A Framework for Enhancing and Assessing Cultural Competency Training

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The globalization of medical practice using accepted evidence-based approaches is matched by a growing trend for shared curricula in medicine and other health professions across international boundaries. Interest in the common challenges of curricular design, delivery and assessment is expressed in conferences and dialogues focused on topics such as teaching of professionalism, humanism, integrative medicine, bioethics and cultural competence. The spirit of collaboration, sharing, acknowledgment and mutual respect is a guiding principle in cross-cultural teaching. This paper uses the Tool for Assessing Cultural Competency Training to explore methods for designing and implementing cultural competency curricula. The intent is to identify elements shared across institutional, national and cross-cultural borders and derive common principles for the assessment of learners and the curricula. Two examples of integrating new content into existing clerkships are provided to guide educators interested in an integrated and learner-centered approach to assimilate cultural competency teaching into existing required courses, clerkships and elective experiences. The paper follows an overarching principle that "every patient–doctor encounter is a cross-cultural encounter", whether based on ethnicity, age, socioeconomic status, sex, religious values, disability, sexual orientation or other differences; and whether the differences are explicit or implicit.

Key Words: assessment tool, cultural competency, learner-centered
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Background: The Landscape

Much has been published about the need to address health disparities through the implementation of cultural competency curricula [1–3]. However, recent systematic reviews have noted the paucity of reports demonstrating the effectiveness of such curricula [4,5]. Challenges in reporting curricular outcomes have been noted in both medical student [6] and residency [7,8] education. Nevertheless, descriptive literature on cultural competency curricula is widely available. There are many articles describing language proficiency training for health professionals [9]; teaching of cross-cultural communication skills using specific models and behavior checklists [10–12]; use of online tools to address unconscious biases and stereotyping in learners [13]; and teaching of skills to interact with patients through an interpreter [14]. The most frequently reported outcomes of learning remain in the domain of knowledge gain using pre- and post-tests [14]. Self-administered instruments for assessment are available [15], but their deficiencies are well documented [16]. Few reports have documented curricular effectiveness using validated measures of attitude and skill, particularly in actual, as opposed to standardized, patient encounters [4]. The challenge of reporting practice and patient care outcomes is not unique to cultural competency training and has been observed in areas such as faculty development and continuing medical education [17]. It is far easier to measure self-reported or intended rather than actual behavior

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change in direct patient care, as educational researchers have long recognized. Nevertheless, demonstrating the effectiveness of cultural competency curricula on patient-centered outcomes remains an important goal. In the absence of a single measurement tool to directly link educational intervention with patient care outcomes, mixed or multiple approaches are a useful compromise to provide evidence of impact. This paper explores the use of a validated needs assessment tool to build cultural competency curricula. The tool allows the selection of appropriate learning objectives from key domains of learning, and can be further used to identify a variety of feasible and appropriate outcome measures to demonstrate curricular effectiveness.

A Curriculum Building Framework

Many medical schools and programs currently document some instruction in cultural competence within their courses or clerkships, with variable levels of attention, ranging from single didactic lectures to more comprehensive hands-on workshops, seminars and instruction, followed by practice and assessment of skills. Because cultural competency curricula are unlikely to be introduced in a vacuum and are more likely to be added to existing courses, it is helpful to have a framework to guide the introduction of new or revised curricula and to answer the questions, "what more is needed?" and "how much is enough?". The Tool for Assessing Cultural Competency Training (TACCT) designed by the Association of American Medical Colleges [18,19] as a needs assessment tool, was recently revised from 67 to 42 learning objectives covering six domains of learning (Table), by seven diverse medical schools in the United States [20]. The validated tool serves a useful function as an inventory as described [20]. The six domains of health disparities, community strategies, bias/stereotyping, communication skills specific to cross-cultural communication, use of interpreters and self-reflection/culture of medicine, are all germane to training, and each domain is supported by up to 10 learning objectives covering knowledge, attitudes and skills (Table). The tool was designed to be applicable across different schools, communities and health professions disciplines. Educators, whether they are teachers within courses, course directors or deans, can select from a menu of objectives to build their lectures, workshops or curricula using the TACCT. The same objectives can then be used to design evaluation measures. The TACCT has been proposed as a tool to track new curricula as additional teaching is implemented and, in particular, has been found to be of use in reporting curricular development to accrediting agencies.

Building on the Foundation

It is often said that assessment drives curriculum. Evaluation plans for new curricula are integral to curriculum implementation. A systematic plan to evaluate learners and the impact of the curriculum serves to increase likelihood of acceptance and long-term sustainability of the new curriculum. Addressing evaluation upfront is akin to adding the roof to a house under construction, with the foundation and walls representing the core instructional materials. What follows are two case studies using the TACCT to build the "house of cultural competency", block by block, resulting in a product that is friendly to the environment and community, within which the new teaching occurs. Each example consists of a typical scenario involving curricular change, strategies adopted by the course leader, and an analysis of how the TACCT was helpful in guiding the change strategy and evaluation process.

Applying the TACCT domain II—community strategies (Table)

Scenario and challenge

A medical school with 100 students per year has an existing rotating family medicine clerkship in 4-week blocks of 10–12 students, offered over 1 year. The clerkship director has access to a variety of multicultural rural and suburban communities through his contacts with past graduates of the residency program. When he finds out that the medical student training is mainly hospital-based, without required exposure to community practices, he proposes that the students learn from these community-based practices. He also has a recent mandate from the Dean to address "cultural competency" skills of his students and to demonstrate relevant learning outcomes at the end of his clerkship. He decides to address the domain of "community strategies" from among the six TACCT domains and to integrate the two goals. He has to implement the curricular change for the coming academic year. How can he meet his goals?

Table. Tool for assessing cultural competency training: description of domains and objectives [20]

Domain I. Health disparities
K1. Define race, ethnicity and culture
K2. Identify patterns of national data
K3. Describe patterns of health disparities
K4. Identify key areas of disparities
K5. Discuss barriers to eliminating health disparities
S1. Concretize epidemiology of disparities
S2. Gather and use data Healthy People 2010
S3. Critically appraise literature on disparities
A1. Recognize disparities amenable to intervention
A2. Value eliminating disparities

Domain II. Community strategies
K1. Describe challenges in cross-cultural community
K2. Understand population health variability
K3. Describe community-based elements
K4. Identify community beliefs and health practices
S1. Collaborate with communities
S2. Describe methods to identify community leaders
S3. Propose a community-based health intervention
A1. Value and address social health determinants

Domain III. Bias/stereotyping
K1. Identify how race and culture relate to health
K2. Identify physician bias and stereotyping
S1. Demonstrate strategies to address/reduce bias
S2. Describe strategies to reduce physician bias
S3. Show strategies to reduce bias in others
A1. Value historical impact of racism

Domain IV. Communication skills specific to cross-cultural communication
K1. Recognize patients' healing traditions and beliefs
K2. Describe cross-cultural communication models
S1. Discuss race and culture in the medical interview
S2. Elicit a cultural, social and medical history
S3. Use physician assessment tools
S4. Elicit information in family-centered context
S5. Use negotiating and problem-solving skills
S6. Assess and enhance adherence
A1. Respect patient's cultural beliefs
A2. Nonjudgmental listening to health beliefs

Domain V. Use of interpreters
K1. Describe functions of an interpreter
K2. List effective ways of working with an interpreter
S1. Identify and collaborate with an interpreter

Domain VI. Self-reflection, culture of medicine
K1. Describe the physician–patient power imbalance
S1. Recognize institutional cultural issues
S2. Engage in reflection about own beliefs
S3. Use reflective practices in patient care
A1. Value the need to address personal bias

K = knowledge; S = skill; A = attitude.

Solution

The clerkship director discusses his goals with the Dean for Medical Education who refers him to the Epidemiology course director. The Epidemiology course would like to extend its teaching in the pre-clinical years (a block of 20 hours on principles of biostatistics, public health and evidence-based medicine) and to participate as teachers in community-oriented

primary care (COPC) projects to reinforce preclinical learning by application to actual practice. The clerkship director negotiates for lectures covering the principles of COPC from the Epidemiology course faculty delivered during his clerkship. He recruits faculty mentors from his own department to guide clerkship students in designing COPC projects for communities to which they will be assigned. The clerkship students are now assigned to community preceptors in pairs. They have to meet with their preceptors, conduct a literature search on their COPC project of choice, then conduct a community needs assessment. During their community rotation (1 full day per week for 4 weeks), they are required to design an intervention for their COPC project in partnership with their community-based physician preceptor. The assignment instruction specifies that cultural diversity should be addressed. The projects are written up, graded by the clerkship director, and presented to the entire class at year end, with a departmental prize awarded to the best project.

Analysis of the strategy

The clerkship director has integrated a new curriculum in cultural competency and epidemiology into his clerkship using an existing resource, the TACCT, to build his learning objectives. With the combination of new lectures, COPC project, homework assignment and team-building among clerkship students, he is able to address knowledge ("describe community-based elements" and "identify community beliefs in health practices"), skill ("collaborate with communities" and "propose a community-based health intervention") and attitude ("value and address social health determinants") objectives. These objectives would be shared with participating faculty and students before the clerkship in preparation for the changes.

Evaluation methods used

Assessment of students will be tied to his stated learning objectives from Domain II of the TACCT. He chooses to administer multiple choice questions (written by the Epidemiology faculty) to test knowledge. He asks for direct observation of patient communication and team-building skills by community-based faculty preceptors using behavior checklists. He reads and assesses the student write-ups of the COPC project using a standard rating form. He revises an existing Objective Structured Clinical Examination (OSCE) station to include assessment of cross-cultural skills (a diabetic patient is now of a minority ethnicity with limited language proficiency and the encounter involves an interpreter). He identifies and uses a validated behavior checklist to assess communication skills in the OSCE interpreted encounter [21]. At the end of the year, he reports student performance in these multiple measures, and evaluations of faculty development sessions to the Dean as part of his program evaluation.

Applying the TACCT domain IV—cross-cultural communication skills (Table)

Scenario

The internal medicine clerkship director is confronted with the challenge of demonstrating that skills for cross-cultural communication require additional training and practice beyond the basic clinical communication skills taught to preclinical students. Her faculty and residents have complained that medical students do not always elicit relevant patient beliefs about illness and treatment and hence lack appropriate skills to improve adherence among their patients. The existing curriculum is packed with content and no hours are available for an additional workshop or didactic sessions to teach these additional cross-cultural skills.

Solution

The clerkship director attends a conference about teaching cultural competency, conducts a literature review and also searches online for communication tools feasible for her students to use in their clinical encounters. She finds the TACCT and decides to include the objectives of domain IV ("communication skills specific to cross-cultural communication") into the clerkship. In particular, she selects the learning objectives of "recognizes patients' healing traditions and beliefs", "elicits a cultural, social and medical history", "uses negotiating and problem-solving skills", "assesses and enhances adherence" and "respects patient's cultural beliefs" as new learning objectives to incorporate. She is delighted to locate the Kleinman questions [22], which she puts on a small laminated card for incoming students. She distributes these cards to faculty and residents and asks that they observe students in interviews, provide feedback to them and review the questions before and after every teaching encounter. As she distributes the cards, she finds that although faculty and residents recognize the Kleinman questions, they

admit that they do not routinely ask these questions in their own practices.

Kleinman's questions [22] to elicit health beliefs in clinical encounters are:

- What do you call your problem? What name does it have?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Will it have a short or long course?
- What do you fear most about your disorder?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?

The briefer *L-E-A-R-N* [23] communication model, which the clerkship director also considered, includes learner behaviors rather than questions for patients: (1) **L**isten with sympathy and understanding to the patient's perception of the problem; (2) **E**xplain your perceptions of the problem; (3) **A**cknowledge and discuss the differences and similarities; (4) **R**ecommend treatment; and (5) **N**egotiate agreement. The clerkship director finds that the Kleinman questions are more practical and less abstract to use for students, particularly because they do not involve the use of extensive direct observation of students to verify recommended behaviors.

Analysis of the strategy

The director identified domain IV of the TACCT to guide the proposed curricular change, and adopted a strategy that involved no additional curricular time. She used the feedback from faculty and residents to direct student learning, introducing the known Kleinman questions for use as a formative teaching tool. Her challenge now is to document that students are indeed using the Kleinman questions in their clinical encounters, and that the use of the questions impacts patient outcomes.

Evaluation strategy

The clerkship director is pleased to locate the Health Beliefs and Attitudes Scale [24] containing a self-assessment of the same constructs of communication addressed by the Kleinman questions. She asks the author for permission to apply the Health Beliefs and Attitudes Scale as a pre- to post-measure of change in student attitudes and their "patient-centeredness". In addition, she conducts interviews of faculty and residents to assess the adoption of the Kleinman questions in practice. Over three successive rotations, she finds observed and self-reported increases in use, not only among students, but also among the residents and faculty, an unanticipated outcome. She reports this encouraging outcome to the Council of Course Directors. Four other clerkship directors express interest in introducing the questions to their own settings. A plan to provide in-depth faculty training on cross-cultural communication is developed with the internal medicine clerkship director as Chair of the planning committee.

Limitations of the TACCT

In both cases, the TACCT provided guidance for curricular planning, implementation and evaluation, but the content and context of the teaching were derived from the course itself, the literature, the faculty and other existing resources. In both case scenarios, the TACCT domains and learning objectives (II and IV) covered knowledge, attitudes and skills, and reflected attention to learner-centered curricula. Both clerkship directors chose multiple assessment methods to demonstrate student learning outcomes. Both incorporated faculty development and "buy-in" from participating teachers to implement their new training. How can the clerkship directors further use the TACCT domains and learning objectives to track the effectiveness of their curricula? One strategy is to survey students and/or faculty at the end of the 1st year of implementation, to ask if each of the new learning objectives incorporated had been met during the respective clerkships.

The TACCT does not allow for assessment of the formal versus informal curriculum. Nor does it help to identify obstacles in implementation or acceptance of the curriculum. For the family medicine clerkship, students may have learnt much more than planned through their immersion in the rural and suburban communities. The experience may even change their career trajectories. However, some students may find the travel time to the communities troublesome, interfering with their studying for examinations. A post-clerkship student survey or a reflective session guided

by faculty at the end of the clerkship may help to capture these aspects of the new curriculum. For the internal medicine clerkship, the Kleinman questions may have been only partially used by some students and students moving on to new clerkships may not continue to apply their new skills, particularly if the questions are not accepted in other disciplines or by other teachers. Now that other clerkships have bought in to the model, a test station in the final-year OSCE, if available, may help elucidate skill retention over time. As the Kleinman communication model is introduced in other clerkships, greater consolidation of the skills may occur through repeated exposure, faculty acceptance and expectation and daily practice. However, the final test of curricular effectiveness lies in patient care outcomes, and direct observation with attention to patient perspectives using patient assessments of learners could also be encouraged as another strategy for evaluation.

Another limitation of the TACCT is that it does not prescribe the level or depth desirable for each stage of learning. For example, the same TACCT learning objectives and domains may be applied to preclinical and clinical students, or used in a required clerkship, and as an elective with different teaching strategies. Educators in leadership roles have to be aware of whether the use of common TACCT objectives in different courses or at different levels of training reflects duplication of teaching or reinforcement and enrichment of earlier teaching.

A survey of all course and clerkship directors across the years of training using the TACCT as a framework and requesting detailed information on content, assessment methods and hours of teaching, can be a powerful tool for curriculum planning and for curriculum tracking.

Two challenges of cultural competency training for future educators remain. First, how can new competencies best be maintained and what level of curricular consolidation is needed to prevent decay of knowledge, attitudes and skills over time? Second, what level and what type of positive patient care outcomes are needed to demonstrate the effectiveness of teaching?

Conclusions

While the TACCT does not offer a complete solution to create sustainable and effective new curricula for cultural competency training, it provides a first step toward a systematic framework within which to build new curricula. Much debate may be generated about the meaning of and wording used for each domain and learning objective. This debate can be constructively tapped in discussion for faculty development. In addition, the TACCT can be used as a tool for multi-institutional studies of emerging curricula and their relative effectiveness. In summary, the TACCT domains and learning objectives provide a shared vocabulary within which new instruction and educational research on cultural competency training can find common international meaning and application.

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