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Discussion

Acquire, apply, and activate knowledge: A pyramid model for teaching and integrating cultural competence in medical curricula

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ABSTRACT

The importance of cultural competence in health care has been more acknowledged since modern societies are becoming increasingly multi-cultural. Research evidence shows that cultural competence is associated with improved skills and patient satisfaction, and it also seems to have a positive impact on adherence to therapy. Based on this evidence, the acknowledged importance of cultural competence and its poor integration into medical curricula, we present a pyramid model for building cultural competence into medical curricula whereby medical students can enhance their skills through acquiring, applying and activating knowledge.

1. Introduction

Contemporary societies are increasingly becoming multi-cultural [1], and medical practitioners encounter patients who bring to medical consultations their own views about health and illness, and are expected to understand the impact of various sociocultural factors on medical conditions [2]. As a result, medical practitioners are faced with the challenge of understanding their patients holistically [3] and communicating with them effectively in order to provide good quality care and improved health outcomes. To achieve a good relationship with their patients and positive health outcomes such as patient satisfaction, adherence to therapy and health improvement, medical practitioners need to be culturally competent [4]. We are presenting below the reasons why cultural competence has been acknowledged as an important skill in medical practice, and whether it is effective in terms of a number of outcomes, such as enhanced skills and attitudes, patient satisfaction, adherence to therapy and health improvement. We also discuss the existing frameworks and models of cultural competence and propose a pyramid model for teaching and integrating cultural competence skills in medical curricula in order to fill into an identified gap in medical education.

2. The need for, and effectiveness of, cultural competence

Betancourt et al. [4](p.297) explained that cultural competence refers to "understanding the importance of social and cultural influences on patients' health beliefs and behaviours; considering how these factors interact at multiple levels of the health care delivery system and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations". This definition reflects the fact that modern societies are increasingly becoming multi-cultural and medical practitioners are faced with the challenge to establish good relationships with their patients from different cultures in order to improve patient satisfaction and achieve positive health outcomes. On this note, there is evidence to suggest that some cultural groups are not satisfied with health care [5], while medical practitioners may find that some cultural groups are difficult to work with because these groups may not speak the language of the host country, lack financial resources and have poor understanding of the existing health care services [6]. Therefore, as Waxler-Morrison et al. [5](p.6) explained, we need to adopt cross cultural care in order to deal with such "problems with health care". Along similar lines, Betancourt et al. [7] outlined three reasons why cultural

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competence is now understood to be an important set of skills doctors should master. First, contemporary societies are diverse and medical practitioners are expected to treat patients who have a perspective or understanding very different from that of biomedicine. Second, the doctor-patient relationship and communication have been associated with patient satisfaction, adherence to therapy and improved health outcomes. On this note, patient dissatisfaction and/or non-adherence resulting from a problematic doctor-patient relationship may have serious financial and psychosocial implications for all parties involved. Since cultural competence is a form of communication and can potentially enhance doctor-patient relations it has become an important aspect of medical practice. Third, cultural competence has been acknowledged as a tool to reduce health inequalities among ethnic groups.

Another reason for the need of cultural competence in health care is the complexity of the factors involved in the development and management of health conditions [8]. Medical practitioners are expected to acquire knowledge from a biopsychosocial perspective in order to have a holistic understanding of their patients. Based on the biopsychosocial model, health conditions are not developed only due to biological factors but may have been the result of psychosocial processes [8]. That is, the health of people of different cultural backgrounds can be influenced by many factors, such as language, sexual identity, mental health, psychological wellbeing, age, race, ethnicity, disability, socioeconomics, education, health, health care, health care systems, health disparities, cultural factors and health beliefs, genetics, familial history, resilience, social, economic, environmental, health systems, and access to health care and so forth [9,10].

To improve health carers' cultural competence, medical educators have employed a number of training programmes that included an array of methods, such as lectures, videos, cultural immersion, demonstration, role modelling, exercises, community service and so forth. The question is, how effective have these interventions been? A number of systematic reviews looked at this important question. Beach et al. [11] reviewed all studies between 1980 and 2003 which explored the effectiveness of healthcare professionals' cultural competence and found that cultural competence was associated with improved attitudes and skills and patient satisfaction. The authors also found a study that showed that cultural competence improved adherence to therapy. Renzaho et al. [12] reviewed all studies of the effectiveness of cultural competence programmes between 2000 and 2011 and found that training in cultural competence had helped practitioners to gain more knowledge and enhanced their cultural sensitivity. Horvat et al's systematic review [13](p.1) aimed to identify a causal relationship between cultural competence and outcomes and therefore focused on "randomised controlled trials (RCTs), cluster RCTs, and controlled clinical trials of educational interventions for health carers that aimed to improve: health outcomes of patients of minority cultural and linguistic backgrounds; knowledge, skills and attitudes of health professionals in delivering culturally competent care; and healthcare organisation performance in culturally competent care". Horvat et al. found no relationship between cultural competence and health outcomes but found that adherence, and understanding between patients and doctors were both improved. Interestingly, they did not find a link between cultural competence and patient satisfaction. A more recent systematic review by Alizadeth and Chavan [14] found 13 relevant studies published between 2000 and 2013. The authors checked the relation between cultural competence and patient satisfaction, adherence and health index (i.e. blood pressure). Most studies supported patient satisfaction and one showed an association between adherence and cultural competence but no link was found between cultural competence and health index. What these systematic reviews pointed out was the scarcity of research studies of the relationship between cultural competence and positive health outcomes.

In spite of the need for further studies of the relationship between cultural competence and health outcomes, there are quite a few reports, frameworks and models of cultural competence. More specifically, in 2003, the journal *Academic Medicine* [15] published a special issue on cultural competence, which included articles about the concept of culture in health care, strategies for tackling cross-cultural miscommunication, cultural competence training and teaching, and racism. More recently, the Association of American Medical Colleges [16] issued a panel expert report about cultural competence education. The report included specific learning objectives and highlighted the importance of healthcare professionals acquiring knowledge in people's social and cultural background. Along similar lines, the *Cultural Competence Train-the-Trainer Manual* [17] outlined a series of teaching methodologies in cultural competence, while the European project C2ME (Culturally Competent in Medical Education) explored expert opinions through a Delphi study and showed that there was consensus about the need for medical students and doctors to be culturally competent [18]. Based on the Delphi study of the C2ME project, Sorensen et al. [19] presented the key cultural competencies that doctors should have. These include: 1) Knowledge of culture, ethnicity, how sociocultural factors can have an impact on people's health and health behaviour, and the specific needs of various ethnic groups. 2) Skills in working with patients based on their social and cultural background and needs.

Other scholars came up with more detailed frameworks or models. Kachur and Altshuler [20](p.102–103) proposed a detailed inventory of knowledge items that students of cultural competence should have acquired. To elaborate, culturally competent clinicians should have knowledge in areas from "racial/ethnic variability" and "physiological variation" to "multicultural contributions to Western medicine", "working with alternative healer", "cultural barriers to investigation", "effect of migration" and so forth. The authors carried on explaining that acquiring knowledge in these areas was relatively easy through lectures and seminars but what required more effort and organisation was the acquisition and improvement of skills. As a result, they expanded their proposal to encompass the development of skills and the promotion of attitudes by giving learners the opportunity to engage in cross cultural care and by immersion in self-reflection and feedback. Finally, the authors highlighted the importance of life-long training and reflection in order to instill learners' skills and attitudes.

In the existing literature, there are few models of cultural competence. Among the popular ones are LIVE & LEARN, the Sunrise, and the Purnell models. Carballeira [21] came up with the "LIVE & LEARN" model. "LIVE" stands for Like, Inquire, Visit, and Experience, and "LEARN" stands for Listen, Evaluate, Acknowledge, Recommend, and Negotiate. This model is not a model of teaching cultural competence but a model of approaching a patient in a culturally sensitive manner. Therefore, during medical consultation healthcare professionals should avoid stereotyping, respect patient's beliefs and values and involve the patient in shared decision making. Another model which has been constructed to guide healthcare professionals during medical consultations rather than to teach doctors or students is Leininger's "Sunrise Model" [22]. Leininger constructed this model because he thought that western medicine did not adequately explore the cultural basis of diseases and illness experience. Thereafter, before deciding on a treatment plan with the patient, this model encouraged healthcare professionals to explore the following: 1) Cultural values and lifeways, 2) Religious, philosophical, and spiritual beliefs, 3) Economic factors, 4) Educational factors, 5) Technological factors, 6) Kinship and social ties, and 7) Political and legal factors.

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