Evaluating a Lecture on Cultural Competence in the Medical School Preclinical Curriculum

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Objective: The authors aim to evaluate the effectiveness of a presentation designed to increase cultural competence.

Methods: A measure was developed to evaluate the attainment of knowledge and attitude objectives by first-year medical students who watched a presentation on the effect of culture on the doctor-patient relationship and effective methods of interpretation for non-English-speaking patients. The test was administered before and after the presentation and data were analyzed using a linear mixed-effects regression model.

Results: Both knowledge and attitudes improved over the course of the lecture.

Conclusions: Those who give individual presentations in multiple instructor medical school courses should supplement their course evaluations with lecture-specific surveys targeted to their specific learning objectives for knowledge and attitudes.

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In the United States, substandard health status has been documented for African Americans, people of Asian and Hispanic origin, and American Indians, even when controlling for socioeconomic status (1). Our assumption is that practicing culturally competent health care has the potential to reduce these disparities and provide better care for all. Cultural competence in medical education can be characterized as teaching knowledge, attitudes, and skills that help physicians develop rapport and understand the health beliefs and practices of their culturally diverse patients (2). The practice of culturally competent health care requires that physicians be familiar with and appreciate the importance of patients’ beliefs about the cause, course, and treatment of the illness and how those beliefs impact diagnosis and treatment. The development of culturally competent attitudes requires encouraging self-awareness and the examination of one’s own values, goals, and stereotypes and how these may negatively affect patient care. Finally, culturally competent skills such as how to use an interpreter and how to elicit an explanatory model can be taught (2, 3).

The Liaison Committee on Medical Education (LCME) has recognized the importance of cultural competence in health care and added objectives ED-21 and ED-22, which state that medical students must learn to understand the patient’s experience of illness and treatment in a cultural context and to identify and address culture and gender biases in themselves and the effect on diagnosis and treatment (4).

Interest in cultural competence among undergraduate and graduate medical educators has increased over the last 20 years. There has been a concomitant increase in resources to assist physicians and other health care workers to learn about this subject. Ochoa (5) has proposed making such efforts a requirement for the accreditation of health professional schools and journal articles have detailed approaches to teaching culturally appropriate care (6–8). Nonetheless, only 8% of U.S. medical schools offer cultural competence education as a separate course. Despite
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many advances and initiatives, a survey by Weissman et al. (9), showed that a large percentage of residents were not comfortable providing cross-cultural care and that they lacked the skills necessary to identify cultural health beliefs and practices affecting medical care. Therefore, evaluation measures are needed to detect improvements in cultural knowledge, skills, and attitudes, and they should be specific to the learning objectives for the educational intervention in the medical student curriculum. There is a lack of consensus, however, on how best to evaluate cultural competence education.

Leamon and Fields (10) described the Brief Instructor Rating Scale (BIRS), which is a process evaluation and contains no content evaluation measures. Test questions are usually written by the course instructor of record and there is no reporting back to the lecturers of how well students mastered their specific objectives. Our measure was an attempt to go beyond multiple choice examination questions and get an objective-specific content evaluation that also measured attitude changes and targeted evaluation to a specific presentation.

Purpose

The purposes of our study were to measure the effectiveness of a presentation designed to increase cultural competence by teaching cultural knowledge about specific ethnic groups; to encourage positive, nonstereotypical attitudes toward patients with limited English proficiency; and to introduce first-year students to interpreting services and teach them interpreting skills. We chose not to evaluate interpreting skills with our measure, which we felt was an inappropriate method to assess those skills.

In 1998, one of the authors (RFL) developed a 2-hour presentation for a first-year medical student course on behavioral sciences and the doctor-patient relationship. We wanted to teach students about the expectations a patient and a physician would bring to the clinical encounter based on their cultures. The presentation, “Cultural Issues in Medicine-Cultural Competence, Patient Expectations, and Using Interpreters,” used excerpts from The Spirit Catches You and You Fall Down (11) to illustrate the differing expectations of Western patients from Hmong patients as an example of cultural influences on the doctor-patient relationship. The presenters were an assistant clinical professor of psychiatry (RFL) and the director of the hospital interpreting service.

Presentation Content

The presentation began with a discussion of U.S. demographics and mandates for cultural competence (12–14). That session was followed by a discussion of interpreting, which included how to arrange the seating in the room, who should and should not be an interpreter, and the difference between “word for word” interpretation and “summary” interpretation. A brief 12-minute training video, The Therapeutic Triad (15), was shown. The video presents the case of a young monolingual Chinese woman who presents in the emergency room, agitated, talking about taking a whole bottle of pills (later revealed to be a folk remedy). The vignettes show what can go wrong, such as an unnecessary psychiatric hospitalization, when a trained interpreter is not used as a cultural broker to explain the meaning of the patient’s communication. Pitfalls in interpretation, some of which were illustrated by the video, were addressed in both the film and in the class. In the last portion of the presentation a panel of interpreters representing Hmong-, Russian-, and Spanish-speaking cultures discussed health beliefs and practices in their cultures and took questions from the audience.

Method

In November 2003, two of the authors (MS, RFL) developed an instrument designed to assess the attainment of knowledge and attitude objectives using a pretest/posttest model, with matched pairs of surveys when possible (16). Since this was a learning objective based questionnaire, there were no previously used measures in the literature suitable for our purposes. The pretest was distributed to the 95 students and collected prior to the lecture; the posttest was distributed and collected at the conclusion of the lecture. Due to the limitations of pencil and paper tests to measure interpreting skills, and in order not to overwhelm the students with too many questions, we did not include measures for skills objectives or for all attitude changes sought by the presentation. Institutional review board approval was not required because this was an educational evaluation.

Measures

We developed a questionnaire that consisted of nine items, each on a seven-point Likert scale, with 1 = strongly disagree and 7 = strongly agree (17). Four questions were set up to measure changes in attitudes and five to measure changes in knowledge. For each question, a direction of response (agreement or disagreement) consonant with the objectives of the course was determined in advance and we defined composite measures that summarized the degree to which the student’s attitude and knowledge reflected the course objectives (Table 1). The questionnaire...