practices to the extent that they can use patients' traits and characteristics similar to traffic rules to guide decisions.

A number of faculty members defined culture holistically as an amalgamation of many factors, such as history and lived experiences. Some faculty members expressed that politics, power, and ways in which groups perceive one another influence culture. A few faculty members mentioned power when they discussed their relationship with patients. Specifically, these faculty members stated that power was relevant to the clinical encounter, because physicians often have greater medical knowledge than many of their patients.

With respect to the relevancy of culture to the clinical encounter, faculty members and medical residents also indirectly raised concerns about stereotypes. There were a number of faculty members and medical residents who proposed that the profession should not frame culture in simple and concrete terms that suggest everyone is the same. For instance, one faculty member responded that "People do not always behave as their culture suggests. There are Catholics who support choice, liberals who are anti-abortion, gays from India and straights from San Francisco." This faculty member indicated that cross-cultural competence is problematic in medicine when physicians expect and interact with patients based on stereotypes. This faculty member also suggested that group members contest seemingly universal beliefs, values, and practices. Indirectly, other faculty members and medical residents raised the issue of stereotypes when they highlighted patients' individuality and diversity within groups.

The close-ended instrument reveals that faculty members' and medical residents' beliefs about culture lean toward modernism; however, open-ended responses and interviews reveal that there are contextual differences between the two groups that the descriptive statistical data did not indicate. Participants' willingness to accept stereotypes also was understood with greater clarity from the analysis of close-ended and open-ended data. In addition to the description of faculty members' and medical residents' philosophy of culture and their willingness to accept stereotypes, this study examined whether or not the two groups shared the same philosophical beliefs. This inquiry

evaluated the similarity between faculty members who teach about culture and medical residents who learn from them how to approach and address cultural issues in clinical encounters.

Comparing Faculty Members' and Medical Residents' Beliefs about Culture and Stereotypes

A multivariate ANOVA test was conducted for faculty members' and medical residents' scores for beliefs about culture and willingness to accept stereotypes to learn whether or not the two groups differ. The multivariate ANOVA test indicated that faculty members and medical residents had significantly different means (F (1, 114) = 4.357, p = .039) for the beliefs about culture variable. Additionally, beliefs about culture across medical specialty, citizenship, gender, parents' education and social class were all significant at $p < .05$. Ethnicity was the only variable that was not significant. See Table 4.3 for the multivariate ANOVA findings.

Table 4.3, Analysis of Variance for Beliefs about Culture

Source	*df*	*F*	η	*p*
	Between groups			
Specialty	1	4.357	.193	.039*
Citizenship	1	5.137	.211	.025*
Gender	1	4.294	.195	.041*
Ethnicity	1	2.926	.166	.090
Education (male)	1	4.679	.203	.033*
Education (female)	1	5.352	.216	.023*
Social class	1	5.137	.211	.025*
Status	1	5.740	.226	.018*

* $p < .05$

While the two groups had significantly different means from one another, this study found few within differences for beliefs about culture for medical residents and none for faculty members. Medical residents' beliefs about culture significantly differed (F (1, 62) = 8.472, p = .005) from one another in terms of gender. Men residents had a mean score of 2.387 (N = 34, SD = .198), and the mean score for women was 2.244 (N =

29, *SD* = .189). Medical residents did not have significantly different means in terms of specialty, year in residency, citizenship, ethnicity, or parents' education and social class.

The findings for willingness to accept stereotypes indicated that there were no differences in scores between faculty members and medical residents. Faculty members had a mean of 2.494 ($N = 49$, $SD = .294$), and medical residents had an average of 2.512 ($N = 63$, $SD = .339$). The level of significance (F (1, 111) = .087, $p = .768$) for the two was greater than $p < .05$. In addition to no significant differences between the two groups, there were no within differences for either in terms of specialty, citizenship, gender, ethnicity, parents' education and social class, or year in residency.

Faculty members were asked open-ended questions about what they teach about culture, which was compared to what medical residents reported they had learned about cultural beliefs, values, and practices during medical school. The purpose of this inquiry was to learn in greater depth why the two groups may have similar or different beliefs about culture. Overall, faculty members and medical residents attributed cultural knowledge and attitudes to experiential efforts more than to didactics. However, the two differed with respect to whom they indicated was responsible for the experiences. Medical residents attributed their experiential learning to themselves and not faculty members. Faculty members believed that they facilitated and provided experiences to teach medical residents about culture, as the comment below suggests

> If residents say they have learned nothing about culture during their training, I take exception to that because they learn something about culture when they see people from different cultures from their own. They have to learn from these experiences, unless they are slow learners. I ask residents how they explain things to patients and if they used the person's vernacular. For example, did the resident tell them what they wanted to know or what they need to know and in a way that the patient could understand it. We don't always do this and it makes a difference.

This issue is examined in depth during interviews with faculty members, which is discussed in the section, *Faculty Members' Perspectives of Cross-cultural Education*. In addition to differences over experiential learning, faculty members and medical residents share a number of similarities with one another with respect to how they discussed cross-cultural education and competence.

Faculty members and medical residents overwhelmingly framed cross-cultural education in terms of knowledge and attitudes. The following faculty member perceived culture as follows,

> Culture helps to frame decision-making. An appreciation for differences helps to more easily forge connections with individuals from other cultures. It is important to listen and learn from your patients to garner a better understanding of their culture and how it influences their life.

Knowledge about culture frequently pertained to specific characteristics and traits. The most prevalent attitudes that the two groups discussed were respect for and sensitivity to differences and stereotypes. Faculty members and medical residents seldom raised the skills domain with respect to how they applied knowledge and attitudes in clinical encounters. Despite similar discussions regarding the domains of cross-cultural competence, faculty members and medical residents departed from one another with respect to their perceived ability to provide cross-cultural care.

Faculty members and medical residents differed starkly in how they characterized their cross-cultural skills. Faculty members widely expressed that they needed to learn more about culture and that cultural knowledge mattered for the clinical encounter. This finding was consistent with their open-ended definitions where they defined culture as highly subjective and difficult to understand. Conversely, many medical residents described specifics that they learned about different cultural groups and certainty about their competence during clinical encounters. However, some medical residents expressed that they had learned nothing about culture during their medical education.

Statistically, faculty members and medical residents have different beliefs about culture but not willingness to accept stereotypes. However, the thematic analysis revealed that the two groups philosophically had similar beliefs about culture, but within their modernist definitions they departed from one another on factors like how fixed and defined cultural beliefs, values, and practices are. Given that faculty members and medical residents have similar and different beliefs about culture, but not willingness to accept stereotypes, this study turned to how predictive the independent variable was for the dependent one.

Understanding the Relationships among Variables

This study hypothesized that one's beliefs about culture predict their willingness to accept stereotypes. Intervening variables also were identified to determine whether or not they have an impact or relationship to the other independent variables, as well as the dependent one. This study used Pearson's correlation to examine the extent to which independent and dependent variables are correlated with one another, as shown in Table 4.4 for faculty members and Table 4.5 for medical residents. All correlations were tested for one-tailed significance. The one-tailed significance test was used because this study hypothesizes that postmodernism results in less willingness to accept stereotypes than modernism.

Table 4.4, Faculty Members' Correlations for Independent and Dependent Variables

	Stereotyping (Dependent)
Independent	
	(N=49)
1. Culture	.237
2. Citizenship	-.278*
3. Gender	.199
4. Social class	.126
5. Specialty	-.166
6. Education (father)	.076
7. Education (mother)	.243*
8. Years Living in U.S.	.024

* Correlation is significant at the .05 level (1-tailed).

Faculty members as a group have few variables that correlated with one another; however, number of years living in the U.S. and citizenship are statistically significant for beliefs about culture and willingness to accept stereotypes respectively. While all participants specified whether or not they were born in the U.S., only individuals born outside the U.S. provided the number of years living in the U.S. Number of years living in the U.S. correlate negatively ($r = -.712$, $p < .01$) with beliefs about culture and suggest that the longer non-natural citizens live in the U.S. the more contextual and less universal they understand cultural beliefs and values. Furthermore, non-natural citizens are less

likely to accept stereotypes than natural born citizens, as the negative correlation (r = -.278, p < .05) between citizenship and willingness to accept stereotypes suggests.

The education of faculty members' mothers correlated positively and significantly with the education of participants' fathers (r = .548, p < .01), parents' social class (r = .585, p < .01), as well as willingness to accept stereotypes (r = .243, p < .01). These findings indicate that the education of both parents strongly correlates with social class where higher educational attainment relates to upper social standing. The educational attainment of faculty members' mothers correlated positively and significantly with willingness to accept stereotypes. This finding indicates that as education increases willingness to accept stereotypes decrease. While the education of faculty members' mothers correlates positively and significantly with willingness to accept stereotypes, the education of their fathers does not. See Appendix K. Faculty Members' Correlations among Independent Variables for all relationships.

Similar to the findings for faculty members, there are few meaningful correlations among variables for medical residents, as shown in Table 4.5.

Table 4.5, Medical Residents' Correlations for Independent and Dependent Variables

	Stereotyping (Dependent)
Independent	
	(N=63)
1. Culture	.402*
2. Year in Residency	-.086
3. Citizenship	-.160
4. Gender	.048
5. Social class (parents)	.049
6. Specialty	-.100
7. Education (father)	.121
8. Education (mother)	.163
9. Years living in U.S.	-.374

* Correlation is significant at the .01 level (1-tailed).

The beliefs about culture variable (r = .402, p < .01) is the only one that correlates with willingness to accept stereotypes. Gender (r = .349, p < .01) correlates positively and

statistically with beliefs about culture. Social class correlates positively and significantly with parents' educational attainment. The education of medical residents' fathers has a correlation of .607 with social class ($p < .01$) and the educational attainment of their mothers is .471 ($p < .01$). These findings suggest that as educational attainment increases so does social class. Additionally, the education of medical residents' mothers and fathers correlates with each other ($r = .603$, $p < .01$) and indicates that both parents have similar educational status. See Appendix L. Medical Residents' Correlations among Independent Variables for all relationships.

In addition to the relationships among variables, this study also hypothesized that beliefs about culture predict willingness to accept stereotypes. The study ran multiple linear regression equations to test the hypothesis for faculty members and medical residents. The multiple linear regression method excluded cases using the listwise method and entered variables using the stepwise method. The following predictor variables were used for the regression equations: beliefs about culture, year in residency, citizenship, gender, parents' social class and educational attainment, status within department, specialty, and number of years living in the U.S. The study did not use ethnicity in any of the equations given that Caucasians comprised 73.3% of the total sample population, 79.1% of faculty members, and 69.4% of medical residents. Furthermore, Caucasians represented one out of eight categories that emerged from the data collection; the instrument allowed participants to state their ethnicity via free text instead of forced categories. Any findings from this variable would be biased.

The outcome of the multiple regression equation for faculty members reveals that citizenship is the only variable that significantly predicts ($p = 0.44$) willingness to accept stereotypes, as shown in Table 4.6.

Table 4.6, Regression Equation for Faculty Members (N=49)

Model	Variable	*B*	*SE B*	β
1	(Constant)	2.809	.157	
	Citizenship	-.283	.136	-.302*

$R^2 \Delta = .091$ for Model 1 ($p < .05$).

* $p < .05$.

The model included 49 cases and indicates that non-natural citizens are less willing to accept stereotypes than individuals born in the U.S. Figure 4.1 shows that the distribution of willingness to accept stereotypes residuals is somewhat negatively skewed with a mean of .01 and a standard deviation of .984.

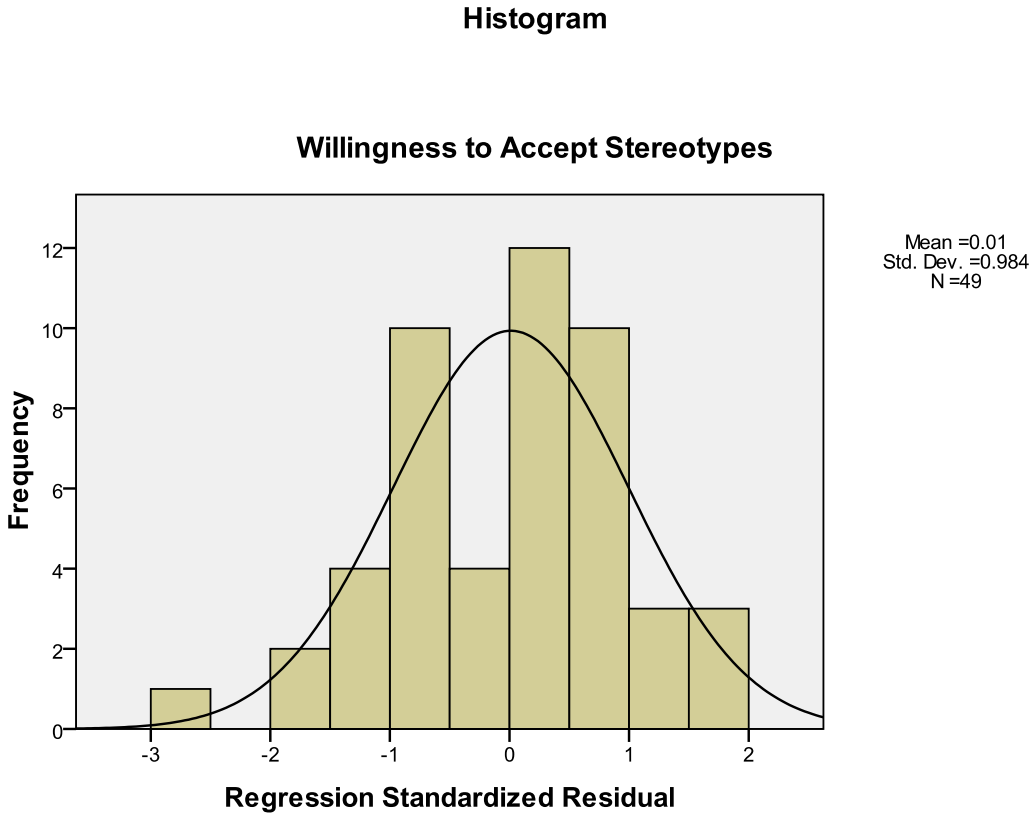

Figure 4.1, Distribution of Willingness to Accept Stereotypes for Faculty Members

The plot of observed and expected cumulative probabilities for willingness to accept stereotypes, shown in Figure 4.2, suggests that predicted and actual values match closely. The differences between observed and expected probabilities, defined as residuals, reside closely to the normal distribution line and suggest that values for willingness to accept stereotypes are from a relatively normal distribution.

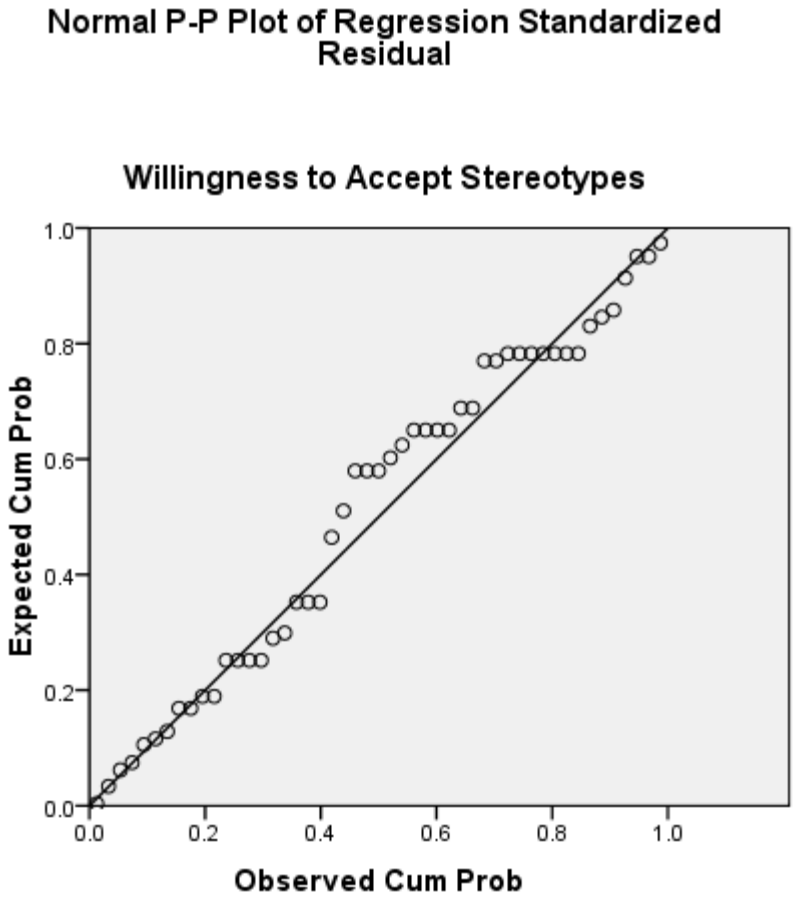

Figure 4.2, Observed and Expected Probabilities for Stereotypes (Faculty Members)

The regression equation for medical residents reveals that beliefs about culture and medical specialty predict willingness to accept stereotypes. Two models, as shown in Table 4.7, emerged from the multiple linear regression analysis.

Table 4.7, Regression Equations for Medical Residents (N=63)

Model	Variable	*B*	*SE B*	β
1	(Constant)	1.051	.458	
	Culture	.627	.196	.384**
2	(Constant)	.974	.446	
	Culture	.730	.197	.447**
	Medical Specialty	-.069	.033	-.256*

R^2 = .147 for Model 1; ΔR^2 = .062 for Model 2.

* $p < .05$. ** $p < .01$.

Models 1 and 2 for this regression equation are significant at p = .002 and p = .001 respectively. Both models indicate that beliefs about culture predict willingness to accept stereotypes for medical residents.

Figure 4.3 suggests the residuals for willingness to accept stereotypes are normally distributed with a mean of .03 and a standard deviation of .995.

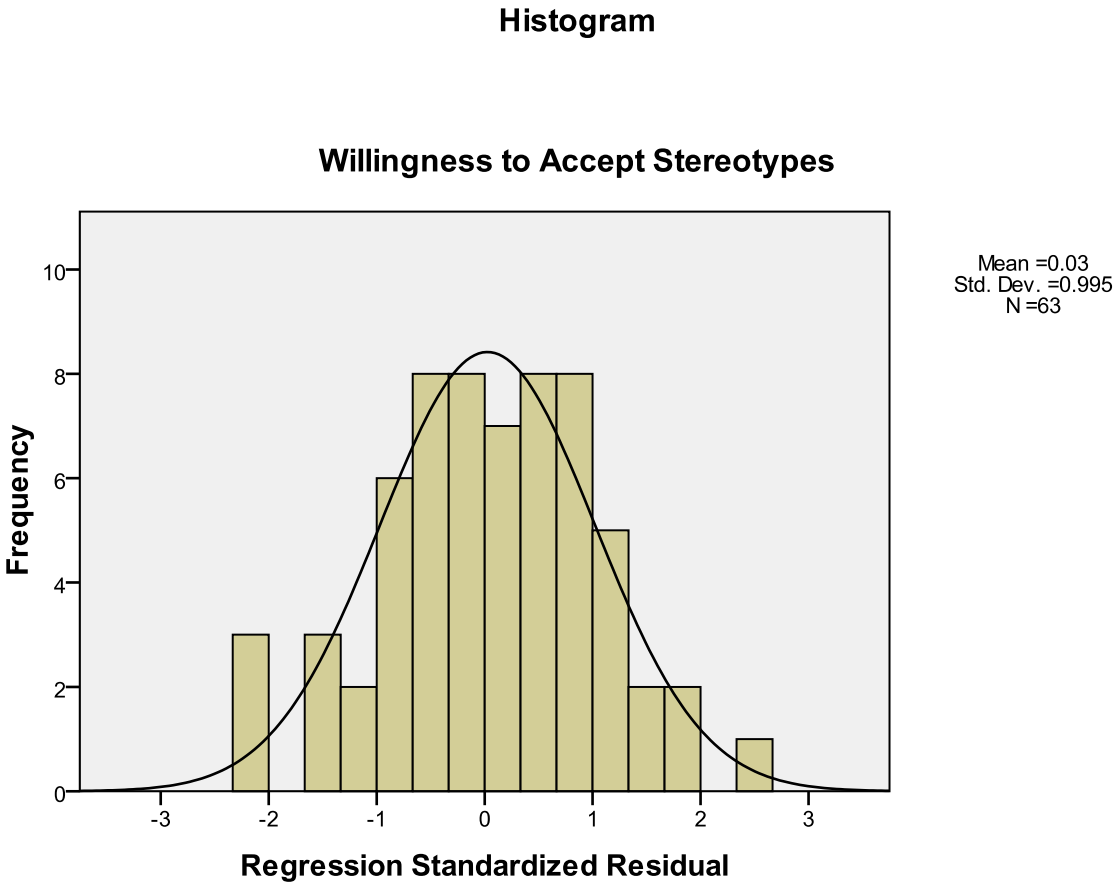

Figure 4.3, Distribution of Willingness to Accept Stereotypes for Medical Residents

Furthermore, the plot of residuals indicates that the observed values closely reside around the normal distribution line, which is also an indication of normality, as shown in Figure 4.4.

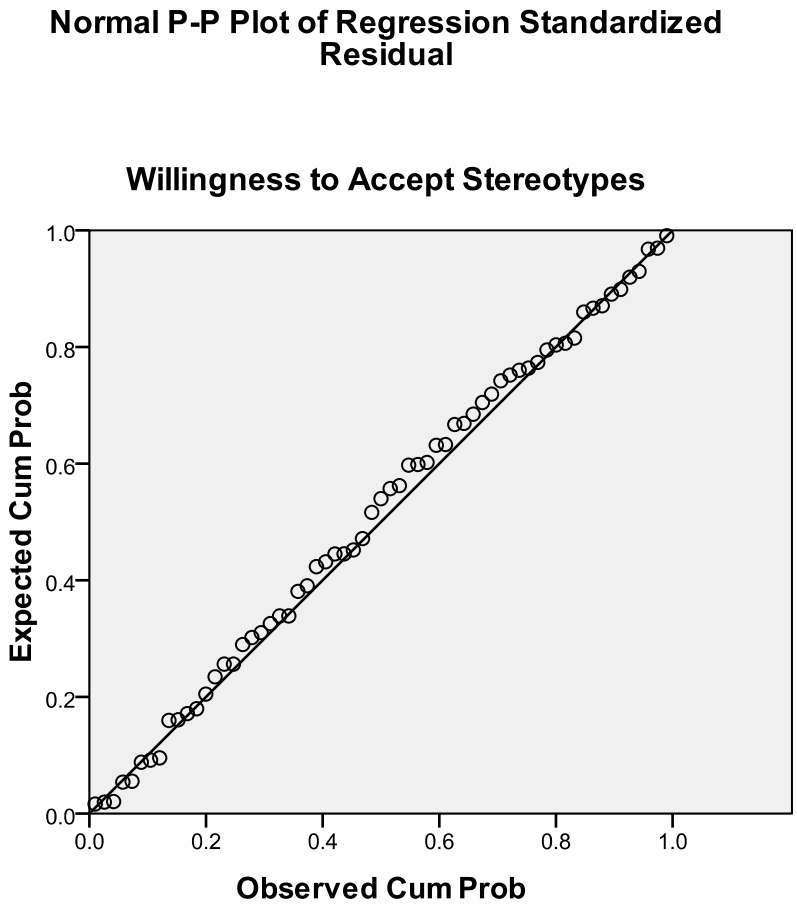

Figure 4.4, Observed and Expected Probabilities for Stereotypes (Medical Residents)

The regression analyses indicate that the beliefs about culture variable is predictive only for medical residents' willingness to accept stereotypes. This study sought to understand and explain not only the results of the regression analyses, but also the similarities and differences between faculty members and medical residents with respect to how they perceive culture and the impact that cross-cultural education may have on physicians' perceptions of others. In depth interviews with faculty members provided insight into what medicine states that it teaches and why medical residents are similar and different from physician educators.

Faculty Members' Perspectives of Cross-cultural Education

Much of the medical education literature that pertains to cross-cultural education and competence found in Chapter 2, *Medical Education, Culture, and Cross-cultural Competence* discusses the importance of didactics to prepare medical students and

residents for clinical encounters when they and their patients have different health beliefs. This study found that faculty members and medical residents do not share similar ideas about what occurs during medical education. Medical residents, in particular, did not raise the importance of didactics. Interviews with faculty members help to explain these differences.

The response rate for interviews was 78.6% where eleven out of fourteen faculty members agreed to be interviewed. Among faculty members who were interviewed, scores for beliefs about culture ranged between 1.615 – 2.429 and willingness to accept stereotypes ranged between 2.000 – 2.833. The mean duration for the interviews was 51 minutes and 42 seconds. See Table 4.8 for the demographic composition of faculty interviews.

Table 4.8, Demographics for Faculty Members' Interviews

	IM	OB/GYN	FCM	PEDS	Total
			Gender		
Male	1	1	2	3	7 (.636)
Female	1	1	2	–	4 (.364)
			Ethnicity		
Arab	–	–	–	1	1 (.091)
Asian Indian	–	–	1	–	1 (.091)
Caucasian	2	2	3	1	8 (.727)
Latino	–	–	–	1	1 (.091)
			Social Class		
Upper	1	1	2	1	5 (.455)
Middle	1	1	2	–	4 (.364)
Working	–	–	–	2	2 (.182)
			Citizenship		
Yes	2	2	3	–	7 (.636)
No	–	–	1	3	4 (.364)
Total	2 (.182)	2 (.182)	4 (.364)	3 (.273)	

Additionally, one participant self-identified as being homosexual and another had emigrated from Europe to the U.S. Despite using a purposive sampling technique, Caucasians and men comprised the majority of participants. The overrepresentation of Caucasians and men occurred, because they are the majority of participants, their responses were salient, and they agreed to be interviewed.

Faculty members often discussed reasons why medical schools should integrate cross-cultural skills into the curriculum. Their reasons often pertained to patient-centered care concepts, but usually in a paternalistic way. When faculty members in this study focused on patients, the goal was often to increase adherence to treatment recommendations. One faculty member explained why culture is important for patient care,

> Overall, cultural training would improve communication and care and make patients respond to providers better. Part of the problem is a lack of sensitivity to gender, sexual preferences, ethnic differences, and so forth. We are taught to treat every patient the same regardless of background, but many times we end up offending them or not getting compliance from them. I think culture improves compliance, outcomes, and overall satisfaction.

Others faculty members discussed the relevancy and importance of cross-cultural education to accreditation, which requires medicine to integrate culture into medical schools and residency programs. A common thread throughout the interviews was a focus on physicians, instead of patients, and what medical professionals can do to improve outcomes. Faculty members frequently discussed the relevancy of culture in a way that made patients peripheral or passive actors during clinical encounters.

Faculty members also discussed culture and cross-cultural education in terms of the art and science of medicine, which is found extensively throughout the literature, particularly in terms of the history of the profession. A number of faculty members' responses reflect how the profession grapples with the extent to which medicine is an art and a science, the extent to which physicians can practice the two simultaneously, and the influence that the two have on cross-cultural education. A faculty member characterized the profession's debate regarding art and sciences as follows,

> The physician scientist emerged in the age of scientific discovery during the 1930s through 1960s as the epitome of what it means to be a doctor. It doesn't meet the needs of diverse populations or the needs of a nation divided by racism. One of the things I am beginning to see as a medical educator is the biomedical

> model as the underpinning of everything we do in medicine. Everything builds on randomized controlled trials and double-blind studies, the gold standard of how we understand things. If that's your model then how do you begin to value differences? It's all about standardizations and limitations that ignore co-factors and confounders. But, life is more complex than that. Until we begin to teach from a broad model, we can't instill the value that culture is important. Biomedicine is part of health, but not all of health.

Nearly all participants associated culture with the art of medicine; however, specific models like biopsychosocial and patient-centered care also emerged from the discussions. Some faculty members discussed the biopsychosocial model in terms of tensions between art and science. Specifically, many faculty members proposed that the profession emphasize the biology aspect of the model more than the psychosocial component.

Faculty members often discussed the patient-centered care model, along with the biopsychosocial framework, as an aspect of the art of medicine. Faculty members stated overwhelmingly that patient-centered care is a way to learn and practice culture in clinical encounters, because the model acknowledges patients' perspectives, recognizes autonomy, and respects individuality. The following faculty member's comment typifies many physicians' perspectives

> The one thing you learn with experience is that patients whom we work with are not a textbook. They come with symptoms and concerns. Sometimes, it's fairly straightforward, but a lot of times it is very complicated. Sometimes a patient will complain about one thing, and we will have to figure out if there is something else that's more serious that's going on with the patient. You have to figure out how to get the patient to feel comfortable with you when dealing with the more serious problem, as well as their initial complaint. Frequently, you can't immediately go to that serious problem because it's not important to the patient. For example, their chest pains might not be important to them because everyone in their family has chest pains and they all die of heart attacks in their 50s, and that's not a surprise to them. But, their aching back is much more important to them. How do you address those things?

This faculty member most closely described patient-centered care where physicians share health care decisions and management with patients. Additionally, this faculty member indicated that patient encounters sometimes require negotiations, which Kleinman (1980) proposed.

Faculty members frequently discussed the science of medicine along with the art of medicine. When some faculty members framed medicine in terms of science, they contrasted culture with what the profession values most in terms of education and

practice. Many faculty members indicated that the profession's emphasis on science makes the integration of art into medical education more difficult, because often there is little to no strong scientific evidence to support the notion that culture matters to clinical encounters or for health outcomes, as the following faculty member stated

> If I had a resident, who asked to see data on whether attending to cultural needs would result in better outcomes, I would have a hard time finding such data and hard numbers. I guess you could look at patient satisfaction surveys, but it would be hard to find out what was done. I guess you could look at physicians who scored higher on cultural sensitivity and see if their patients of diverse backgrounds were more satisfied. I bet there are some patient testimonials, but not hard numbers. When we talk about professionalism and communication, the data most compelling are the malpractice data. Some physicians are nice, not for the patients' sake, but for the sake of trying to be nice. I bet physicians, who are more culturally insensitive, have a better chance of being sued. It's hard to measure if cultural sensitivity result in better patient outcomes.

This comment suggests that scientific evidence is important and necessary to make the case that culture is relevant to health care. However, others contested the notion that there is no support that culture is relevant and questioned more broadly what constitutes evidence.

A few faculty members suggested that culture is self-evident and matters because patients believe their specific beliefs, values, and practices are relevant. These faculty members proposed that evidence should be defined broader than the profession's interpretation, because cultural groups often have support for their beliefs. These culturally based forms of evidence may not conform to the standards of modern medicine and clinical trials, but for many individuals their beliefs and values are as valid as biomedical data. Other faculty members proposed that scientific evidence is much more subjective and emergent than the profession prefers to acknowledge. This point was made most poignantly by the following faculty member,

> When I was just starting to practice medicine, baby formula was thought to be just as good as breast milk and some felt that a baby was better off taking formula than being breast fed. Now the pendulum has swung completely back to the other side and I agree with the current thinking. I didn't have a problem teaching patients to breast feed. It wasn't seen as a problem then. It was convenient to use bottles, but the thinking was that it really wasn't necessary to breast feed. Of course, now we know about immunity and baby-mother bonding, which are all things that we know are good about breast feeding. I've seen the pendulum swing

> back and forth many times because the culture of medicine does not remain static. This brings up another point; do these other cultures remain static?

This faculty member and others did not discount the validity of scientific evidence, but suggested that medicine frames and defines the concept in narrow ways based on the profession's cultural beliefs and value.

Some faculty members indicated that the profession has not reached a harmonious consensus about the extent to which art and science influence practice and that the two conflict and compete with one another. Similar to Starr (1982), some faculty members stated that the trend toward science over art has grown along with an increase in medical specialization. Indirectly, other faculty members stated that primary care physicians understand the importance and relevance of culture more than other specialties like orthopedics, surgery, and radiation oncology. Some faculty members proposed that these specialties focus so intensely on one specific bodily system or disease that specialists fail to see the whole patient to include their cultural beliefs, values, and practices.

A number of faculty members proposed that the primary reason the profession has not reconciled the art and science of medicine is because the two depart from one another in terms of beliefs about knowledge and evidence. However, other faculty members suggested that medical practice is really an amalgamation of the two and art is the application of general knowledge about diseases to specific clinical encounters. This idea was the only one to suggest explicitly that the profession should meld art and science into medical education. While most faculty members framed art and science in terms of conflict with one another, they seldom contextualized the issue in terms of power, politics, and history. Most faculty members discussed, only peripherally, how medicine ebbs and flows between how extensive art and science influence education and practice.

The art and science of medicine provided context for many faculty members who believe that medical residents are much more interested in learning about science than culture. However, many faculty members took exception to medical residents who reported that they had learned little or nothing about culture during their medical education. Faculty members raised three major issues when they discussed what they teach and what residents should have learned about culture: curriculum, instruction, and

integration issues. In terms of curriculum and instruction, faculty members discussed what they teach formally and informally.

When faculty members discussed what they teach they often described specific content that they teach didactically and experientially, such as languages. Although faculty members did not mention knowledge, attitudes, and skills explicitly, they suggested that they and other medical educators teach knowledge and attitudes. Most faculty members suggested that knowledge and attitudes are the domains where the profession is most likely to have success didactically. Specifically, faculty members described attitudes as the appreciation of differences, awareness, and ethics, whereas they defined knowledge as specific information about traits, characteristics, principles, and languages.

Some faculty members indicated that cross-cultural skills are not teachable didactically. Other faculty members stated that cross-cultural skills are subjective, nuanced, and complex and that these factors make culture difficult to teach, since it does not fit within the scientific framework in which physicians learn medicine. A faculty member poignantly made the point,

> In terms of teaching culture, there are lots of articles on how the medical profession immediately took up culture and said we're going to learn everything about it and become experts in every culture because that's what we do in the rest of training. I can no more become an expert in every single cultural group I come in contact with any more than I can master quantum physics. It's an undoable task. If you begin to understand people and the skills that you need like listening, sensitive questioning, and always seeking to understand, it will help you understand it's not 'my way or the highway' when faced with conflict. I am much better at doing that with people who don't look like me than I am with people whom I assume share all my values.

When faculty members described cross-cultural skills medical residents should possess, their descriptions often pertained to attitudes like recognition of patients' perspectives, individuality, and the uniqueness of clinical encounters.

Faculty members frequently discussed curriculum and instruction together when they described what they teach about culture. Faculty members often indicated that they teach culture both didactically and experientially; however, most stated that only the basics and foundations of cultural knowledge are teachable through coursework and seminars. Without exception, faculty members proposed that much of what medical

residents learn about culture is experiential and informal. Faculty members stated that medical residents learn about culture every time they interact with patients, but added the caveat that it is incumbent upon educators to ensure medical residents understand what patients say implicitly and explicitly about their cultural beliefs, values, and practices,

> Cultural training has to be experiential. You can't give a lecture on what it is to be African-American and expect residents to know what it is to be African-American in this country any more than you can say what it is to be Irish-American. Lectures give people false confidence. They might pass a test without having met anyone who is African-American or Irish-American. That is the beauty of working in a large urban and diverse city, meeting people from China, Pakistan, Poland and other eastern European countries. On any given day, I had no idea who I was going to meet. You need a way to know what the resident is taking away from that experience, a way to debrief them, and this doesn't happen in medical education. There is no way for them to talk about their experiences, formally or informally. They end up forming opinions about groups of people without recognizing that that's what they are doing.

Explicitly, this faculty member proposed that medical schools should improve how they mentor medical residents. Implicitly, this faculty member suggested that experiential cross-cultural education necessitates encounters with diverse patients so that residents can learn the extent to which individuals have different beliefs, values, and practices.

Mentoring emerged frequently when faculty members discussed how some medical residents learn about culture. This informal process requires faculty members to spend time with medical residents and to teach, through example, how to conduct effective cross-cultural encounters. Additionally, some faculty members proposed that medical schools also should debrief residents about the history they obtained from patients. Other faculty members raised a concern that medicine does not reward faculty members for time spent with medical residents and that substantive mentoring often occurs informally and sporadically, as this faculty member summarized,

> Medical education does not rewards being judgmental, but getting hard facts, knowing the right answers, and making everything clear. Being an intuitive perceiver is not rewarded in medical education. If it is, it's done informally, like the praise of a particular faculty member for respecting and honoring a family's core values.

This faculty member suggested that medicine and the profession reward physicians and medical residents who understand science and receive high scores on examination boards and other tests, not the extent to which they practice cross-cultural skills in clinical

encounters. A number of faculty members indicated that this informal process leads to outcomes that are inconsistent.

Faculty members also raised questions about how serious the profession is in terms of preparing physicians to be cross-culturally competent. Many faculty members stated that it is important to have qualified educators and subtly suggested that they provide effective cross-cultural didactics, experiences, and mentoring. Implicitly, faculty members suggested that their experiences with culturally diverse patients qualify them to teach about culture. None of the participants mentioned specific and formal training they had received that made them qualified to teach about culture.

A few faculty members expressed the notion that not all faculty members are qualified to provide cross-cultural education. One faculty member surmised what may be occurring,

> If people, who are not adept at recognizing cultural issues, are put in the situation to train others then that is a big problem. It could potentially create the position where you have the blind leading the blind. I can see that happening, because we bemoan the fact that we come from a biomedical background. Even though in medicine we talk about biopsychosocial issues, the biomedical model gets emphasized and the psychosocial is put on the backburner in medical schools and in residency programs.

This faculty member further proposed that others with specific training in culture should teach cross-cultural skills.

Many faculty members explained that professionalism played a major role in how they teach and what medical residents learn. They often attributed the lack of differences among primary care specialties and between themselves and medical residents to professionalism. One faculty member referred to the medical profession as follows,

> Medicine is an enculturation process that teaches someone more than science and facts. It's adopting the culture, accepting certain behaviors, expectation of yourself and others, there is a strong tradition and history that influences the way you act and perceive situations. It influences your future. It definitely is adopting a new culture. There is even a whole different language that you use in medicine – we have different words for the same things that we have to translate for non-doctors.

Others like the faculty member below were much more critical and blunt,

> Residents don't recognize how much they are brainwashed into the medical culture. I don't think any of us know how much we are in the beginning. For instance, we tell our sick medical jokes in groups where it's not appropriate, just

> because we don't recognize it's inappropriate anymore. We think that because we think something is humorous, lay people will too.

Many faculty members described themselves, their colleagues, and medicine as having a common language, belief system, and similar values. Most faculty members also distinctly viewed themselves as different from patients, as the previous comment suggests. Faculty members stated that physicians use medical terms that many of their patients do not understand; yet, much of their terminology has lay equivalents, such as arrhythmias, which means irregular heartbeats.

Faculty members frequently cited end-of-life issues as a common example where medicine's cultural beliefs and values sometimes conflict with patients' ideas about health. Many faculty members stated that medicine in the U.S. values doing everything possible to save lives, as this faculty member proposed,

> I think it's a challenge why so many physicians can't help folks in end-of-life situations transition to a more palliative care model. This model has a whole different gold standard. If you're so strictly rigid and taught the biomedical model, how do you know when it's okay to let a person die? I think the underlying adherence and strict belief that the biomedical model is the gold standard and the only way to understand health is part of the rigidity that we're seeing in younger learners. It's part of the enculturation process.

This faculty member spoke to medicine's biomedical beliefs and values, which are rooted in scientific evidence and which are central to the enculturation of medical students and residents.

Many faculty members stated that medical school and their residency program were an enculturation process that influenced and changed them. Some faculty members explicitly mentioned that their personal beliefs and values during residency were not always consistent with their professional roles, but as aspirants to become physicians they readily adopted the culture of medicine. Most discussed their medical education as scientific and standardized, and proposed that many within differences present when they entered medical school dissipated during their enculturation into the profession. Many faculty members described this enculturation process as what medicine does and does not value and reward. Almost without exception, faculty members stated that medicine does not reward differences and that this influences the extent to which physicians recognize diversity among patients. Medical education teaches students and residents that science

is universally applicable and that medicine is about science. This minimizes the need to attend to patient differences.

Several variations emerged regarding how faculty members perceived their professional education and how power is relevant during clinical encounters with patients. A few faculty members proposed that power was relevant during clinical encounters, because physicians sometimes take a paternalistic role with some patients. These physicians attributed the paternal role they adopt for most clinical encounters to their medical education where they were taught to take the lead and provide answers. A few faculty members indicated that the trend toward patient-centered care where power is shared has led some physicians away from the more paternalistic way to practice medicine. One faculty member complicated the role of power and suggested that physicians' efforts to practice more patient-centered care does not change the relationship with some patients who expect them to take the lead and provide answers. This faculty member suggested that sometimes physicians must take the lead and that power, inherent in clinical encounters, is complex, especially since physicians have a medical knowledge advantage over many patients.

However, other faculty members examined power in a macro and broader sense than the individual patient – physician relationship and proposed that medicine ultimately positions its beliefs, values, and practices as the one right answer for health care and treatment. A number of faculty members expressed that they were conflicted over patient autonomy and stated that patients should follow physicians' treatment recommendations, which are rooted in science and evidence. Although many of these faculty members stated that it is important to recognize culture and the rights of individuals, they proposed that it also is their role to educate patients about why they should adhere to treatment recommendations. Only a few faculty members discussed power as it pertains to their high social status and the historic relationship between patients and physicians where medical providers usually wield more influence. These faculty members proposed that most patients defer to physicians' authority, but others with similar social class to physicians are more active and participatory during encounters.

Faculty members also discussed professionalism in terms of physicians being cross-culturally competent or not. Many stated that physicians either possess innate

cultural skills or not. This viewpoint was summarized best by a faculty member who stated

> I personally believe that at this stage in a person's life, who is already an adult, it's hard to teach people professionalism. They either have it or they don't. If somebody doesn't have some seed of cross-cultural competence or professionalism to build upon or expand, it's hard to teach the concept didactically.

Other faculty members broached the issue more subtly and stated that medicine could not teach a person to be a respectful or a decent human. These faculty members suggested implicitly that physicians and medical residents have inherent limits regarding the extent to which they can become cross-culturally competent. Faculty members did not make a similar assertion regarding aspects of science as innately limited.

Faculty members made a number of group comparisons among themselves, medical specialties, residents, and patients. When faculty members talked about patients, they described this population as being somewhat universal and seldom raised any within differences like gender, social class, and religion. The majority of faculty members were surprised to learn that there are virtually no statistical differences in beliefs about culture or willingness to accept stereotypes among medical specialties. When they learned that primary care specialties do not differ from one another, they often proposed that other specialties, which typically do not have long-term relationships with patients are likely different. Other faculty members maintained that their specialties are probably more culturally aware than others in the study. Across faculty members' interviews, the relevance of culture, the art and science of medicine, medical education, and professionalism were major findings that emerged.

Summary

The findings from statistical and thematic analyses suggest that faculty members and medical residents understand the nature of culture in somewhat modernist terms, but the two have significantly different means for the beliefs about culture variable. However, faculty members and medical residents have similar scores for willingness to accept stereotypes. The regression analysis for the two groups reveals that the beliefs about culture variable is a predictor for willingness to accept stereotypes for medical residents, but not for faculty members. Medical residents also departed from faculty

members with respect to what they stated they had learned about culture during their professional education. Faculty members proposed that they provide didactics and experiences, but medical residents did not attribute their cross-cultural skills to medical educators. Overall, faculty members stated that cross-cultural education is difficult to teach and requires some innate aptitude or desire to respect diverse beliefs, values, and practices. The study's implications and conclusions are presented in the following chapter.

Chapter 5: Discussion & Conclusions

This chapter summarizes the findings and implications, proposes further research into the inquiry, and presents conclusions. The findings discuss the results of the statistical and thematic analyses. The implications suggest what and how the medical profession should address culture and cross-cultural education. This study also proposes additional research that can contribute to medicine's understanding of culture. Finally, the conclusions summarize the interpretations and implications of the study.

Interpretation of Findings

This study hypothesized that cross-cultural education in medicine influences faculty members' and medical residents' beliefs about culture, which predict one's willingness to accept stereotypes. Furthermore, this study hypothesized that a postmodern definition of culture decreases one's willingness to accept stereotypes. The hypotheses were tested statistically, and thematic analyses of open-ended responses and interviews explained further the survey findings. Four research questions guided this study and are the basis to understand what faculty members and medical residents believe about culture and stereotypes, the extent to which the two groups are similar, whether or not cultural beliefs, values, and practices predict willingness to accept stereotypes, and the impact of cross-cultural education.

Descriptions of Beliefs about Culture and Willingness to Accept Stereotypes.

The first research question asked what faculty members and medical residents philosophically believe about the nature of culture and how willingly they accept stereotypes. The survey findings indicate that faculty members and medical residents define culture in terms of modernism in which they indicate that cultural knowledge is relatively stable, isolated from other factors, and determined largely innately. The thematic analysis of faculty members' and medical residents' open-ended responses regarding what they believe culture to mean, how they identify themselves, what factors are influential, and what they learned during their medical education provide context for what the statistical data indicated. While faculty members and medical residents share a similar philosophy of culture, the thematic analysis of participants' open-ended responses suggest that within the profession's modernist read of culture the two groups depart from

one another, as well as share similar perceptions about cultural beliefs, values, practices, and cross-cultural education.

Four broad themes emerged from faculty members' and medical residents' discussions about their beliefs about culture: shared traits and characteristics; the complexity of cross-cultural competence; the relevancy of the skill set to health care; and, ways in which some professionals unintentionally misuse and misunderstand groups' beliefs, values, and practices. The discussions revealed how faculty members and medical residents perceive culture similarly, as well as differently from one another. In terms of shared traits and characteristics, faculty members define cultural knowledge more contextually, nuanced, and less uniformly compared to medical residents. Faculty members also discussed factors, such as cultural identity, more complexly and nuanced than medical residents. When faculty members discussed cultural traits and characteristics, they often added the caveat that individuals do not adhere to group beliefs, values, and practices always, which is a partial break from essentialism.

Medical residents define culture with much more certainty than faculty members, and many of them expressed that culture is simple to understand. Many medical residents indicated that they could learn groups' cultural beliefs, values, and practices in a way that would aid their medical decision-making, which suggests they believe culture is somewhat stable. Despite these differences, both groups overwhelmingly indicated that culture is a system that has structure and boundaries and that shared beliefs, values, and practices can be defined. While faculty members and medical residents described domains of culture like race, ethnicity, and religion, they seldom discussed the confluence of these factors and how their interactions make culture complex and contextual. Language, gender, and social class seldom were raised, which suggest that faculty members and medical residents have narrow and limited views of culture that exclude some domains. Betancourt (2004, 2006a, 2006b) and Dogra, Giordano, and France (2007) cautioned the medical profession that definitions of culture limited to race and ethnicity are incomplete and unhelpful to physicians in making clinical decisions.

In addition to the ways that faculty members and medical residents define culture, both groups implicitly and explicitly discussed the relevancy and importance that individuals' beliefs, values, and practices have on the patient – physician relationship and

health outcomes. Many faculty members and medical residents indicated that culture matters, because beliefs and values influence the decisions that patients make about their health. Others expanded upon this theme and discussed the importance of culture for treatment adherence. Faculty members and medical residents frequently focused on how patients are different from themselves, the importance of these differences to clinical encounters and outcomes, and the impact of effective communication. The two groups suggested that patients would more likely follow clinical advice when physicians make encounters and treatment recommendations more culturally acceptable for people. This finding is consistent with Kleinman's (1980) proposal that physicians need to engage in translations and negotiations with patients if they want to improve adherence and health outcomes.

Faculty members and medical residents also proposed that they should acknowledge the role that culture plays, because not all patients hold the same or similar beliefs as the profession. They indicated that cross-culturally competent physicians should have an open mind, demonstrate sensitivity and respect for differences, and avoid making assumptions about patients. The attitudinal approach to cross-cultural education that many faculty members and medical residents suggested is found throughout the medical literature, particularly the works of Dogra (2001; 2004, 2007). However, faculty members and medical residents seldom raised the skills domain of cross-cultural education as being relevant to practice. The attitudinal ways, in which many faculty members and medical residents approach patients, position physicians in power during clinical encounters. Even faculty members and medical residents who advocate the patient-centered care model and other patient-centric efforts to integrate and include patients' perspectives like culture into the clinical encounter seldom break the paternal role that many physicians assume. The practice of patient-centered care often does not entail patients and physicians sharing power. Oftentimes, patient-centered care, for some, means that medical professionals should educate individuals why they should be adherent to treatment recommendations.

However, a few faculty members found the paternal role that many physicians adopt to be problematic, but do not know how to change the relationship. These faculty members suggested that the power differences in most patient encounters made the

practice of cross-cultural skills difficult, because some individuals do not understand or perceive their cultural beliefs, values, and practices as relevant to clinical encounters. Many patients expect physicians to have medical answers about their disease or illness and do not want to be participatory or share management of their care. While a few faculty members expressed concerns about power, the two groups seldom discussed the influence that social class may have on clinical encounters. As described in Chapter 4, *Description of Validity, Reliability, and the Population*, the majority of faculty members and medical residents (89.6%) come from middle or upper class homes, which differ from the University of Kentucky Albert B. Chandler Hospital's payer mix.

In 2009, the University of Kentucky Albert B. Chandler Hospital captured 33.3% of all Medicare, 66.1% of all Medicaid, and 38.7% of all managed care and commercial patients in the Lexington, Kentucky market compared to Central Baptist, Saint Joseph East, and Saint Joseph Main hospitals (Karpf, 2009). The payer mix data describe insurance plans and indicate that the majority of low income patients in the Lexington, Kentucky market seek care at the University of Kentucky; thus, social class, along with race, ethnicity, and gender differences among patients and physicians are likely salient. Banks, Billings, and Tice (1993) and Narayan (1997) found social class, along with race, ethnicity, and gender, a complication to what appears and emerges as groups' beliefs, values, and practices. These domains of culture shift and influence what people believe, value, and practice in certain contexts. Furthermore, physicians cannot understand culture completely without considering the impact that social class may have on clinical encounters, interpretations, and reasons why patient may or may not follow treatment recommendations.

In addition to culture's relevancy to clinical encounters and health care, faculty members and medical residents subtly discussed ways in which some in their profession misuse and misunderstand culture. This discussion by participants most closely tied beliefs about culture to willingness to accept stereotypes. Across the medical literature regarding cross-cultural education, some in the profession, particularly Beagan (2000, 2003), cautioned physicians not to integrate, teach, or practice cross-cultural competence in a way that stereotypes patients. Other researchers are concerned about generalizations and incomplete definitions of culture (Betancourt, 2004, 2006a, 2006b; Dogra, 2001;

Dogra & Carter-Pokras, 2005; Dogra, et al., 2007; Dogra & Karnik, 2003); however, the issue only subtly emerged from the open-ended responses of faculty members and medical residents.

Regardless of how faculty members and medical residents understand culture, both groups believe that generalizations and assumptions about others are problematic. However, despite the implicit concerns about stereotypes, the scores for faculty members and medical residents indicate that overall they are willing to accept generalizations. One of the most important benefits of mixed method designs is that quantitative and qualitative data complement each other. While faculty members and medical residents appear more willing than not to accept stereotypes based on close-ended findings, interviews and open-ended responses indicate that the two groups are concerned about patient individuality and, implicitly, stereotypes.

The incongruousness between close-ended and open-ended findings may indicate that both groups, to an extent, make generalizations and stereotype others, but they also understand they should not do so or should do so cautiously. Social identity theory is explanatory here where the framework proposes that people unintentionally stereotype others when group belongingness is high (Huddy, 2004; O'Flynn & Britten, 2006). The theory suggests members with strong belongingness may see themselves as similar, one of the requirements for groups to exist, but they also see others more stereotypically, less variant, and defined by fixed beliefs, values, and practices (Bartsch & Judd, 1993; Brown, 2000). As discussed later in this chapter, medicine is a profession where members identify strongly with their group and likely perceive others more stereotypically than they do themselves (Bartsch & Judd).

The descriptions of the beliefs about culture variable suggest that the two groups hold a modernist perception of culture, but a more contextual analysis of faculty members and medical residents reveals that there are differences within their modernist understanding. A similar finding emerged for the willingness to accept stereotypes variable where participants subtly and implicitly discussed concerns about stereotypes; yet, seem willing to accept generalizations about others. The descriptions of faculty members' and medical residents' beliefs about culture and willingness to accept stereotypes are important to understanding whether or not the two are different, if there

are within group differences, and the influence that education may have on participants, which is discussed in the following section.

Comparisons between Faculty Members and Medical Residents.

Beyond descriptive findings, this study asked whether or not faculty members and medical residents have the same scores for beliefs about culture and willingness to accept stereotypes. This study recognized that medical residents most likely do not enter medical schools without a definition of culture; however, as part of their education to become physicians, they are supposed to learn from faculty members how to conduct clinical encounters when they and their patients hold different beliefs about health. The multivariate ANOVA test indicates that faculty members and medical residents have significantly different means at $p < .05$ for the beliefs about culture variable. The thematic analyses of faculty members' open-ended responses reveal that they overall define culture more completely than do medical residents, which is described in this chapter, *Descriptions of Beliefs about Culture and Willingness to Accept Stereotypes.* The thematic analysis also suggests that cross-cultural education may explain why faculty members and medical residents hold somewhat different beliefs about culture. While the two groups perceive cross-cultural education somewhat alike, they also have major differences, regarding what and how they learn.

Faculty members stated they are responsible for medical residents' cross-cultural education. However, medical residents attribute their knowledge and preparedness for cross-cultural encounters to their clinical and personal experiences. A number of medical residents indicated they had learned nothing about culture during their medical education, which raises questions regarding how extensively faculty members teach about culture and the methods they use. Several studies found that cross-cultural education is a limited part of the medical curriculum (Dogra & Wass, 2006; Gates & Bradley, 2009; Kai, et al., 2001; Kairys & Like, 2006; Leishman, 2004; Park, et al., 2005; Park, et al., 2006; Weissman, et al., 2005). Medical residents at the University of Kentucky also suggested that cross-cultural education is not taught widely. Their scores for beliefs about culture differ from faculty members and do not support necessarily the assertion that cross-cultural skills are taught.

Contrary to the notion that cross-cultural content is not a part of the medical curriculum, faculty members attribute their more extensive experiences with patients to why medical residents do not understand culture, as completely and complexly as they do. Faculty members asserted that they have many more opportunities to learn how unique patients are and how much there is to know about culture. Medical residents seldom raised concerns about needing to learn more about culture, whereas a few faculty members stated they had learned over time that medicine and clinical practice entail art and science and that patients' belief, values, and practices impact health decisions and outcomes. Medical residents seldom described medicine as an amalgamation of art and science and often focused primarily on the importance of biology to health care. The medical professional clearly conveys the importance of science and biology, which dominate examinations and licensure boards (Starr, 1982). Despite accreditation requirements that cross-cultural education should be integrated into the medical curriculum, faculty members' assertions that experiences with patients are central to learning about cultural beliefs, values, and practices suggest that culture may be a limited aspect of the curriculum as medical residents indicated. In addition to these differences, faculty members and medical residents share a few similarities, such as how they describe cross-cultural competencies.

The medical profession largely describes cross-cultural education and competence in terms of three domains: knowledge, attitudes, and skills, as discussed in Chapter 2, *Medical Education, Culture, and Cross-cultural Competence*. However, these three domains did not emerge equally when faculty members and medical residents discussed cross-cultural education and what they had learned during their medical education. The two groups focused primarily on attitudes and, to a lesser extent, knowledge. Faculty members and medical residents described attitudes, as awareness of, sensitivity to, and appreciation of cultural difference. The two groups indicated that attitudes of physicians impact communication and the patient – physician relationship. Faculty members and medical residents indicated the goal of attitudes is to improve health outcomes. When the two groups discussed knowledge, they often framed this domain in terms of facts and expertise regarding beliefs, values, practices, and languages that they can learn. Faculty

members complicated the notion of learning cultural facts and indicated that groups can be diverse.

A departure from the literature, neither faculty members nor medical residents raised the importance of skills. The absence of a discussion about skills questions the extent to which medicine has integrated cross-cultural education into the curriculum. Attitudes and knowledge may be the domains where faculty educators are most comfortable to teach whereas skills are the application of attitudes and knowledge and may be more difficult to measure. Across definitions of culture, perceptions of cross-cultural education, and descriptions of skills, the open-ended response of faculty members and medical residents provided context for how the groups are different and similar in terms of the beliefs about culture variable. Along with beliefs about culture, this study also determined how similarly and differently medical residents are from faculty members regarding their willingness to accept stereotypes.

The multivariate ANOVA test for the willingness to accept stereotypes variable indicates that the two groups do not have significantly different scores. With respect to stereotypes, faculty members' and medical residents' open-ended responses cautioned against assumptions and expectations. Although the two groups close-ended scores suggest that they are willing to accept stereotypes, their open-ended responses indicate that they are sensitive to patients' individuality. The differences between the close-ended and open-ended responses may pertain more to how the study collected data than incongruence between research methods. The close-ended items explicitly did not mention the word stereotypes or variations of the term, but asked broadly about perceptions. However, concerns about assumptions, generalizations, and expectations emerged from faculty members' and medical residents' responses to open-ended questions.

This study surmised that concerns about stereotypes, which participants expressed more subtly as individuality, emerged, in part, because the profession and the medical literature, regarding culture, pervasively cautions physicians not to assume and generalize about patients. For example, Beagan (2000), Betancourt (2004, 2006a, 2006b), and Dogra, Giordano, and France (2007), leading researchers in culture and medicine, all cautioned the profession not to stereotype patients. Although the history of medicine did

not emerge explicitly from faculty members or medical residents, a number of medical professionals have written about medicine's racist (Clark, 2003; Francis, 2001; Kai, et al., 2001; Suite, et al., 2007; Williams & Rucker, 2000) and sexist (Hoffman, et al., 2000; Rogers, 2006; Ruzek & Becker, 1999) past, which also may explain why participants stressed the importance of treating patients equally and individually.

Despite faculty members' and medical residents' close-ended scores indicating a willingness to accept stereotypes and the thematic analysis cautioning against generalizations, there are no meaningful differences between the two groups with respect to this variable. However, the thematic analysis was important to understand that faculty members and medical residents are sensitive to and aware of the problems of stereotypes, even if they unintentionally engage in generalizations. The comparisons between faculty members and medical residents reveal that the two differ with respect to beliefs about culture, but not willingness to accept stereotypes. Given this finding, this study sought to learn the relationship between the two variables and the effect that demographics may have on willingness to accept stereotypes.

Relationship among Beliefs about Culture, Demographics, and Stereotypes.

The third research questions asked whether beliefs about culture and intervening variables like gender, parents' social class and education, medical specialty, citizenship, and year in residency predicted or explained one's willingness to accept stereotypes. A multiple linear regression analysis reveals that beliefs about culture are only predictive for medical residents. The relationship between culture and stereotypes for medical residents is positive, which means that as one's beliefs about culture become more context sensitive and nuanced their willingness to accept stereotypes decreases, which this study hypothesized. Medical specialty also has predictive and explanatory value for medical residents. The relationship between medical specialty and willingness to accept stereotypes is negative and indicates that residents in Internal Medicine are more likely to accept stereotypes than those in Pediatrics. Pediatrics residents are more likely to accept stereotypes than Family and Community Medicine. And Family and Community Medicine residents are more likely to accept stereotypes than those in Obstetrics and Gynecology. While this finding was not hypothesized, the response rates among the specialties may be somewhat explanatory as a measure of interest in culture and patient

individuality. Family and Community Medicine and Obstetrics and Gynecology had higher response rates than Internal Medicine and Pediatric residents (See Appendix F. Response Rate by Group and by Specialty).

Citizenship is the only variable that predicts or explains stereotypes for faculty members. Faculty members who were born outside the U.S. were less willing to accept stereotypes than those who were born inside the U.S. The finding about citizenship also was not hypothesized and did not emerge from the thematic analysis of participants' open-ended responses. However, during interviews, a few foreign-born faculty members attributed the explanatory nature of citizenship for willingness to accept stereotypes to the U.S. focus on identifying individuals by race and ethnicity and the lack of diversity in Kentucky, as compared to other states and countries. These faculty members proposed that a focus on race and ethnicity can divide people and may lead some to categorize individuals according to these domains. The result of categorizing people into race and ethnicity may be stereotypes. The subtext of their explanations pertains to group identity, which social identity theory helps to explain. Social identity theory proposes that a focus on group membership and identity can increase stereotypes and discrimination (Billig, 2002; Billig & Tajfel, 1973; Tajfel, 1982; Tajfel, et al., 1971). While a few faculty members explained the citizenship finding as cultural differences between countries, most did not have an idea why foreign born physicians perceived stereotypes differently than naturalized citizens.

The finding that the beliefs about culture variable did not predict faculty members' willingness to accept stereotypes was unexpected, because social identity theory proposes that strong group identity heightens stereotypes (Bartsch & Judd, 1993; Brown, 2000). However, interviews with faculty members helped to explain why group belongingness yielded different outcomes for the two groups. As discussed in the section *Faculty Members, Medical Residents, and Cross-cultural Education.*, faculty members suggested that they are much more likely to display variance or deviate from their scientific education than medical residents. Faculty members added that they had learned more than medical residents, as a result of their extensive experiences with patients, whom they had learned are unique and should be treated as individuals. They proposed that medical residents understand that patients are individuals, but their inexperience and

reliance on science obscured how different people are. Faculty members' analysis of medical residents is consistent with the groups' description of culture in somewhat fixed and stable terms.

Social identity theory helps to explain faculty members' differences with medical residents and why cultural beliefs are less salient and predictive for their willingness to accept stereotypes. While faculty members and medical residents are similar groups, they also differ in a number of ways too, such as their definitions of culture, what they attribute their cross-cultural skills to, and most importantly, their experiences with patients. As faculty members alluded to, medical residents vary less than faculty members, in part, because they seek to be members of medicine and readily adopt, consciously or not, what they perceive to be the beliefs, values, and practices of the profession. Faculty members, as a group, are more experienced, comfortable with their status as physicians, and comparatively seek less to demonstrate their strong belongingness to the profession; thus, they are more willing to display more variance than medical residents. During in depth interviews with faculty members, they expanded upon the role that medicine and medical education had on residents and their cross-cultural skills, which is discussed in the following section.

Faculty Members, Medical Residents, and Cross-cultural Education.

This study examined what faculty members believe they teach about culture compared to what medical residents reported that they learned during their professional education. Interviews with faculty members reveal that they and medical residents depart most diametrically with respect to how they learn about culture. The analysis and conclusions drawn from the interviews also indicate that faculty members have few differences when describing their beliefs about culture and cross-cultural education. As rich as faculty members' interviews were and as many different examples they cited, they described more or less the same concepts. The concepts that faculty members raised coalesced around four broad themes. The themes pertained to drivers or reasons why medical schools should care about culture, the art and science of medicine, medical education and residents, and professionalism.

Faculty members in this study primarily raised patient adherence and accreditation as reasons to teach about culture; however, the literature is much more

extensive and includes drivers like patient satisfaction, health outcomes, disparities, and advocacy groups. Faculty members seldom raised these other drivers as reasons to teach about culture, which indicate that their frame of reference, in terms of cross-cultural education, pertains more to medicine and professionalism than to patients. Faculty members explained that culture is important to adherence, because it may increase or encourage patients to follow the advice of physicians. Adherence, in many respects, is about power, because many physicians perceive knowledge about cultural beliefs, values, and practices as ways to encourage patients to follow their treatment recommendations, not about individuals' perspectives. Furthermore, their discussions often focused on how physicians should behave and what their goals should be, instead of what patients want and need from clinical encounters.

Many faculty members believe that accreditation requirements make cross-cultural competence important for medical residency. Although no one attributed the importance of accreditation solely to why they teach about culture, some faculty members suggested that medicine and their colleagues perceived cross-cultural education, as more relevant to health care and outcomes after the profession's stance was codified. However, ACGME, which required cross-cultural education in 2001, made the requirement, as well as others, broad (Joyner, 2004). While ACGME requires cross-cultural skills as part of residency education, the broadness of the competency contributes to the diffuseness, in which medical educators integrate the content. Despite the vagueness in which ACGME guides residency programs with respect to cross-cultural content, none of the faculty members questioned what they should teach about culture or whether or not they met the requirements for the competency. Since no one questioned ACGME cross-cultural requirement and its vagueness, this study questions how important the competency is for accreditation. Joyner questioned the validity and reliability of residency accreditation and not just the cross-cultural requirement. The suggestion was that accreditation requirements are interpretive. In addition to drivers, many faculty members discussed medicine and culture in terms of art and science.

Many faculty members framed the art and science of medicine in terms of medical and health care models. A number of faculty members explicitly raised the biopsychosocial model, an approach to medicine that melds art and science, as a way to

integrate culture into the curriculum. The biopsychosocial model proposes that clinical encounters should be holistic, in that, biology, psychology, and social factors of patients are all relevant for health decisions (Alonso, 2004; Astin, et al., 2008; Borrell-Carrio, et al., 2004; Butler, et al., 2004; Checkland, et al., 2008; Fava & Sonino, 2008; McLaren, 1998; Suls & Rothman, 2004). Many faculty members suggested that culture fits into the social aspects of the model, in that, cultural beliefs, values, and practices are group based and determined. Several faculty members acknowledged that medicine has tried to balance art and science through efforts like the biopsychosocial model, but they often indicated that the biological aspect of the framework frequently receives the most attention and focus in medical education, examination boards, and licensure.

Along with the biopsychosocial model, many faculty members suggested that cross-cultural education can be integrated into the patient-centered care model, which proposes that the patient – physician relationship and health care are enhanced when the two are full partners and managers (Engebretson, et al., 2008; Koehn & Swick, 2006; Martin, et al., 2004; Ponte, et al., 2003). Many faculty members suggested that this model is widely accepted within the profession. Although the patient-centered care model seeks to encourage patients' participation as active players in their health care, a few faculty members recounted how they try to use the framework, but meet resistance from patients who want physicians to manage their care. While the intent of the model is well-intentioned, the implementation of patient-centered care ignores the power and relevance of social class differences between some individuals and physicians. Physicians, who are often middle to upper class, have higher social status than many of their patients and greater medical knowledge. These two factors are insurmountable for some patients who do not see themselves as equal partners during medical encounters. Among the physicians who raised this issue, none discussed the relevance of social class.

The biopsychosocial model is problematic, because it focuses almost exclusively on science, and physicians' practice of patient-centered care ignores the influence of their social class and power as reasons why some patients are reticent to be participatory or managers in their health care. Despite the problems with the two models, they are indications that medicine acknowledges and seeks to understand patients' perspectives of their health. However, faculty members, in their discussions of the biopsychosocial and

patient-centered care models, acknowledged that the profession continues to grapple with how extensive art and science influence medicine and health outcomes.

Some faculty members suggested the tilt toward science and evidence complicated the integration of culture, which is the art of medicine. While most faculty members did not define specifically what they meant by scientific evidence, they implied that there are no disagreements about the concept. However, they are split over what constitutes evidence for culture's relevancy to health care and outcomes. Some faculty members defined randomized controlled trials as the gold standard for evidence, which is consistent with the literature (Jackson, 2002; Jenicek, 2006; Rogers, 2004b; Saunders, 2000). Other faculty members proposed that the profession's definition of evidence is constructed too narrowly, as there are other valid forms of proof.

Despite the profession's inclination toward viewing and practicing science to the extent that art is almost excluded, most faculty members expressed that medicine and health care should include both. Their reasons for practicing art and science differed where some faculty members proposed that art and cross-cultural education were important, because they can be tools to convince patients about the efficacy of scientific treatments. Other faculty members expressed that culture is relevant to health care and outcomes, because patients consider their cultural beliefs, values, and practices important and often make decisions based on them. Both views implicitly position physicians in a paternal role with their patients, who need to be guided and protected by medical professionals. Even though the profession advocates cross-cultural education and other aspects of care like patient-centered care, physicians often use science to legitimate their power in the relationship and largely guide clinical encounters. As Starr (1982) found in his analysis of the rise of the medical profession in the U.S. and as many faculty members implied, physicians acquired power based on their connection to science and the lay public's acknowledgement of the legitimacy of scientific and technological knowledge in medicine.

The debate within the profession regarding the extent to which medicine is art and science provided context for one of the starkest differences between faculty members and medical residents. Medical residents often indicated they learned about culture independently of their professional education; however, faculty members asserted they

are responsible and provide cross-cultural education. Although none of the faculty members expressly discussed case studies, which is prevalent in the literature as a pedagogic approach (Beagan, 2000, 2003; Gregg & Saha, 2006; Groopman, 2007; Kleinman, 1980; Turbes, et al., 2002), they implied the use of this method when they explained the importance of experiential learning from actual patient encounters. None of the faculty members discussed specifically how they used case studies, which can pathologize patients, present them simplistically, and suggest that individuals are passive. Narayan (1997) and Tice (1998) found case studies problematic in the ways that individuals are constructed as objects and how some middle class professionals use or interpret cases to essentialize others. Faculty members did not discuss problems with using case studies and implicitly cited this specific pedagogic approach to refute medical residents' claims that they do not learn about culture during medical education.

The two groups, despite their differences about who fostered and facilitated medical residents' education, agreed that experiences with patients are more valuable than didactics. Faculty members identified three reasons why they and medical residents differed with respect to whether or not medicine provided cross-cultural education. Faculty members proposed that culture is difficult to teach; the profession has not made cultural beliefs, values, and practice as important as other content domains; and, residents are more interested in learning science, which is "real medicine."

All of the faculty members, who were interviewed, indicated that culture is a difficult and abstract construct to teach, especially for a profession like medicine, which highly values science. A few faculty members suggested that they and some of their colleagues were not prepared to teach about culture, because they were not certain how well they understand what the term means for medicine. Other faculty members indicated that their experiences qualified them to teach about culture, because they understand patients have diverse beliefs, values, and practices across and within groups. Several faculty members also suggested their interest in diverse cultures and openness to other viewpoints are skills that they could teach. Although in comparison to most residents, faculty members complicated their definitions of culture and indicated that the construct is complex.

Faculty members indicated that culture is complex, but did not explain why they believe so. For example, no one raised the concern or issue that the profession has not defined cogently what culture means or that there are many definitions and philosophical perspectives. The absence of discussions about how others define culture implies that the medical profession is not debating the definition and nature of culture. Some faculty members indicated that culture is limitedly important to the medical profession, which is reflected in the curriculum. While organizations like the IOM (Baquet, et al., 2004; Betancourt, 2006b; Bloche, 2005) advocate cross-cultural education and ACGME (Brotherton, et al., 2004; Joyner, 2004; Lattore & Lumb, 2005) requires the content domain for residency, medical residents seldom are evaluated on this skill set to the extent that they are with science-based content. Several faculty members attributed the limited placement of culture in the curriculum and the lack of evaluation most directly to why medical residents are not interested more in cultural beliefs, values, and practices. Faculty members indicated that the medical profession, medical examination boards, and licensure all focus on science, and residents are more concerned about professional standards which determine whether or not they will practice medicine, not cross-cultural skills.

Professionalism, which several faculty members raised, summarizes why the two groups are alike, as well as different from one another. Several faculty members identified science as central to the enculturation process and the reason why physicians are overwhelmingly similar. A few faculty members indicated that they understood they were being assimilated into a profession during their medical education. These faculty members identified medicine as having beliefs, values, practices, and a language uniquely different from theirs, which they abandoned when there was a conflict. Although faculty members did not mention Flexner specifically, other medical professionals have credited the revolutionary educator for saving medical education in the early twentieth century (Arky, 2007; Mindrum, 2006; Moseley, 2006; Regan-Smith, 1998). Flexner, in 1910, proposed that medicine should be scientific and standardized and many interpreted this to mean that the profession should be guided solely by science, which was not his intent. Flexner also proposed that physicians should rely upon intuition and communication skills. However, science has guided medical education for almost one hundred years.

Faculty members implied that science is the reason most physicians are similar to one another, because they learn the same content the same way, an implicit acknowledgement of Flexner. When faculty members were presented with results that indicated that they and other specialties did not differ regarding beliefs about culture or willingness to accept stereotypes, they often cited science. In addition to science, social identity theory also is explanatory for professional identity and why faculty members provided similar data during interviews. While faculty members discussed different experiences, there was much redundancy. Social identity theory proposes that legitimate ingroups may perceive themselves as less variant than a larger outgroup, especially when ingroup members want to belong to the group (Bartsch & Judd, 1993). Perceptions of less variance among group members contribute to stronger identity and cohesion. Faculty members strongly identified themselves as unique, and individuals inside and outside of medicine recognize that physicians are a legitimate group. Both identity and recognition by others are essential for strong group collectiveness and cohesion (Lalonde & Silverman, 1994; Tajfel, 1982). The result is that physicians want to belong to their group and share similar beliefs, values, and practices, which emerged during interviews.

While faculty members used science to explain similarities and professionalism among physicians, they offered art and experiences as explanatory reasons for differences between themselves and medical residents, whom they identified as being a different, but similar, group. Faculty members indicated that they and medical residents share similar education and desire to belong to the same group, but differ markedly in terms of experiences with patients. With respect to cross-cultural education, faculty members suggested that medical residents do not realize fully the integration of art and science. The suggestion was that medical residents do not have sufficient experiences to reflect and discern when art is important or relevant for their scientific education. Faculty members also acknowledged that medicine as a profession values science more than art, which is evidenced in the ways that medical education evaluates students and residents, the examination boards that specialties administer, and the state licensure tests that physicians must pass prior to practice. Faculty members did not discount the value of science, but proposed that a significant difference between themselves and residents

pertained to appropriate uses of art and recognition that scientific evidence does not always provide answers.

Although faculty members raised professionalism as an issue for themselves and medical residents, they ignored aspects of the art of medicine which are equally relevant and important. As Starr (1982) proposed in his examination of medicine's rise as a profession, physicians gained status, power, and control over health care largely after making science a central part of their profession. However, social class and power were seldom raised as components of professionalism or how they impact the patient – physician relationship. Medical professionals, particularly the population at the University of Kentucky, are largely middle to upper class, whereas their patients are not.

Tice (1998), who examined social workers, is instructive for how middle class professionals may misread and objectify those outside their social group. Tice found that professionalism obscured for some social workers the extent to which they constructed individuals as objects and how some projected their beliefs and values upon others. The professionalization of medicine also may have blinded some physicians to perceive that everyone holds their middle and upper class beliefs and values, which is problematic in terms of teaching and practicing cross-cultural skills. The central thesis of this study questions whether or not the ways, in which medicine understands culture, impact clinical decisions. This study found that cross-cultural competence may be a less effective skill if physicians are oblivious to the impact and role that social class, along with race, ethnicity, and gender, has on understanding diverse cultural beliefs, values, and practices.

Implications

This study raised several issues around cross-cultural education, specifically curriculum and instruction, content experts, and relevancy for medical residents. As the results to the research questions indicate, clinical experiences are a major aspect of cross-cultural education. During residency education, residents primarily gain clinical experience with actual patients, who have real problems. Medical residents' clinical encounters typically entail the resident learning patients' history, discussing the findings with a faculty member, and making diagnoses and treatments. However, prior to this extensive contact with patients, medical residents gain experience as students.

Medical students largely gain clinical experience via standardized patients who simulate encounters, teach communication skills, and assess clinical knowledge. Standardized patients score medical students using checklists to indicate whether or not they were asked certain questions and how they were treated. Medical students also gain experience from objective structured clinical examinations (OSCE), which are similar to the standardized patient approach where proficiency is determined somewhat using checklists to determine whether or not a student demonstrated or completed a task. OSCE's are usually specific to a content domain, such as communication skills or anatomy, and are used to evaluate knowledge, attitudes, and clinical skills.

These training examinations can be passive, such as written tests, or they can be active and use standardized patients. However, a commonality independent of the passive or active strategy is that a checklist for performance is usually a characteristic of the OSCE's. The impact of checklists on cross-cultural education may be that cultural skills are learned and practice in a discreet and narrow way where beliefs, values, and practices are presented as isolated and stable facts. Although medicine relies heavily upon these types of experiences to teach medical students and residents, this study proposes the profession should provide cross-cultural education more evenhandedly and should use both didactics and experiential efforts.

Medicine also uses films and actors to teach didactic materials like communication skills; cultural content also can be integrated using this medium, as well. The use of media, such as television and film, may be a strategy to introduce this complex and sensitive material in a way that is not threatening for learners. The use of popular culture via television and film may facilitate discussions among medical residents and faculty members whereby they may be more comfortable and candid discussing and questioning cultural beliefs, values, and practices of fictitious characters rather than actual people (Lewis, 2004).

Gates (2006) found discussions among nursing students to be rich, engaging, and diverse when using popular culture to discuss cultural encounters. The nursing students were shown Bring the Pain, an episode from the popular medical drama series Grey's Anatomy, to examine and evaluate cross-cultural encounters between patients and physicians (Gates). The nursing students not only candidly discussed the relevance of

cultural beliefs, values, and practices, but engaged in educating their peers about their personal learning experiences, as they related to the episode.

The use of this media also can be used to contextualize culture historically, as in the origins and purpose of cultural knowledge, along with the multiple ways in which shared beliefs, values, and practices can be defined, such as modernism and postmodernism. Additionally, the case for culture in medicine also should be made beyond demographic factors like race and ethnicity to include discussions about the impact of history and politics on beliefs, values, and practices. However, a central pedagogic strategy that often is missing from experiential and didactics is structured debriefings.

Debriefing clinical encounters between patients and medical residents, as well as didactics, can provide formative assessment whereby faculty members can identify what residents are learning, make comparison between actualized and desired outcomes, provide feedback, and correct misperceptions (Rudolph, Simon, Raemer, & Eppich, 2008). One of the benefits of structured debriefing is that educators continuously monitor and assess what learners take away from experiences, as well as some didactics. A more formal process of experiential learning like debriefing may facilitate medical residents in reflecting upon clinical encounters, identifying ones that are culturally relevant, as well as ones that are not. Debriefing clinical encounters also may dispel the notion among many medical residents that they learn nothing about culture from faculty members or during their professional education. However, debriefing is most effective when educators and learners know the goals and rules around debriefing, when feedback is not judgmental, and when the learning environment is open and participants are comfortable to discuss and disagree with one another (Rudolph, et al.). Honesty, respectful criticism, and support underlie the process (Rudolph, et al.).

Culture is too complex of a construct for faculty members to rely on medical residents to understand and connect independently of structured debriefing all the nuances of patients' beliefs, values, and practices. Whether or not cross-cultural education occurs didactically or experientially, faculty members need to assess what medical residents and students understand. Although this study found cross-cultural didactics and experiences lacked structured debriefing, cultural content is an aspect of

medical education. As important as experiences are to cross-cultural education, this study proposes that the almost sole reliance on experiential education can be an abdication of faculty members' responsibility to provided didactics.

However, cross-cultural didactics do not need to be a standalone course, since this may make the content appear separate from medicine whereas it is not. For example, some cross-cultural content is presented in specific workshops, components of courses, or as electives. Content about culture should be integrated appropriately and measurably into current courses to include didactics about patient – physician communication, the biopsychosocial model, and the patient-centered care model, as well as clinical and scientific coursework. This study proposes that experiences and didactics are necessary to learn about culture and that medicine should increase the extent and depth of both approaches with the caveat that the profession uses knowledgeable educators who have expertise in cross-cultural education.

Content experts can teach medical residents or collaborate with faculty members about the broader definitions and ways in which to frame culture. The use of content experts to teach medical residents or faculty members are ways in which medicine can subsume cross-cultural education in a broader and more complete way under the auspices and control of the profession. Medicine's inclusion of content experts from other disciplines, such as the social sciences, also may give the profession influence in the broader arena of cross-cultural education.

Along with content experts, medicine has stated that increased diversity among faculty members, staff, and students is a goal. While not relying on minorities solely to teach the majority about different cultural beliefs, values, and practices, medicine may find that diverse individuals who work in teams and collaborate on projects share, teach, and learn from one another. The medical profession has implemented this learning strategy across disciplines like nursing, pharmacy, and nutrition where professionals and students work collaboratively to provide better outcomes for patients. The same strategy may be effective in terms of cross-cultural education.

Medicine's role in the larger arena of cross-cultural education may depend on how serious and valuable the profession takes the issue. The informal ways that medicine largely has integrated culture and the profession's reliance on non-experts to

teach do not convey to medical residents that cross-cultural education is essential or that the skill is important for practice. To address these issues, medicine should make the case that culture is relevant and important in similar ways that the profession makes science important. This study does not suggest that culture or the art of medicine is more important or more relevant than science, but medicine makes anatomy and pharmacology important in the ways that it evaluates students. For example, faculty members test and require projects from students regarding their knowledge of anatomy and pharmacology. Many faculty members expressed that medical residents believe their professional education is about science, which the profession evaluates and rewards. Medicine should measure and evaluate cross-cultural skills meaningfully. Cross-cultural skills should be measured like other competencies and integrated with assessments for science-based content, so this aspect of medicine does not appear separate and distinct from "more important" requirements.

The implications that emerged from this study are believed to be relevant for primary care medicine in terms of how the profession defines culture and teaches cross-cultural skills. The findings also are instructive with respect to why expertise in curriculum and instruction is important, specifically as pedagogic strategies may result in unintended consequences like stereotyping. Primary care medicine, based on the results of this study, may need to re-evaluate how medical education integrates culture and how important the profession conveys the skill to medical residents. While the findings from this study are believed to have relevance for primary care medicine, a number of factors limited what this study learned and the implications for the broader medical arena.

Limitations

This research has several limitations that impact the generalizability of the findings. Only one U.S. medical school out of 131 and only 4 out of dozens of specialties participated in the study. Along with the small sample size, all data were self-reported via surveys and interviews. Also, the topics of culture and cross-cultural competence are sensitive for some participants given that accreditation bodies require the skills, and the medical community advocates the importance of cultural knowledge to clinical encounters. Some participants may have responded favorably to the issue, and this research obtained no additional evidence like patients' perceptions and satisfaction with

clinical encounters to glean physicians' cross-cultural competence. Furthermore, participants likely were not representative of the larger medical community, because those who are interested in the issue most likely participated in the study. While these limitations impact the findings, the intent of this study was to learn from a small group of primary care physicians how they defined culture and what this meant in terms of stereotypes.

This research also is limited, in that, some faculty members and medical residents may have provided politically correct answers, since medical organizations, such as the AMA, and accreditation bodies like ACGME have endorsed cross-cultural competence as a skill that physicians should possess. This study sought to minimize this limitation and focused on what faculty members and medical residents understand about culture, instead of whether or not they believe that culture is relevant for clinical encounters or what their agreement is with the larger medical community.

Additionally, when asked what they had learned about culture during medical school, some faculty members and medical residents likely found the question difficult to filter and separate from other knowledge sources that influenced their philosophical perspectives and personal epistemology. This study sought to minimize this limitation and compared medical residents to faculty members as a way to glean differences between what educators believe they teach and what learners report they learn.

Future Research

The limitations this study identified, along with what was learned, provide the basis for a number of proposed research projects. This study addressed an aspect of cross-cultural education that the medical literature has not examined fully; focused on how primary care physicians define culture; and, examined differences and similarities in definitions between faculty members and medical residents. However, faculty members and medical residents indicated that primary care medicine, even across subspecialties, likely shares similar definitions of culture whereas other medical specialties, which were not included in the sample population, probably have different philosophical beliefs. Faculty members also proposed that medical students prior to their enculturation into medicine may have more diverse views about culture than residents. The gist of these

suggestions is to expand this study across specialties and learners, as well as, a diverse sample of academic health centers and community providers.

Faculty members suggested that a broader population in medicine beyond primary care would provide a more complete description of what the profession understands about culture. However, this study also learned that health care professions like nursing and physician assistant studies are grappling with cross-cultural competence. In a pilot study with nursing students at the University of Kentucky, Gates (2006) found the profession attuned to the relevance and importance of culture for patient and clinical care. The nursing students, who participated in the pilot study, often discussed patients as active participants in their health much more so than medical residents, who framed individuals' cultural beliefs, values, and practices in objectified ways (Gates). Contrarily, the pilot study with physician assistant students at the University of Kentucky revealed that this population perceived culture much more definitively and narrowly than medical residents. Physician assistant students also were much more willing to accept stereotypes than medical residents.

The results of the two pilots revealed that health care professions, such as nursing and physician assistant studies, are grappling with culture differently, have different philosophies, and vary in terms of how extensively they have integrated the construct. The differences among the professions are reasons to examine further what they understand about culture and how they integrate cross-cultural skills. A multidisciplinary study may be instructive for how professions may improve their cross-cultural skills, as well as learn how colleagues approach cultural encounters. For example, nursing as a profession examines patients in a more complete and holistic way than medicine. Nursing students are educated early in their careers to develop care plans for patients whereby they address clinical, as well as psychosocial needs like whether or not the person understands their treatment plan or if they are capable of following recommendations. Medicine tends to use checklists and focus intently on the disease or illness instead of broader concerns that a patient may have. These differences between professions provide the foundation and justification for a larger more comprehensive study across health care professions.

In addition to a study across health professions, a broader study could provide guidance for where and when culture should be integrated into the curriculum. A longitudinal study of medical students, as well as other health profession students, could provide data regarding their beliefs about culture and stereotypes, and whether or not they change as they progress through training. This inquiry also could provide data about the extent to which professions enculturates students. For instance, do students enter medical school with diverse beliefs and many within differences, which are minimized over time? These data may be informative with respect to when medicine and others should integrated culture into the curriculum.

This study proposes that medicine should make culture meaningful and relevant for medical residents and medical students through evaluation. This necessitates the creation of valid and reliable instruments to evaluate cross-cultural skills. This study and evidence from the literature indicate that medicine has not evaluated meaningfully whether or not faculty members and medical residents have cultural skills (Dogra & Carter-Pokras, 2005; Dogra & Wass, 2006). Oftentimes, assessments query attitudes and beliefs about race and ethnicity, and not how prepared or competent one is to interact in clinical encounters when cultural differences between patients and physicians are important (Dogra & Carter-Pokras; Dogra & Wass). Medicine frequently proposes these types of instruments as tools to measure cross-cultural competencies of physicians.

Patients are the central reason why medicine is interested in cross-cultural education; however, research often focuses on them in indirect ways. This research also discusses patients indirectly through faculty members and medical residents. Primary care physicians in this study provided their thoughts about how individuals should be cared for during clinical encounters, but what are patients' perceptions of medicine and the impact of cultural beliefs, values, and practices? This question goes beyond patient satisfaction with specific services and health outcomes. Further studies should examine patients' beliefs about culture and stereotypes and their relevance for health. Do patients consider culture, theirs as well as medicine's beliefs, values, and practices, during clinical encounters? Also, what might patients want from cross-cultural encounters with physicians? The purpose of such a study would not be to learn information about specific groups, but to provide an idea of whether or not patients and physicians have shared goals

and perceptions about cross-cultural encounters, and whether or not these factors impact health outcomes.

These suggested studies emerged from the current research findings, as well as what this study did not learn. These proposed studies are an expansion and extension of this research and what remains to be investigated. Culture is complex and is framed in many different ways; some are explanatory and others are problematic. Among the ways to frame culture, this research proposes the following definition.

Culture is about our shared beliefs, values, and practices, but only as a basis for discussion. Shared beliefs, values, and practices do not control what we believe, what we value, or how we behave. Culture is constantly evolving as we age, mature, and argue within and across groups about who we are, what we believe and value, and how we behave. There are multiple factors and variables that define what we mean when we talk about culture. These factors pertain to our family, region of origin, social class, economic status, who we choose to associate with and who we do not. Factors that are salient for some will not be so for others. Culture is less about physical features and appearances in a global world, because we interact with many more cultures today than we did yesterday. We can communicate online and talk to people from Japan or France. We have airplanes and can travel to anywhere in the world within a day. Of course, only those with the financial resources can do that kind of traveling or communicating, which is a factor for how some members are impacted. All of these variables influence, not define, who we are. And, the lessons for medicine may be that physicians need mostly to know that their patients may be influenced by factors other than what they know or understand and that specific knowledge about culture is not enough, one must be able to discern and tap into what these differences are and how they impact health decisions. Of course, the sole responsibility does not rest just with medicine or physicians. Patients, perhaps, should be cross-culturally competent too and understand that medicine as a profession has beliefs, values, and practices that emerge from internal and external contestations among its members. Cross-culturally competent patients may help decrease the paternal role that many physicians take and encourage more individuals to be more active and participatory in their care.

Conclusions

The purpose of the study was to learn whether or not faculty members' and medical residents' philosophical beliefs about culture predict or explain the extent to which they are willing to accept stereotypes, and the impact that education has on how they understand cultural knowledge. This study was framed in terms of social identity theory and sought to explain the distinctiveness between faculty members and medical residents (group identity) with respect to their beliefs about culture and their willingness to accept stereotypes (group interactions). The theory proposes that group members want to belong to their group and likely see those outside their group more stereotypically than they view themselves (Bartsch & Judd, 1993). However, social identity theory also contextualizes group identity and interactions and proposes that factors like status, group size, and who makes the comparison are relevant (Bartsch & Judd).

Social identity theory provides the framework to examine intragroup and intergroup relationships, and modernism and postmodernism are the anchors for how faculty members and medical residents understand culture. As the analysis for the first research question revealed, faculty members and medical residents overwhelmingly define culture in modernist terms, which critics like Gregg and Saha (2006), Koehn and Swick (2006), and Kripalani et al (2006) proposed led to stereotypes. Faculty members and medical residents at the University of Kentucky did not heed the cautions that Betancourt (2004, 2006a, 2006b), Beagan (2000), and Dogra, Giordano, France (2007) raised about the limitations of cross-cultural education when framed primarily in terms of race and ethnicity.

The narrow ways in which faculty members and medical residents discussed culture suggest they believe groups are defined primarily by race and ethnicity and to a limited extent gender and socioeconomic status. The limited ways in which faculty members and medical residents define culture are consistent with how many social scientists and medical educators frame culture philosophically. However, some medical researchers propose that groups are comprised of many distinct and different factors, which are not separate and isolated from each other and which interact or influence beliefs, values, and practices (Dean, 2001; Tervalon & Murray-Garcia, 1998). Although a number of faculty members stated that culture is complex and contextual, many framed

cultural knowledge in concrete terms and essentialized beliefs, values, and practices for group members (Koehn & Swick, 2006). In essence, many medical professionals are trained to categorize patients in order to make predictions about health beliefs, values, and practices (Groopman, 2007; Helman, 2000; Kleinman, 1980).

The modernist definition of culture emerged from both groups' open-ended and close-ended responses. While both groups overall define culture in terms of modernism, faculty members have many more nuances and variations of beliefs than medical residents. Faculty members attributed these differences to their greater experience and exposure to other groups. Social identity theory helps to explain the experiential difference between faculty members and medical resident. The framework proposes that biases and prejudices decrease with exposure to others (Tajfel, 1982). Faculty members have much more contact with more diverse patients and they often have sustained relationships with individuals, which likely explain the differences the two groups have regarding beliefs about culture.

As Banks, Billings, and Tice (1993), Narayan (1997), and Poddar (2003) suggested, the intersection of multiple factors like ethnicity, gender, social class, history, and politics influence what groups believe, value, and practice and how they differ. Surprisingly, there are few points of departure between faculty members and medical residents, at least with respect to beliefs about culture and willingness to accept stereotypes. While this study found between group differences regarding beliefs about culture in terms of medical specialty, citizenship, gender, parents' education, social class, and year in residency, faculty members and medical residents have far fewer within differences. Motivation to belong to the profession of medicine is likely explanatory for why there are so few within differences between faculty members and medical residents, which postmodernism and, to an extent, social identify theory propose as reasons why individuals form groups. In the case of physicians, their specialized education codifies and legitimizes them as a unique group with shared beliefs, values, and practices, which social identity theory expects of non-arbitrarily formed groups.

Betancourt (2006b) and Beagan (2000) further explained this finding, in that, medical education trains physicians not to recognize differences among patients, as well as themselves. Beagan (2000) referred to this process, in the title of her work, as

"producing neutral doctors for (almost) neutral patients." Another way to frame and attribute the lack of within differences for the two groups is that medicine is an enculturation process that minimizes and eliminates individual differences. The curricular standardization that Flexner (1910) proposed is explanatory for why there are so few differences within the groups. The effect of curricular standardization and science has been to eliminate many differences among medical students and residents.

Despite the similarities between faculty members and medical residents, the groups depart from one another with respect to how predictive and explanatory beliefs about culture are for willingness to accept stereotypes. The variable is only predictive for medical residents and indicates that a more emergent and contextual definition of culture results in less willingness to accept stereotypes. This finding is consistent with the medical literature, which suggests that an essentialist definition of culture results in stereotypes (Beagan, 2003; Gregg & Saha, 2006; Turbes, et al., 2002).

Stereotypes are problematic in medicine when physicians make assumptions and expect certain behaviors that lead them not to ask certain questions or consider other treatment recommendations (Beagan, 2003; Gregg & Saha, 2006; Turbes, et al., 2002). However, beliefs about culture are not predictive or explanatory for faculty members. This finding is a surprise and is not supported by the literature, but is explained best by faculty members' greater experience and their acceptance of variance within their group. Social identity theory supports this assertion, in that, groups, whose membership is restricted, allows more variance among members (Bartsch & Judd, 1993; Jetten, et al., 2004). Physicians, as a group, are closed to those who have not completed medical school and who have not passed licensure examinations. Social identity theory posits that closed groups are more likely to accept within group variances than groups that are arbitrarily formed (Bartsch & Judd; Jetten, et al.). The greater experience and exposure to other groups by faculty members also lead them to understand that groups' members contest beliefs, values, and practices.

Faculty members' views of culture are modernist, but their experiences with diverse patients may make them sensitive to and resistant to stereotype patients. This study found that the predictive value of beliefs about culture for willingness to accept stereotypes is group dependent. Beliefs about culture predict willingness to accept

stereotypes among medical residents, but not faculty members. This finding suggests that cross-cultural education is most important for medical residents, who are statistically and thematically different from faculty members, at least with respect to culture. However, this study did not interpret this finding entirely as evidence that medical residents had learned nothing about culture from faculty members. The similarities between faculty members and medical residents with respect to their beliefs about culture suggest that residents have learned something about the cultural aspect of practice. However, based on the results to the research inquiries, this study questions the extent to which faculty members teach about culture, as well as how medical residents interpret and apply cross-cultural skills they learn during medical school.

Faculty members and medical residents differed starkly with respect to what they believe they had learned about cross-cultural competence during medical school. Faculty members in this study identified a number of curricular and instructional approaches that they use to teach cross-cultural skills, such as case studies, trigger films, and simulations with standardized patients. These approaches are all cited prominently in the medical literature and have the potential to increase one's willingness to accept stereotypes, as these strategies sometimes portray patients narrowly and with fixed beliefs, values, and practices (Beagan, 2003; Gregg & Saha, 2006; Turbes, et al., 2002). Beagan (2003) and Tice (1998) cautioned that we should use cases judiciously, because some portrayals present individuals in objectified and flat one dimensional ways. For example, communication issues between patients and physicians often are framed in terms of limited English proficiency among immigrant populations. Communication issues also may emerge with native English speakers who do not understand the language of medicine.

While faculty members indicated that they prepare medical residents didactically for cross-cultural encounters, both groups indicated that experiences are the best methods to learn and to acquire the skills. However, extensive or sole reliance on experiences is an abdication of faculty members' responsibility to teach about culture. Experiences as the primary source for cross-cultural education are problematic, because medical residents have limited long-term relationships and fewer contacts with patients than

faculty members, so they often do not have an opportunity to learn reflectively and completely from these encounters.

Faculty members in this study questioned the extent to which art and science should comprise medical education. Many faculty members acknowledged that medical residents primarily believe that they should learn science, which they associate with "doctoring." Implicitly, faculty members did not dispel this notion. Many faculty members stated that cross-cultural education is important and relevant, if only from patients' perspectives, but they also proposed that individuals need to have an internal aptitude or interest in culture, which provides insight into their epistemological beliefs. The belief about an innate aptitude for cross-cultural competence in many ways minimizes the importance of didactics, and implicitly, makes the skill set a less valuable concept to teach, since cross-cultural capabilities are determined innately.

The findings with respect to the groups' beliefs about culture, ways in which they are similar and different, the extent to which predictor variables explain willingness to accept stereotypes, and perceptions about cross-cultural education culminated to portray a mixed picture of how extensively medicine has integrated cultural content. Medicine, to some extent, formally integrates culture into the medical curriculum through didactics, but cross-cultural competence mostly is conveyed informally through clinical experiences. However, the informal curriculum is dependent upon individual faculty members and their beliefs about culture. The outcome is that cross-cultural education is a larger component of some medical residents' education than others. The informal manner in which much of cross-cultural education occurs conveys the limited importance of the issue to medical residents, since faculty members only informally address the issue.

As problematic as the informal ways that culture is taught, this study concluded that some faculty members responsible for cross-cultural education have little to no background to teach the content. Medicine uses content experts to teach other disciplines like pharmacology and anatomy, but not for culture and other aspects of the art of medicine like ethics. A few faculty members expressed lack of comfort to teach about culture; conversely, others did not. Who teaches about culture is problematic and suggests to some medical residents that cultural knowledge is not specialized or complex

like scientific fields. Furthermore, medicine's decision not to use content experts raises questions about how in depth medical educators teach culture. While some faculty members who teach about culture may discuss beliefs, values, and practices complexly, often their definitions are descriptive instead of explanatory. The extent to which they teach culture formally through didactics likely is limited in terms of content and range of perspectives.

In addition to who teaches about culture, this study also questions how medicine delivers cross-cultural content. Experiential learning emerged as the primary pedagogic method that faculty members use to teach cross-cultural skills. This method is more or less the same as case studies, which can be problematic in the ways that patients are portrayed as universal, passive, and uncomplicated; however, medicine does not need to abandon the uses of cases altogether. Faculty members can expand the strategy they use to teach about culture and require students to develop treatment plans based on cases, as well as critique case presentations and how patients are presented. This strategy should also allow peers to learn about cultural diversity and its impact on health care and outcomes from one another, others in the medical and health professions, and patients. This pedagogic strategy also may reveal the diversity of definitions regarding culture.

While there are issues and concerns about how primary care medicine at one academic health center defines culture, how faculty members teach the skill set, and who provides instruction, this study found that some physicians want their profession to invest more research and interest into cross-cultural education, because of the social and practical implications for more appropriate and effective care. The social implications of cross-cultural education pertain to patients who want their perspectives respected and validated, while the practical components pertain to better health outcomes (Fadiman, 1997; Groopman, 2007; Helman, 2000; Kleinman, 1980). This acknowledgement indicates that some medical professionals believe culture is relevant and that medicine may need to include other disciplines with content expertise in the construct. Further studies within and outside of medicine may provide evidence to the medical profession that research and collaborations with other disciplines is necessary in order to understand better the complex construct called culture.

Appendices

Appendix A. National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2
Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4
Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5
Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6
Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7
Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8
Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Appendix A (continued). National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Standard 9
Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10
Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11
Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12
Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13
Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14
Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Appendix B. Original Beliefs about Culture Instrument

Beliefs about Culture **Please respond to the following statements based on your personal perspective and indicate the extent to which you agree or disagree with the statements by marking only one answer.**	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
1. Although I may not exhibit every cultural characteristic of my group, there are some traits that I cannot escape.	☐	☐	☐	☐	☐
2. Learning about culture should be about key principles and not specific characteristics.	☐	☐	☐	☐	☐
3. Being able to communicate in a culturally appropriate manner takes a lot of work.	☐	☐	☐	☐	☐
4. We learn how to belong to our culture.	☐	☐	☐	☐	☐
5. I have a lot of control over how much I learn in didactic courses.	☐	☐	☐	☐	☐
6. Cross-cultural competence is a skill to keep physicians on the right track.	☐	☐	☐	☐	☐
7. Cross-cultural competence is a skill that is learned and not innate.	☐	☐	☐	☐	☐
8. Culture is simple to understand.	☐	☐	☐	☐	☐
9. Experts are born with a special gift to excel in some area.	☐	☐	☐	☐	☐
10. Learning definitions word for word about culture is necessary in order to use what one has learned.	☐	☐	☐	☐	☐
11. Cultural groups have clearly defined beliefs, values, and behaviors.	☐	☐	☐	☐	☐
12. Specific facts about specific cultural groups are important for interacting with individuals outside my cultural group.	☐	☐	☐	☐	☐
13. Learning about culture entails memorizing facts.	☐	☐	☐	☐	☐
14. Cultures are largely unchanging.	☐	☐	☐	☐	☐
15. I can solve problems even if I do not remember facts and details, as long as I understand key principles.	☐	☐	☐	☐	☐
16. A way of learning about culture is to examine ones personal beliefs, values, and practices.	☐	☐	☐	☐	☐
17. Gifted people do not have to work hard to do well.	☐	☐	☐	☐	☐
18. Specific knowledge about group beliefs, values, and behaviors are valuable to the clinical encounter.	☐	☐	☐	☐	☐
19. There is an objective truth for almost everything.	☐	☐	☐	☐	☐
20. Culture becomes confusing when other concepts like history, politics, and/or power are part of the discussion.	☐	☐	☐	☐	☐
21. Cultural characteristics are not certain.	☐	☐	☐	☐	☐
22. It is frustrating when people discuss culture and seem not to be able to express what they really believe the concept to mean.	☐	☐	☐	☐	☐
23. Culture has little meaning without knowing the context in which it is applied.	☐	☐	☐	☐	☐
24. There is one best way to teach cross-cultural skills.	☐	☐	☐	☐	☐
25. Successful people discover how to improve their ability to learn.	☐	☐	☐	☐	☐

Appendix B (continued). Original Beliefs about Culture Instrument

Beliefs about Culture **Please respond to the following statements based on your personal perspective and indicate the extent to which you agree or disagree with the statements by marking only one answer.**	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
26. I cannot learn about other cultures on my own.	☐	☐	☐	☐	☐
27. Even if the truth is not known today, it is obtainable through scientific inquiries.	☐	☐	☐	☐	☐
28. I cannot understand the culture of a group without knowing the internal debate among group members.	☐	☐	☐	☐	☐
29. If culture cannot be defined with certainty, then the concept is not worth learning.	☐	☐	☐	☐	☐
30. Culture is more meaningful when it is taught as a fact instead of a changing concept that is socially constructed.	☐	☐	☐	☐	☐
31. If there are no straightforward answers for culture, then there is not much value in studying or learning to become cross-culturally competent.	☐	☐	☐	☐	☐
32. There is usually a single correct approach to dealing with clinical encounters when culture is relevant.	☐	☐	☐	☐	☐
33. Only death and taxes are certain.	☐	☐	☐	☐	☐
34. When cross-cultural communication is important to the encounter, it is important to approach the situation without preconceived notions.	☐	☐	☐	☐	☐
35. Appropriate cross-cultural encounters is not about knowing the answers, but knowing how to find the answers.	☐	☐	☐	☐	☐
36. Today's facts may be tomorrow's fiction.	☐	☐	☐	☐	☐
37. People are born with predisposed cultural traits.	☐	☐	☐	☐	☐
38. It is intellectually stimulating to think about issues that have no clear right answer.	☐	☐	☐	☐	☐
39. I try to integrate multiple aspects of culture into the clinical encounter.	☐	☐	☐	☐	☐
40. It is simplistic to think that culture is a tidy concept.	☐	☐	☐	☐	☐
41. I appreciate learning about culture when it is organized in a defined manner and deviates little from key points.	☐	☐	☐	☐	☐

Please continue to the next section, which seeks to learn the extent to which you agree or disagree with statements pertaining to cultural groups.

Perceptions about Cultural Groups **Please respond to the following statements based on your personal perspective and indicate the extent to which you agree or disagree with the statements by marking only one answer.**	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
1. Sometimes when I meet new people, I can predict their behaviors or attitudes just from knowing what cultural groups they belong.	☐	☐	☐	☐	☐
2. In daily life, there is so much to pay attention to, it helps if you can make a few assumptions about a person.	☐	☐	☐	☐	☐
3. When interacting with others, it is very important to have a sense of what cultural groups they belong.	☐	☐	☐	☐	☐
4. Making assumptions based on observations can be harmful, but is essential for interacting with members of real groups.	☐	☐	☐	☐	☐

Appendix B (continued). Original Beliefs about Culture Instrument

Perceptions about Cultural Groups Please respond to the following statements based on your personal perspective and indicate the extent to which you agree or disagree with the statements by marking only one answer.	Strongly agree	Agree	Disagree	Strongly disagree	Not sure
5. People differ so much from one another, it is impossible to generalize about them.	☐	☐	☐	☐	☐
6. You cannot get through life without generalizing about people, even though such generalizations may be overstated.	☐	☐	☐	☐	☐
7. It is impossible to know how a person will behave from knowing what cultural groups the person belongs.	☐	☐	☐	☐	☐
8. Cultural expectations about people prevent you from seeing them for whom they really are.	☐	☐	☐	☐	☐
9. Trying to make predictions about how others behave may have too much influence on how we interact with them.	☐	☐	☐	☐	☐
10. The opinion that other groups have different beliefs and values from yourself does not mean that you have a negative view of the person.	☐	☐	☐	☐	☐
11. If we treated everyone as if they were a unique individual, there would be a lot less conflict in the world.	☐	☐	☐	☐	☐
12. Generalizations are useful in daily life even though they are not always correct.	☐	☐	☐	☐	☐

Cultural Identity and Understanding

Please respond to the following questions, which seek to understand in greater depth what you personally believe about culture and how you come to hold these beliefs.

1. What does culture mean to you?

2. Which cultural group(s) do you belong?

3. What gives you a sense of belonging to your cultural group?

Appendix B (continued). Original Beliefs about Culture Instrument

4. What factors make culture a complicated or clear-cut concept?

5. What has influenced you the most in how you understand culture?

6. What is the most important aspect about culture that you learned during your medical training?

Please provide the following data about yourself.

Gender:

Race:

Were you born in the U.S.?

☐ Yes ☐ No

If you were not born in the U.S., how many years have you lived in the US?

Status in Department:

☐ Year 1 ☐ Year 2
☐ Year 3 ☐ Faculty

During your childhood, what was the highest level of education that your parents completed:

☐ Primary school
☐ High school
☐ Post-secondary (trade, technical)
☐ Undergradate degree
☐ Graduate degree
☐ Doctorate

List your parent's occupations during your childhood:

Describe your family environment, during your childhood (Check all that apply):

☐ Growing up, I lived in a house.
☐ My parents owned other properies than our residence.
☐ My parents rented the house I grew up in.
☐ I grew up in an apartment.
☐ My parents hired domestic workers.

Thank you!

Appendix C. Revised Beliefs about Culture Instrument

Beliefs about Culture

Thank you for consenting to participate in this study about cross-cultural training in medical education. Your feedback is important in order to better understand what the profession means when it talks about culture. Your participation and responses will be confidential and securely stored.

The Beliefs about Culture instrument is comprised of four sections:
Section 1. Personal Perspectives about Culture
Section 2. Perceptions about Cultural Groups
Section 3. Cultural Identity and Understanding
Section 4. Demographics

Please provide your agreement with each statement in Sections 1 and 2. Sections 3 and 4 are comprised of open-ended questions.

Thank you for agreeing to complete this questionnaire.

Madison L Gates
University of Kentucky
mgates@email.uky.edu

Personal Perspectives about Culture

SA=Strongly agree
A=Agree
D=Disagree
SD=Strongly disagree

Please indicate your agreement with each of the following statements.

	SA	A	D	SD	Not sure
Although I may not exhibit every cultural characteristic of my group, there are some traits that I cannot escape.	◯	◯	◯	◯	◯
Learning about culture should be about key principles and not specific characteristics.	◯	◯	◯	◯	◯
Being able to communicate in a culturally appropriate manner takes a lot of work.	◯	◯	◯	◯	◯
I have a lot of control over how much I learn in didactic courses.	◯	◯	◯	◯	◯
Cultural groups have clearly defined beliefs, values, and behaviors.	◯	◯	◯	◯	◯
Learning about culture entails memorizing facts.	◯	◯	◯	◯	◯
I can solve problems even if I do not remember facts and details, as long as I understand key principles.	◯	◯	◯	◯	◯
Specific knowledge about group beliefs, values, and behaviors are valuable to the clinical encounter.	◯	◯	◯	◯	◯
There is an objective truth for almost everything.	◯	◯	◯	◯	◯
Successful people discover how to improve their ability to learn.	◯	◯	◯	◯	◯
I cannot understand the culture of a group without knowing the internal debate among group members.	◯	◯	◯	◯	◯
If culture cannot be defined with certainty, then the concept is not worth learning.	◯	◯	◯	◯	◯
Only death and taxes are certain.	◯	◯	◯	◯	◯
When cross-cultural communication is important to the encounter, it is important to approach the situation without preconceived notions.	◯	◯	◯	◯	◯

Please continue

Appendix C (continued). Revised Beliefs about Culture Instrument

Perceptions about Cultural Groups

SA=Strongly agree
A=Agree
D=Disagree
SD=Strongly disagree

Please indicate your agreement with each of the following statements.

	SA	A	D	SD	Not sure
Sometimes when I meet new people, I can predict their behaviors or attitudes just from knowing what cultural groups they belong.	◯	◯	◯	◯	◯
In daily life, there is so much to pay attention to, it helps if you can make a few assumptions about a person.	◯	◯	◯	◯	◯
When interacting with others, it is very important to have a sense of what cultural groups they belong.	◯	◯	◯	◯	◯
Making assumptions based on observations can be harmful, but is essential for interacting with members of real groups.	◯	◯	◯	◯	◯
People differ so much from one another, it is impossible to generalize about them.	◯	◯	◯	◯	◯
You cannot get through life without generalizing about people, even though such generalizations may be overstated.	◯	◯	◯	◯	◯
It is impossible to know how a person will behave from knowing what cultural groups the person belongs.	◯	◯	◯	◯	◯
Cultural expectations about people prevent you from seeing them for whom they really are.	◯	◯	◯	◯	◯
Trying to make predictions about how others behave may have too much influence on how we interact with them.	◯	◯	◯	◯	◯
The opinion that other groups have different beliefs and values from yourself does not mean that you have a negative view of the person.	◯	◯	◯	◯	◯
If we treated everyone as if they were a unique individual, there would be a lot less conflict in the world.	◯	◯	◯	◯	◯
Generalizations are useful in daily life even though they are not always correct.	◯	◯	◯	◯	◯

Cultural Identity and Understanding

What does culture mean to you?

Which cultural group(s) do you belong?

What factors make culture complicated?

What aspects about culture have you learned during your medical training?

Please continue

Appendix C (continued). Revised Beliefs about Culture Instrument

Demographics

Please provide the following data about yourself.

Gender

Ethnicity

Were you born in the U.S.?

◯ Yes ◯ No

If you were not born in the U.S., how many years have you lived in the U.S.?

Status in Department

◯ Year 1 ◯ Year 2 ◯ Year 3 ◯ Faculty

During your childhood, what was the highest level of education that your parents completed?

	Primary school	High school	Post-secondary (trade, technical)	Undergraduate degree	Graduate degree	Doctorate
Father	◯	◯	◯	◯	◯	◯
Mother	◯	◯	◯	◯	◯	◯

During your childhood, which best describes the position that your parents held within a business or organization?

	Managerial (ownership and control of assets, credentialed)	Supervisory (some control of assets, some credentials required)	Non-managerial/Non-supervisory (uncredentialed)	Not in workforce
Father	◯	◯	◯	◯
Mother	◯	◯	◯	◯

During your childhood, did your parents participate in decisions about products and services that would be delivered and who would be hired, as well as other key decisions?

	Yes	No
Father	◯	◯
Mother	◯	◯

During your childhood, did your parents supervise the work of others or direct others in what to do?

	Yes	No
Father	◯	◯
Mother	◯	◯

Thank you

Appendix D. Preliminary Interview Guide

1. What was most surprising about what residents reported that they have learned about culture?
2. Why do there appear to be so few differences between medical residents and faculty members?
3. Why do you think that faculty tended to say much more often than residents that culture was difficult to define and understand, whereas some residents explicitly stated that culture was not complicated at all?
4. Very few residents state that they needed to learn more about culture compared to faculty, what does this suggest about cross-cultural teaching or residents?
5. When residents described didactics, it was often in terms of attitudinal changes or specific knowledge about specific cultural groups, skills like communicating, bridging, and negotiating with patients were seldom mentioned. What skills should residents be learning?
6. What concerns do you have about teaching cross-cultural skills and what concerns do you have about residents learning about culture?
7. Many residents described learning in terms of experiences instead of didactics, is cross-cultural competence a concept that can be learned or is it one that must be experienced?
8. Absent from the findings was any questions or concerns about evidence for or relevance of culture to the clinical encounter, why?

Appendix E. Summary of Beliefs about Culture Findings

STUDY BACKGROUND

Faculty and residents in Family and Community Medicine, Internal Medicine, Obstetrics & Gynecology, and Pediatrics, all at the University of Kentucky, comprised the study population.

This research seeks to examine whether or not a relationship exists between one's definition of culture (the dependent variable) and acceptance of stereotypes (the independent variable). The study is guided by four research questions:

1. What do faculty and residents believe about the nature and meaning of culture?
2. What is the relationship between culture and stereotyping?
3. What is the extent to which medical education impacts beliefs about culture?
4. What do faculty believe that they are teaching residents about culture?

The survey was comprised of two scales, *beliefs about culture* and *acceptance of stereotypes*. The *beliefs scale* assessed how one views culture, i.e., as a concept that is emergent, relational, and environmental (minimum score of 1) or one that is stable, discrete, and innate (maximum score of 4). The scale for *acceptance of stereotypes* ranged from 1 (least willing) to 4 (most willing). The following independent variables also were considered: gender, ethnicity, citizenship, parent's education, PGY status, parent's social class, and department.

STATISTICAL FINDINGS

Faculty and residents had statistically different ($p<.05$) scores on the *beliefs about culture* scale. The differences among PGY status and faculty also were significant at $p<.05$. Overall, faculty (mean score of 2.245) perceived culture to be more context-sensitive than all residents (2.323). First years (2.361) perceived culture in more concrete terms than anyone else. Lower scores coincide with a more complicated understanding of culture. However, there were no statistical differences between faculty and residents in their *acceptance of stereotypes*. Faculty had a mean score of 2.494 on a 4 point scale, while residents had a mean of 2.512. Although the differences were not statistically significant, faculty tended to reject stereotypes more than residents. Differences in PGY also were not statistically significant, but suggested that third years rejected stereotypes more than first years.

Residents. Examining residents as a group, gender was the one variable where there was significant difference ($p<.05$) with respect to *beliefs about culture*. There were no differences within the group in terms of ethnicity, citizenship, parent's education, PGY, parent's social class, and department. With respect to *acceptance of stereotypes*, there were no statistical differences within the group. Gender had a .349 correlation with beliefs about culture, which was statistically significant at $p<.001$. Female residents were more likely to perceive culture more contextually than male residents. *Beliefs about culture* was correlated with *acceptance of stereotypes* at .402 and was statistically significant at $p<.001$. *Beliefs about culture* and medical specialty were the independent

variables that predicted *acceptance of stereotypes*. These predictors were statistically significant at p=.001.

Faculty. Faculty, as a group, had no statistical differences from one another in terms of *beliefs about culture* or *acceptance of stereotypes*. Citizenship was correlated with stereotyping at -.278 and was statistically significant at $p<.05$. This correlation suggested that faculty who were born in the U.S. were more likely to accept stereotypes than those who immigrated to the U.S. None of the independent variables were statistically significant for predicting *acceptance of stereotypes*.

OPEN-ENDED FINDINGS

Definitions of culture. Faculty and residents overwhelmingly defined culture as sets or patterns of generational or learned beliefs, values, and practices that individuals share and that make a group identifiable. Variations included defining culture as a way to view, understand, and interact with the world. Very few faculty and residents discussed culture as a concept that is difficult to define or as complex. Faculty defined culture much less according to characteristics like race, ethnicity, and religion than residents.

Group identity. Faculty and residents almost uniformly identified their cultural groups in terms of ethnicity, geographic location, religion/faith, and to a lesser extent, gender and class. Few participants identified with one group, but when they did, ethnicity was overwhelmingly the descriptor that they used. Faculty differed from residents in that they identified the medical profession as a cultural group.

Complicating factors. There were few differences between faculty and residents when they described factors that complicate culture. Factors were classified into 3 groups: the way that culture is defined, how the concept is used and misused, and characteristics. Many faculty and residents believed that culture is complicated because there is diversity within groups and differences between groups are sometimes minimized as many traits and characteristics are shared. This often was referred to by faculty and residents as the blending or blurring of culture. However, only faculty tended to raise the subjectivity and nuances in which culture can be defined as a complicating factor. Conversely, a few residents did not believe that culture was complicated at all.

Learning about culture. Faculty and residents differed most in what they believed they have learned during their medical training. While not raised often, some faculty discussed power, medical and personal culture, and the impact that these issues may have on patients encounters whereas residents did not raise these concerns. Faculty also mentioned the need to learn more about culture. There were a number of residents who stated that they have learned little or nothing about culture during their medical training, others believed that most of their learning was attributable to experience and not didactics. Both groups believed that culture mattered to the clinical encounter; however, this view was expressed strongest among faculty. Faculty and residents overwhelmingly discussed learning in terms of attitude changes. However, there were few mentions about acquiring knowledge and when this aspect of learning was raised, content was mostly

about specific facts about groups. Descriptions of skills that are required to bridge and negotiate cultural differences were largely absent.

SUMMARY

Overall, residents had few within group differences with respect to *beliefs about culture* and *acceptance of stereotypes*, while faculty had none. The two also differed from one another in how complicated they view culture, their group identity, and what they have learned.

Appendix F. Response Rate by Group and by Specialty

		Residents	Faculty
IM	Complete	23	7
	No Response	55	12
	% Complete	.295	.368
Ob/Gyn	Complete	11	13
	No Response	11	21
	% Complete	.500	.382
FCM	Complete	13	22
	No Response	17	21
	% Complete	.433	.512
Peds	Complete	17	8
	No Response	32	15
	% Complete	.347	.348
Complete		64	50
No Response		115	69
% Complete		.358	.420

Appendix G. Response Rate by Completed and No Response

		Responses		
		Complete	No response	Population
	Status in Department			
Residents	N	64	115	179
	% Residents	.358	.642	1.000
	% Responses	.561	.625	.601
Faculty	N	50	69	119
	% Faculty	.420	.580	1.000
	% Responses	.439	.375	.399
Total	N	114	184	298
	% Total	.383	.617	1.000
	% Responses	1.000	1.000	1.000
	Medical Specialty			
Internal Medicine	N	30	67	97
(IM)	% IM	.309	.691	1.000
	% Responses	.263	.364	.326
Obstetrics/	N	24	32	56
Gynecology (Ob/Gyn)	% Ob/Gyn	.429	.571	1.000
	% Responses	.211	.174	.188
Family Community	N	35	38	73
Medicine (FCM)	% FCM	.479	.521	1.000
	% Responses	.307	.207	.245
Pediatrics	N	25	47	72
(Peds)	% Peds	.347	.653	1.000
	% Responses	.219	.255	.242
Total	N	114	184	298
	% Total	.383	.617	1.000
	% Responses	1.000	1.000	1.000

Appendix H. Distribution by Ethnicity and Parents' Education

	N	Percent	Cumulative	N	Percent	Cumulative
			Ethnicity			
African-American	3	.026	.026			
African-Decent	1	.009	.035			
Arab	1	.009	.044			
Asian	9	.078	.122			
Biracial	1	.009	.131			
Caucasian	77	.670	.801			
Latino/a	10	.087	.888			
SE Asian	3	.026	.913			
System Missing	10	.087	1.000			
N	115	1.000				
			Parents' Education			
		Father			Mother	
Doctorate	24	.209	.209	6	.052	.052
Graduate degree	25	.217	.426	37	.322	.374
Undergrad degree	24	.209	.635	26	.226	.600
Post-secondary	15	.130	.765	14	.122	.722
High school	17	.148	.913	21	.183	.904
Primary school	6	.052	.965	7	.061	.965
System Missing	4	.035	1.000	4	.035	1.000
N	115	1.000		115	1.000	

Appendix I. Culture Score for Faculty Members and Medical Residents

	Faculty			Medical Residents		
	N	M	SD	N	M	SD
Citizenship						
Yes	43	2.227	.198	45	2.303	.184
No	6	2.295	.106	18	2.366	.252
Total	49	2.235	.189	63	2.321	.205
Gender						
Female	23	2.234	.220	29	2.244	.189
Male	25	2.252	.145	34	2.387	.198
Total	48	2.243	.183	63	2.321	.205
Ethnicity						
Arab	1	2.357	–	–	–	–
African-American	–	–	–	3	2.619	.180
African-Decent	–	–	–	1	2.143	–
Asian	4	2.234	.072	5	2.400	.247
Biracial	1	2.077	–	–	–	–
Caucasian	34	2.259	.176	43	2.305	.188
Latino/A	3	2.264	.162	7	2.259	.261
SE Asian	–	–	–	3	2.294	.139
Total	43	2.255	.164	62	2.320	.207
Parent's Social Class						
Upper	20	2.210	.163	27	2.309	.223
Middle	23	2.252	.217	33	2.332	.196
Working	4	2.188	.183	3	2.312	.219
Not in workforce	2	2.393	.051	–	–	–
Total	49	2.235	.189	63	2.321	.205

Appendix I (continued). Culture Score for Faculty Members and Medical Residents

	Faculty			Medical Residents		
	N	M	SD	N	M	SD
Educational Attainment of Participant's Father						
Doctorate	11	2.256	.161	13	2.337	.180
Graduate degree	9	2.186	.145	16	2.323	.251
Undergrad degree	10	2.231	.254	14	2.309	.202
Post-secondary	5	2.290	.232	10	2.258	.179
High school	9	2.211	.217	8	2.338	.214
Primary school	4	2.330	.079	2	2.536	.051
Total	48	2.239	.190	63	2.321	.205
Educational Attainment of Participant's Mother						
Doctorate	3	2.311	.104	3	2.216	.187
Graduate degree	18	2.177	.197	19	2.266	.228
Undergrad degree	7	2.243	.205	19	2.362	.205
Post-secondary	4	2.368	.188	10	2.311	.193
High school	11	2.284	.165	10	2.369	.194
Primary school	5	2.154	.216	2	2.429	.101
Total	48	2.233	.191	63	2.321	.205

Appendix J. Stereotypes Score for Faculty Members and Medical Residents

	Faculty			Residents		
	N	M	SD	N	M	SD
Citizenship						
Yes	43	2.525	.296	45	2.546	.350
No	6	2.278	.167	18	2.427	.301
Total	49	2.494	.294	63	2.512	.339
Gender						
Female	23	2.430	.339	29	2.495	.304
Male	25	2.547	.244	34	2.527	.370
Total	48	2.491	.296	63	2.512	.339
Ethnicity						
African-American	–	–	–	3	2.917	.300
African-Decent	–	–	–	1	2.500	–
Arab	1	2.250	–	–	–	–
Asian	4	2.241	.184	5	2.400	.260
Biracial	1	2.083	–	–	–	–
Caucasian	34	2.537	.295	43	2.525	.357
Latino/A	3	2.300	.174	7	2.374	.309
SE Asian	–	–	–	3	2.500	.000
Total	43	2.475	.296	62	2.515	.341
Parent's Social Class						
Upper	20	2.448	.276	27	2.506	.371
Middle	23	2.510	.298	33	2.504	.324
Working	4	2.667	.436	3	2.657	.226
Not in workforce	2	2.436	.027	–	–	–
Total	49	2.494	.294	63	2.512	.339

Appendix J (continued). Stereotypes Score for Faculty Members and Medical Residents

	Faculty			Residents		
	N	M	SD	N	M	SD
Educational Attainment of Participant's Father						
Doctorate	11	2.446	.191	13	2.569	.308
Graduate degree	9	2.397	.331	16	2.468	.271
Undergrad degree	10	2.667	.260	14	2.400	.418
Post-secondary	5	2.591	.337	10	2.439	.334
High school	9	2.421	.336	8	2.726	.290
Primary school	4	2.551	.304	2	2.800	.424
Total	48	2.502	.292	63	2.512	.339
Educational Attainment of Participant's Mother						
Doctorate	3	2.391	.289	3	2.583	.300
Graduate degree	18	2.383	.288	19	2.425	.370
Undergrad degree	7	2.579	.244	19	2.524	.308
Post-secondary	4	2.631	.180	10	2.473	.405
High school	11	2.624	.306	10	2.651	.310
Primary school	5	2.450	.389	2	2.625	.177
Total	48	2.495	.297	63	2.512	.339

	(N=49)							
	1	2	3	4	5	6	7	8
1. Culture	1.000	.119	.049	.133	-.018	.064	.072	-.712*
2. Citizenship	.119	1.000	.110	.038	.424**	.057	-.034	-.412
3. Gender	.049	.110	1.000	.013	-.007	.103	.191	-.090
4. Social class (parents)	.011	.038	.013	1.000	.054	.685**	.585**	-.180
5. Specialty	-.018	.424**	-.007	.054	1.000	.315*	.187	-.090
6. Education (father)	.064	.057	.103	.685**	.315*	1.000	.548**	.005
7. Education (mother)	.072	-.034	.191	.585**	.187	.548**	1.000	.229
8. Years Living in U.S.	-.712*	-.412	-.090	-.180	-.090	.005	.229	1.000

* Correlation is significant at the .05 level (1-tailed).
** Correlation is significant at the .01 level (1-tailed).

	(N=63)								
	1	2	3	4	5	6	7	8	9
1. Culture	1.000	-.164	.139	.349**	.041	.259*	.026	.199	-.052
2. Year in Residency	-.164	1.000	-.266*	-.069	-.010	.061	.113	.133	.451*
3. Citizenship	.139	-.266*	1.000	.020	-.070	.033	-.053	-.032	–
4. Gender	.349**	-.069	.020	1.000	.108	.105	.054	.079	.322
5. Social class (parents)	.041	-.010	-.070	.108	1.000	.273*	.607**	.471**	.251
6. Specialty	.259*	.061	.033	.105	.273*	1.000	.181	.154	.103
7. Education (father)	.026	.113	-.053	.054	.607**	.181	1.000	.603**	.321
8. Education (mother)	.199	.133	-.032	.079	.471**	.154	.603**	1.000	.299
9. Years living in U.S.	-.052	.451*	–	.322	.251	.103	.321	.299	1.000

* Correlation is significant at the .05 level (1-tailed).
** Correlation is significant at the .01 level (1-tailed).

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Vita

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EDUCATION

University of Kentucky, Lexington, KY
Masters of Science in Education, May 1995

Clemson University, Clemson, SC
Bachelor of Science in Financial Management, May 1990

ACADEMIC HONORS AND FELLOWSHIPS

- Holmes Scholars, University of Connecticut, 1995-96
- Lyman T. Johnson Associate Fellowship, University of Kentucky, 1994

PROFESSIONAL & RESEARCH EXPERIENCE

University of Kentucky (September 1996 – present)

Department of Family and Community Medicine
- Data Research Analyst (September 2004 – present)
- Curriculum Coordinator Senior (January 2003 – September 2004)

Department of Agriculture and Natural Resources
- Extension Associate (October 1996 – December 2002)

TEACHING EXPERIENCE

University of Connecticut (1995 – 1996)

Department of Curriculum and Instruction
- Student Teacher Supervisor (1995 – 1996)

PEER REVIEWED PUBLICATIONS

Gates, M.L. & Brown, E.L. (accepted). Unlearning culture in medical education: A path to eliminating health care disparities. In E.L. Brown & P. Gibbon (Eds.), *Ethnicity and Race*. Charlotte, NC: Information Age Publishing.

ARTICLES

Gates, M.L. (2009). All Systems Go? Tips for Selecting an EHR That Meets Your Needs. *CorrectCare*. (Part 1 of 4)

PEER-REVIEW PRESENTATIONS

Gates, M.L., & Baxter, A.Q. (December 2009). Research and Evaluation in Correctional Medicine: The Role of EHR to Enhance and Design Studies. Paper presented at 3rd Annual Academic & Health Policy Conference on Correctional Health. Fort Lauderdale, FL.

Rees, J., **Gates, M.L.**, & Baxter, A.Q. (May 2009). Case for Electronic Health Records in Corrections: Reasons to Transition Now. Paper presented at 2009 Corrections Technology Association. Albany, NY.

Gates, M.L., & Bradley, K.D. (April 2009). Measuring Cross-cultural competence in medical education: A review of curricular effectiveness and attitudinal studies. Paper presented at 2009 American Educational Research Association. San Diego, CA.

Connell, A. & **Gates, M.L.** (2009, January). "Electronic Health Records and Chronic Diseases: benefits of using an EHR to document and analyze provider behavior, institutional compliance, & inmate health outcomes." Paper presented at 2009American Correctional Conference, Orlando, FL.

Brown, E.L., **Gates, M.L.**, & Dawson, P. (2008, November). "From classroom-based cyber space: the Evolution of a cultural diversity course in teacher education." Paper presented at National Association of Multicultural Educators 2008 Annual Conference, New Orleans, LA.

Gates, M.L., Brown, E.L., & Dawson, P. (2008, November). "Training higher education faculty to teach about culture: what we can do to promote social justice." Paper presented at National Association of Multicultural Educators 2008 Annual Conference, New Orleans, LA.

Brown, E.L. & **Gates, M.L.** (2008, July). "Using distance learning and other technologies to develop cross-cultural sensitivity, technology literacy and multicultural instructional competence in future educators." Paper presented at Ed-Media 2008, Vienna, Austria.

Brown, E.L. & **Gates, M.L.** (2008, July). "Creating global partnerships to increase economic opportunities for disadvantaged adolescents." Paper presented at Ed-Media 2008, Vienna, Austria.

Brown, E.L. & **Gates, M.L.** (2008, June). "Improving academic achievement and economic opportunity for disadvantaged students." Paper presented at 2008 Diversity Conference, Montreal, Quebec, Canada.

Gates, M.L. & Brown, E.L. (2008, June). "The effect of culture on diagnoses, treatment recommendations and outcomes." Paper presented at 2008 Diversity Conference, Montreal, Quebec, Canada.

Brown, E.L. & **Gates, M.L.** (2008, June). "An academic intervention model for underperforming students." Paper presented at 2008 International Conference on Learning, Chicago, IL.

Gates, M.L. & Brown, E.L. (2008, June). "Multicultural education in medical schools: is the concept important in medical training." Paper presented at 2008 International Conference on Learning, Chicago, IL.

Gates, M.L. (2008, May). "Transforming the medical culture: fostering buy-in for an electronic health record." Paper presented at 2008 National Conference on Correctional Health Care, San Antonio, TX.

Gates, M.L. & Brown, E.L. (2007, June). "Cross-cultural competence in medical education: illusion or reality." Paper presented at 2007 International Conference on Learning, Johannesburg, South Africa.

Brown, E.L. & **Gates, M.L.** (2007, June). "The collaborative role of religious institutions in educating African-American youth." Paper presented at 2007 International Conference on Learning, Johannesburg, South Africa.

Brown, E.L. & **Gates, M.L.** (2006, November). "Knowing, valuing, sharing: precursors to acknowledging, accepting, and respecting." Paper presented at 2006 Annual Conference, Phoenix, AZ.

Gates, M.L. (2006, January). "Kentucky correction's electronic health record (EHR): concept to implementation and lessons learned." Paper presented at American Correctional Association 2006 Winter Conference, Nashville, TN

Gates, M.L. (2005, October). "Implementing electronic health records: the challenges of institutional change." Paper presented at 2005 National Conference on Correctional Health Care, Denver, CO.

Gates, M.L. & Hutchinson, K. (2005, April). "Cultural competence education and the need to reject cultural neutrality: the importance of what we teach and do not teach about culture." Paper presented at 2005 Spring Research Conference, Cincinnati, OH.

Gates, M.L. (1996, January). "Reproductiveness of current reforms as illustrated in Brave New World, supporting the concept of constancy." Paper presented at the Holmes Scholars Annual Meeting, Washington, DC.

PROFESSIONAL MEMBERSHIPS AND COMMITTEES

- Kentucky Department of Corrections Electronic Medical Records Team, Facilitator, 2005 – present
- Kentucky Corrections Health Services Network (KCHSN), Member, 2004 – present
- Southern Group on Educational Affairs (SGEA), Member, 2003 – 2004
- Department of Family and Community Medicine, Education Committee for Six-Year Review, Staff Member, 2004
- Department of Family and Community Medicine, Clinic and Administrative Committee for Six-Year Review, Staff Member, 2004
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