

How should ethnic diversity be represented in medical curricula? A plea for systematic training in cultural competence

Abstract

Ethnic diversity has become a common reality in European societies, including those of Germany and the Netherlands. Given that ethnic minority groups and immigrants are known to be especially vulnerable to inequalities in health, access to services and quality of care, the need for cultural competency training in medical education is widely acknowledged. This paper presents four key issues in providing medical students and physicians with the knowledge, attitudes and skills to adapt medical care to ethnically diverse populations. It then describes two educational programmes delivered by the University of Amsterdam (UvA Academic Medical Centre, the Netherlands) and Giessen University Medical School (Germany), respectively, to illustrate that translating theoretical educational objectives into educational practice can lead to different teaching programmes depending on specific local conditions. In the conclusions, emphasis is placed on the need for systematic approaches that do not limit their focus to patients and groups of specific ethnic or migration backgrounds. Issues of culture, communication and research in relation to ethnically diverse populations are magnifications of general problems in medicine and healthcare. Explicit attention to ethnic diversity thus offers a view through a 'magnifying glass' of subjects of much broader importance and can be a means for improving health care in general.

Introduction

Despite regional specificities, ethnic diversity has become a common reality of all European societies and will increasingly be so in the future. Various periods of organized labour immigration since the late 19th century, histories of colonialism and, more recently, processes like the fall of the Iron Curtain, wars in South-Eastern Europe, European integration and globalization have contributed to the present situation. Currently, about 20% of the populations of Germany and the Netherlands have a migration background, albeit with considerable regional differences [1]. (<http://statline.cbs.nl/StatWeb/publication/?VW=T&DM=SLNL&PA=71090ned>). From a historical vantage point it becomes clear that migration and diversity are essential features of human societies at large.

Ethnic diversity is associated with disparities in health, access to services and quality of care [2], [3], [4], [5], [6], [7]. However, this general statement does not apply to all migrants or members of ethnic minority groups. Variation predominates and migration background or foreign ethnicity should not be regarded as general risk factors for disease or problems in health care. However, it has been shown that in the case of migrants, for example, physicians are more likely to conduct unnecessary dia-

gnostic procedures or to prescribe drugs without properly defined indication [8], [9].

Providing medical students and physicians with the knowledge, attitudes and skills to adapt medical care to ethnically diverse populations is the goal of cultural competence training [10], [11], [12], [13]. In this paper, we will introduce the key topics for cultural competence training and then describe two cultural competence programmes, one at the Academic Medical Centre (AMC) / University of Amsterdam in the Netherlands and one at Giessen University Medical School in Germany. These descriptions will show that the translation of abstract educational concepts into learning objectives can lead to differing teaching programmes in line with local specificities. We end by underlining the importance of systematic cultural competence training in medical education, not only to prevent that 'ethnic diversity issues' are taught without appropriate theoretical foundation and context, but also to show that cultural competence can be a vehicle for improving health care in general [10], [11], [12], [13].

Key issues

Based on a framework, recently published by Seeleman and colleagues [13], we propose the following key topics for cultural competence training:

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Epidemiology: knowledge of ethnic variations in disease epidemiology and reactions to therapy

Research in the Netherlands has shown that diabetes mellitus is more prevalent among South Asians than among groups of other ethnic origins [14]. German studies have suggested that compared to the general population coronary heart disease (CHD) becomes prevalent among Turkish patients at a younger age, although Turkish migrants in general are supposed to enjoy relatively better health ('healthy migrant effect') [15], [16], [17]. Physicians need to know about these variations, because of the increased probability of diabetes being present in a young Hindustani patient with symptoms of fatigue or of CHD being present in a young Turkish patient. However, ethnic variations in epidemiology often cannot be explained by traditional patterns of risk factors and the precise aetiology needs to be further investigated. Ethnicity alone is not a causal explanation either and the very definition of ethnic boundaries for research is a controversial issue [18].

Culture, ethnicity and identity

Cultural background affects an individual's perception of health and expectations of health care. Physicians must be aware of how culture shapes patients' and their own way of thinking and behaviour. 'Culture' is often mistakenly interpreted as being synonymous with ethnicity, nationality or ancestry and its meaning has to be assessed carefully in order not to give way to stereotype [11]. Members of foreign ethnic groups are often wrongly assumed to share a core set of beliefs and habits regarding aspects like health and disease, independent of their particular biographies and social and economic factors. Yet culture is dynamic, changes over time, incorporates individual experiences and thus differs between people irrespective of their ethnicity. Indeed many second generation migrants manage to successfully combine multiple ethnic orientations within their personal identity [19]. A static view on culture and ethnicity, in contrast, impedes a real understanding of individuals and the problems they face.

Social, economic and legal context

Ethnic minority groups more often live in disadvantageous social circumstances and physicians must recognize that this is at least part of the explanation of ethnic disparities in health and also affects health care. For migrants, their living conditions before, during and especially after the migration process can have important effects on their health and the very possibilities to cope with disease, even more so for those who have suffered torture or trauma. For refugees, asylum seekers and undocumented migrants, access to health care is frequently comprom-

ised, due to legal regulations and the rigour with which these are enforced [4], [20].

Communication

Physicians must be aware of the importance of (non-)verbal communication, especially when language and/or cultural barriers exist. They need skills to adapt their communication style to particular patients to ensure that they properly understand the patient's problem and present information to the patient in a form the patient can understand. In the case of language barriers, this includes skills to adequately estimate patients' levels of language mastery and comprehension and to make effective use of (in)formal interpreters [13], [21].

Amsterdam and Giessen: two examples

Academic Medical College/University of Amsterdam (AMC/UvA)

In Amsterdam, more than 35% of the population has a non-Western ethnic background compared to 11% of the total population of the Netherlands. Some of the non-Western population were originally labour migrants, with the largest groups originating from Turkey and Morocco. Others are refugees from Afghanistan, Iran, Iraq, and Somalia. Unlike Germany, the Netherlands has among its population a group of people from former Dutch colonies: Surinam, the Dutch Antilles and Aruba. These groups are mainly of African or South-Asian origins.

The AMC/UvA medical school aims to systematically integrate diversity issues in the medical curriculum, because being able to deal with diversity is considered an integral part of general medical competence. If medical issues relating to ethnic minority patients are treated separately, students might erroneously conclude that these issues and the competencies to deal with them are intrinsically different from the general medical competencies. In fact, diversity competencies are special aspects of general competencies, such as adaptation of communication to the patient's level. By integrating diversity in the curriculum we hope to contribute to the prevention of stigmatization and to train students to consider diversity issues as a matter of course in their medical reasoning and professional conduct.

The importance of diversity training is emphasized by the inclusion of diversity in the general learning objectives of the programme of AMC/UvA medical school. A central coordinator of the diversity training programme has been appointed (MLE-B). Some elements of the programme that were developed and tested on a small scale in recent years will be implemented as an obligatory component of the medical education programme in the near future. Evaluations of the small scale programme showed that

students felt greater openness towards and had a better understanding of different cultures.

The teaching methods were chosen to fit the learning objectives. Ethnic differences in disease epidemiology and reactions to therapy are taught in regular lectures when appropriate, for example in lectures on the epidemiology of cardiovascular disease and on pharmacotherapy of hypertension. If patient cases are presented in small group sessions on clinical reasoning, teachers are trained to stimulate students to reflect on any changes in their reasoning if the patient were of a different sex, or 30 years older, or from a different ethnicity. Small group sessions will also be used to help students become aware of the effects of their own cultural identities and how these affect their professional interaction with patients. The skills training programme also addresses skills for dealing effectively with language barriers. Students learn to check patients' language comprehension; how to work with a professional interpreter (e.g., how to prevent side conversations), and how to instruct an informal interpreter (because a formal interpreter may not always be needed or available). In obtaining information from and getting information across to patients, students and physicians have to be aware of the potential effects of differences in perceptions of disease and expectations of care; it is important to note that not only do these mechanisms play a role in interactions with patients from ethnic minority groups, they can also impact interactions with other patients.

A text book on ethnic diversity in Dutch medical practice is available [22].

Giessen University Medical School

In Germany, about 20% of the population is currently considered by the Federal Bureau of Statistics to have a migration background [1], a figure that rises to 50% and over among children and youth in some areas of the Ruhr valley and cities like Berlin and Hamburg. The main groups are of a Turkish background and German nationals immigrated from countries of the former Soviet Union, who share a complex Russian-German identity and have severe problems of social integration [23], [24].

At Giessen University, 'migrants' health' was included in the undergraduate curriculum as an elective course ('*Wahlfach*') for advanced students in 2003 [25], [26]. The limited number of highly motivated participants (7-15) creates an open and interactive learning environment¹. The general framework combines an explicitly interdisciplinary approach and clinically applied ethnography: In addition to medical subjects from the fields of epidemiology, internal medicine and psychosomatics, the programme addresses relevant issues from sociology, cultural anthropology and history as well as legal aspects and transcultural communication (including cooperation with interpreters). A topic that is particularly appreciated by the students is 'Islam and Medicine', which offers practical knowledge for dealing with Muslim patients [26].

The ethnographic perspective includes both attitudes and analytical pathways for disentangling complex situations. Ethnography is the key methodology of cultural and social anthropology, combining a holistic approach of observation and analysis with a critical attitude towards generalizing statements about ethnic groups or cultural traits. Social situations are examined explicitly within a particular "local" context. Applied to medicine, the principal goal is to determine which issues are at stake from the patient's point of view [11]. Moreover, it promotes a reflective mindset with regard to one's own perspective, priorities and possible prejudices in a given situation.

In the Giessen course, the ethnographic perspective is exemplified most vividly by a meeting with social workers specialized in providing assistance to immigrants. Students learn about the real lives and biographies of migrants and get to know local resources for solving problems of patients who, for example, are in danger of losing their job and legal status due to disease. The authentic case stories call attention to the moral attitudes and the scope of action of the health care professionals involved. An ethnographically oriented term paper completes the course: students are encouraged to record and analyze observations during clinical clerkships of their own and their peers' conduct, attitudes and professional performance. Course evaluations show that students enjoy the interdisciplinary perspective and the open atmosphere of the course, which stimulates discussion and reflection. Participants feel better prepared for dealing with patients from different ethnic backgrounds and many of them express regret that the course is not obligatory for all medical students.

Conclusions

A closer look at ethnic disparities in health status and health care usually shows that the issues at stake are not specific to immigrants or to particular social groups defined by origin, language or religion. Cultural distance and diverging perceptions of disease can also result from differences in social status, formal education and professional training. A recent ethnographic study on intercultural communication with migrant patients in German hospitals showed, for instance, that problems and misunderstandings were mainly due to physicians' rather poorly developed attitudes and skills for patient centred communication [27]. In essence, issues of culture, communication and research in relation to ethnically diverse populations are simply magnifications of general problems in medicine and health care. Explicit attention for ethnic diversity provides a view through a '*magnifying glass*' on issues of much broader importance. As one student from Giessen put it in the course evaluation in 2003: the core theme of the course was 'learning how to deal with 'non-standard patients'' [25].

The guiding principle for medical education thus seems to be to '*think global and teach local*' [26]: Students have to be provided with the skills and knowledge to assess

global issues such as causes, routes and conditions of migration as well as the cultural backgrounds, living conditions and needs of the *local* populations they serve. The aim for curriculum development is to achieve coherence both internally (between different elements of the curriculum and between medicine, ethics and human rights, the humanities and medical anthropology) and externally (with the local context of the medical school). In this way, future physicians will be enabled to deal fruitfully with the always intriguing interplay of medicine and social, cultural, legal and other aspects, for the sake of the delivery of humane and effective medical care in an increasingly globalizing world.

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¹ In 2009 this course has been expanded towards a real 'global' dimension, by the introduction into a larger project of academic cooperation with two Latin American universities in Ecuador and Peru (Pontificia Unioversidad Católica del Ecuador/Quito and Universidad Nacional Mayor de San Marcos/Lima), for the strengthening and extension of medical education in regard to 'intercultural cooperation' in health care in the three countries involved (founding by DAAD/German Academic Exchange Service 2009-2012).

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