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Multicultural environment in higher education: The knowledge and perceptions of medical teachers of UNIKL RCMP, Malaysia

ATM Emdadul Haque[1], Mainul Haque[2], and Wan Putri Elena Wan Dali[3]

1. Faculty of Medicine, UniKL RCMP, No. 3, Jalan Greentown, 30450 Ipoh, Malaysia
2. Faculty of Medicine and Defense Health, National Defense University of Malaysia, Kem Sungai Besi, 57000 Kuala Lumpur, Malaysia
3. School of Health Sciences, Health Campus, Universiti Sains Malaysia, 16150 Kubang Kerian, Kelantan Malaysia

RESEARCH

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Corresponding Author:
ATM Emdadul Haque
Faculty of Medicine
UniKL RCMP, No. 3, Jalan Greentown, 30450 Ipoh, Malaysia
Email: emdadul@unikl.edu.my

ABSTRACT

Background

A clear majority of teaching staff in UniKL-RCMP are expatriates with different cultural backgrounds, and the university currently accepting international students with a different cultural background in addition to the local culturally diverse students.

Aims

The purpose was to determine the knowledge and awareness of the lecturers of Faculty of Medicine regarding multiculturalism and the importance in the medical profession.

Methods

This was a cross-sectional study. A questionnaire was developed based on the relevant demographic information and knowledge and awareness of the cultural issues and the validity was discussed with a survey expert.

Results

A total of 43 teachers took part in the survey. The respondents were mostly male, expatriate and had very fewer experiences in teaching students of different cultural background. The most important thing affecting teachers' competence was their experience in teaching students of different culture, and the teachers with experience in teaching in a multicultural environment felt more competent than the ones without experience. Gender or teaching experience did not have a significant impact on their feeling of competence. However, the teachers believed that training on special education program might have helped them more than their educational background to help develop the cultural competence of the students from different cultural backgrounds.

Conclusion

This study showed that teachers need more training and experiences of the multicultural education program and to facilitate the development of cultural competence of students with cultural diversity, which should be taken into consideration in the faculty development activities.

Key Words

Multicultural environment, higher education, knowledge, perceptions, medical, teachers, UNIKL RCMP

What this study adds:

1. What is known about this subject?

The cultural competency is regarded as one pf important competent of medical profession to ensure better healthcare for any community.

2. What new information is offered in this study?

The UniKL-RCMP teachers are quite aware about cultural competence and knowledgeable to train future medical doctors. Although, teachers need some training need in this

regards.

3. What are the implications for research, policy, or practice?

Multiple researches reported that cultural competency is essential to ensure healthcare for all. Research in this regard is very important to develop proper policy and practice.

Background

Sir William Osler, the father of the modern medicine, avowed "man can do nothing; with it, even with a fragment, as a grain of mustard-seed, all things are possible to him……. In all ages, the prayer of faith has healed the sick, and the mental attitude of the suppliant seems to be of more consequence than the powers to which the prayer is addressed".[1] Dr Richard Clarke Cabot instituted the Clinico-Pathological Conference at the Massachusetts General Hospital in 1910. Dr Richard really acquainted about standing of religious studies in medical practice at least 20 years before he co-authored a book named "the art ministering to the sick".[2] Dr Richard wrote "In medicine these problems are thrust upon us, urgent as a bleeding wound . . . . of the ordinary physician but he is consulted one or more of the deepest problems in metaphysics and religion - not as a speculative enigma, but as part of human agony".[3] "Human health has multiple sources: material, social, cultural and spiritual".[4] Religion make available stuff those are healthy, comfort, happiness; "including social care, existential meaning, a sense of purpose, a coherent belief system and a clear moral code".[4] "Religion is shaped by its social context in ways that affect its social role. Religion is no panacea when it comes to improving health".[4] Multicultural education developed in the course of the civil rights movement of the 1960s and 1970s.[5,6] Multicultural education instigated by eminent academics such as George Washington Williams, Carter G Woodson, WEB DuBois, and Charles H Wesley.[5] These eminent scholars the principal objective of the research "was to challenge the negative images and stereotypes of African Americans prevalent in mainstream scholarship",[5] and "to perpetuate a more positive and accurate depiction of African-Americans in all walks of life".[7] These eminent educators also took the initiative to make establish the same right of entry and openings for all students of USA.[8] Multicultural educations are defined as "a progressive approach for transforming education that holistically critiques and responds to discriminatory policies and practices in education".[7] Cultural competencies, regularly spoken in many educational medicine journals, conference papers and books during the past decade, is professed by medical educationalists and endorsing authorities as scarce in the core curriculum, and also the different medical students group.[9–11] Cultural competencies also called as cultural awareness, cultural sensitivity, or simply multiculturalism, usually, has a convinced program of study component that is knowledge or skill-based.[8] Growing health inequalities across the globe has been reported; which has directed to an extensive range of governmental and educational inventiveness. Each such initiative is retorting to the requirement to better prepare medical and other health professional students and healthcare providers to encourage a more culturally competent healthcare system.[12] The major justification for the insertion of cultural diversity and competence within the undergraduate medical curriculum especially in modern countries is the requirement to communicate efficiently with the increasing quantity of patients of various racial, cultural, linguistic, and religious backgrounds.[13–17] "Demographic changes anticipated over the next decade magnify the importance of addressing racial/ethnic disparities in health and health care".[18] There are ample evidence of inequalities in health status and health care between marginalized population, which also include indigenous local peoples, low income, low educational group, although many of these countries have universal medical care. These inequalities are predominantly deceptive in chronic and communicable diseases, infant health, mental health, and life expectancy.[19–25] Thereafter, "cultural competence has gained attention as a potential strategy to improve quality and eliminate racial/ethnic disparities in health care".[26] Several studies reported that Malaysian medical educational environment has multi-cultural environment[27–31] as because Malaysia has three major different ethnic groups like Malay, Indian and Chinese in Peninsular Malaysia.[32] There are also many of indigenous communities like Orang Asli of Peninsular Malaysia; in Sarawak, the indigenous peoples are collectively called Orang Ulu or Dayak; and in Sabah, the 39-different indigenous ethnic groups are called natives or Anak Negeri.[33] In Malaysia, race and ethnic issues are the predominant cause of any conversation of "discrimination and inequality. Race and ethnic relations have long played a key role in the politics, economy, society and culture of Malaysia, with the preferential treatment of the Bumiputera dating back to the British colonial era".[34] Furthermore, UNICEF reported that "despite Malaysia's achievements in health and education, tens of thousands of children living in urban slums and rural, remote communities endure troubled and painful childhoods due to economic, social and rural - urban disparities".[35] The cultural competence ensures and enriches the patient-physician communication, it also safeguards medical students to earn better knowledge,

skills, and attitudes that will develop medical students as better professionals to work effectively with patients and their families, as well as with other members of the medical community.[36] Teaching and training cultural competence among medical students of advanced world has climbed to the front position of a number undergraduate medical program to train future medical doctors to "provide high-quality, culturally competent care".[10] A vast majority of academic staffs in University Kuala Lumpur, Royal College of Medicine Perak (UniKL RCMP), 3, Jalan Greentown, Ipoh, Perak, Malaysia; are expatriates with diverse cultural upbringings, and the university currently accepting international students with different cultural background in addition to the local culturally diverse Malaysian students. The purpose of this study was then to determine the knowledge and awareness of the lecturers of Faculty of Medicine regarding multiculturalism and the importance of cultural competence in the medical profession.

Method

This was a cross-sectional descriptive study. A questionnaire was developed based on the relevant demographic information, and knowledge and awareness of the cultural issues on a 6-point Likert scale, and the validity of the questionnaire was discussed with a survey expert of UniKL RCMP. The questionnaire contains two sections. Section 1: Sociodemographic part; and Section 2: Principal evaluation part. It has 15 statements in 6-point Likert scale. The maximum score was 90 and minimum was 15. Statement 1, 4, 5, 12 and 15 were to access knowledge level of multicultural medical education and statement 2, 3, 6-11, 13-15 were to evaluate perception level. The scale was considered 60 and above as good, 45–60 as average and below 45 as poor. The questionnaire was pretested among 10 academic faculty members and it was found that the survey instructions and items were easily comprehensible and suitable for study. The teaching staffs who participated in the pretesting program were excluded from the final study. Most of the sections of this questionnaire demonstrated acceptable values of Cronbach's alpha, with a range between 0.672 and 0.882, which indicated that both instruments possessed good internal consistency and reliability. The evidence of convergent validity was shown by the significant correlations between the items of each section and the overall mean in each section (rs=0. 332–0.718; $p<0.05$).[37,38] The ethical approval was taken from the ethical committee of UniKL RCMP. The data was collected in February 2016 after obtaining ethical approval. The total number of lectures was only eighty-three. Therefore, considering small study population, universal sampling was adopted. A total of 73 (83-10=73) questionnaires along with the informed consent form was then distributed to all the medical lecturers of the faculty, and the respondents were requested to return them to the researcher giving a week time. The data was then compiled and analysed using SPSS Version 21 (IBM Corporation, Armonk, NY).

Results

Among, 73 questionnaires were distributed, 43 lecturers returned it by one week, giving a response rate of 58.90 per cent. Much of study respondents were 50 and 60 years+ (61.4 per cent), male (72.7 per cent), expatriate (61.4 per cent), teaching experience >10 years (43.2 per cent) and had multi-cultural teaching experience >5 years (56.8 per cent) [Table 1]. The total knowledge, awareness and perceptions score was 77±7.70; detail of knowledge, awareness and perceptions score is depicted in Table 2. There were no statistically significant ($p>0.05$) differences observed when between different age groups and knowledge and awareness (Table 3). Similarly, there were no statistically significant ($p>0.05$) differences observed when between different gender (Table 4), teaching experiences (Table 5), multicultural experiences (Table 6), and knowledge and awareness.

Discussion

"Mail: 50 per cent adequate, 60 per cent good, 70 per cent very good, Phone: 80 per cent good, Email: 40 per cent average, 50 per cent good, 60 per cent very good, Online: 30 per cent average, Classroom paper: >50 per cent = good, Face-to-face: 80–85 per cent good".[39] Therefore, the current study response rate was corresponding with mentioned report. The total knowledge and awareness/ perception scores were found good regarding multicultural teaching at UniKL-RCPM. The current study response rate was quite similar with another research regarding multicultural competencies.[40] This was quite praiseworthy findings for UniKL-RCMP. This may be due that Malaysia is the unique example of multicultural society. Thereafter, UniKL-RCMP is admitting a good number of foreign students for a quite long time beside local Malaysian students. Hence, teachers with years of experience to handling different ethnic, national, and religious background they have developed the skill and attitude automatically with experience. Another, comparative study conducted in the developed world reported that there were disparities in areas of cultural awareness.[40] Nonetheless, one doctoral thesis from the University of Tennessee revealed that teachers were generally possessed positive attitudes in the direction of cultural diversity.[41] This study, unfortunately, was not able find no statistically significant ($p>0.05$) differences when compared with relevant demographic

characteristics like ages, gender, teaching experiences, and experience of multicultural teaching. This may be due that this small cohort and they work in very cooperative and congenial environment. Therefore, newly appointed teachers quickly learned the in-house policy and practice of UniKL-RCMP. It may be due to that attitude and practice speedily trickle down from highly experienced teachers regarding multicultural teaching. This is a cross-sectional study with its inherent limitation. Therefore, the findings were only a snapshot, not live video picture. Therefore, the well-designed prospective study is advocated to develop more cultural orientated medical doctor and to ensure better health care for Malaysia.

Conclusion

Multicultural competence programs have proliferated in many parts of both developed and developing modern world because increasing to increasing national diversity in medical school. Thereafter, many regulating and accrediting agencies of medical schools in different countries throughout the world are increasingly giving directives to the medical schools to ensure Multicultural competencies. Subsequently, medical schools are giving increasing effort to ensure multicultural competencies by developing more concern teachers in this issue and revisiting the medical education curriculum to train physicians to provide high-quality, culturally competent care. This study found that UniKL-RCMP medical lecturers do possess good level knowledge and awareness.

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PEER REVIEW

Not Commissioned. Externally peer reviewed.

CONFLICTS OF INTEREST

The authors declare that they have no competing interests.

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ETHICS COMMITTEE APPROVAL

The current study obtained ethical approval from Institution Review Board of University of Kuala Lumpur, Royal College of Medicine Perak, 3, Jalan Greentown, 30450 Ipoh, Perak, Malaysia.

Table 1: To identify the demographic characteristics of the respondents in relation to this survey

Variables	n (%)
Age (years)	
30 – 39	6 (13.6)
40 – 49	11 (25.0)
50 – 59	12 (27.3)
60 & above	15 (34.1)
Gender	
Female	12 (27.3)
Male	32 (72.7)
Nationality	
Malaysian	17 (38.6)
Indian	11 (25.0)
Others:	
Bangladesh	6 (13.6)
Iraq	1 (2.3)
Myanmar	6 (13.6)
Pakistani	2 (4.5)
Tanzanian	1 (2.3)
Ethnicity: If Malaysian	
Malay	17 (38.6)
Indian	11 (25.0)
Teaching experience	
<5 years	12 (27.3)
5 – 10 years	13 (29.5)
11 – 20 years	10 (22.7)
>20 years	9 (20.5)
Teaching experience in a multicultural class/ institute/environment	
No experience	4 (9.1)
1 – 5 years	15 (34.1)
6 – 10 years	14 (31.8)
>10 years	11 (25.0)

Table 2: To determine the level of knowledge and awareness of the respondents

Variables	Mean (SD)
Knowledge score	26.48 (2.73)
Awareness/Perceptions score	50.52 (5.46)
Total knowledge and awareness/perceptions	77.0 (7.70)

Table 3: To correlate the level of knowledge and awareness with Ages of the respondents

Variables	Age (years)				
	30–39	40–49	50–59	60 & above	p-value*
Knowledge	25.17 (4.36)	26.18 (2.82)	27.08 (2.23)	26.73 (2.31)	>0.950
Awareness	49.17 (8.98)	50.00 (4.45)	50.08 (6.14)	51.80 (4.00)	>0.950

*One-way ANOVA

Table 4: To correlate the level of knowledge and awareness with the Gender of the respondents

Variables	Gender		
	Male (n=12)	Female (n=32)	p-value*
Knowledge	26.25 (3.44)	26.56 (2.48)	0.74
Awareness	49.25 (5.93)	51.00 (5.29)	0.35

*Independent t-test

Table 5: To correlate the level of knowledge and awareness with the Teaching of the respondents

Variables	Teaching experience				
	<5 years	5–10 years	11–20 years	>20 years	p-value*
Knowledge	26.83 (2.98)	26.09 (3.09)	25.90 (2.60)	27.48 (2.73)	>0.950
Awareness	50.17 (6.77)	50.92 (6.69)	49.90 (3.93)	51.11 (3.37)	>0.950

*One-way ANOVA

Table 6: To correlate the level of knowledge and awareness with the Multicultural Teaching experience of the respondents

Variables	Multicultural Teaching				
	No experience	1–5 years	6–10 years	>10 years	p-value*
Knowledge	25.75 (3.20)	25.67 (3.02)	26.93 (2.79)	27.27 (2.00)	>0.950
Awareness	49.50 (8.70)	48.47 (5.42)	52.43 (5.79)	51.52 (5.46)	>0.950

*One-way ANOVA