



4 Training Residents to Address the Needs of a Socially Diverse Population

Co-leads

Saleem Razack

Farhan Bhanji

Authors

Saleem Razack

Farhan Bhanji

Lilian Ardenghi

Marie-Renée Lajoie

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FAMILY PHYSICIANS
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Executive Summary

This paper is based on a literature review intended to identify issues and trends on socio-cultural diversity training in postgraduate health professions education.

This literature for PGME consistently and increasingly states the need to better prepare medical residents to serve a socio-culturally diverse population. The ultimate aim of these educational initiatives is not only to improve physician-patient communication and health outcomes for all, but also to provide residents with the attitudes, knowledge and skills needed to understand the historical factors and power dynamics that lead to health disparities, and the physician's role in the maintenance or change of the status quo.

Based on our review of the literature, we have identified three important messages in the context of the future of medical education in Canada, related to diversity training in PGME:

1. Globalization and increasing diversity in Canadian society are realities that call for an examination of how socio-cultural diversity is taught and modeled to resident physicians in postgraduate training.
2. In attempting to prepare residents to serve a socio-culturally diverse population, various curricular models and pedagogical strategies have been proposed and discussed in the literature. Most of these emphasize the need for critical self-reflection and development of not only skills and knowledge, but also attitudes that are respectful of diversity.
3. Curricular initiatives for the cultural training of residents need first and foremost to foster professional identity formation that is respectful of difference, mindful of the role of history, privilege and marginalization in the lived experiences of patients and families, inculcating of a sense of thoughtful inquiry into the systems of meaning that matter to patients, and which is also willing to question the culture of biomedicine.

Background

In the past two decades, postgraduate health professions education literature has included an increasing number of articles on socio-cultural diversity training. Interest in this issue has come from the recognition of the stark health disparities among ethnically and socio-economically diverse populations, and the acknowledgement that health professionals have a role to play not only in addressing the needs of these underserved populations, but also in working towards eliminating such health disparities. Less convergent, however, are the strategies suggested in this literature as to how to prepare physicians to fully embrace and play their role in eliminating health disparities in a society that is increasingly more diverse.

In Canada, residents are exposed to people from various countries of origin, religious backgrounds, and economic status, and whose native language and proficiency in English and/or French also varies tremendously; there is also diversity in sexual orientation, age, special needs and place of residence (rural versus urban). Thus, in today's globalized world, health professionals are faced with unprecedented opportunities for interaction with socio-culturally diverse populations. For instance, in Canada's largest city, Toronto, over 49% of the population of the census metropolitan area is foreign-born^a, making this city the most ethnically diverse of any on Earth. Medical residents must be prepared not only to serve this diverse population, but also to acknowledge the historical and current circumstances that bring about health disparities, marginalization and oppression of particular societal groups (such as is the case with Canada's Indigenous peoples). Clearly, these realities call for an examination of how socio-cultural diversity is taught and modeled to resident physicians in postgraduate training, as postgraduate training rises to meet the demands of these demographic shifts.

This paper is one of 24 papers commissioned for the Future of Medical Education in Canada Postgraduate (FMED PG) Project. In this paper, we discuss the main issues, trends and challenges reported on the literature on socio-cultural diversity training in postgraduate health professions education. We use the term socio-cultural diversity to denote individuals' diversity in class, economic status, age, gender, sexual orientation, first language spoken, country of origin, religious background, mental and physical abilities, and geographical location (rural versus urban). Also included in this definition of socio-cultural diversity are divergent worldviews and beliefs about health and illness that can result from the different life experiences of individuals from socially diverse backgrounds. Socio-cultural diversity training, therefore, refers here to any educational initiative that aims at preparing health practitioners to care for socio-culturally diverse populations. In employing socio-cultural diversity training as a general term to index other terminology found in the literature, we aim at (a) simplifying the discussion of literature that presents a variety of conceptualizations of socio-cultural diversity training, each with its corresponding terminology, and (b) distinguishing our position as authors from those encountered in the literature on this topic, so as not to conflate our own particular views on this topic with those presented in the literature we review here.

It is important, however, to examine the terminology used in the literature, as different terms are aligned with theoretical perspectives underlying the educational initiatives proposed or implemented, even though this association is often times implicit and not overtly presented or discussed in the literature. Socio-cultural diversity training in postgraduate medical education has focused primarily on practical skills that residents are expected to demonstrate when interacting with socially and culturally diverse populations (e.g., communication skills training using language interpreters), to the detriment of the establishment of a sound theoretical

^a Retrieved from http://www.toronto.ca/toronto_facts/diversity.htm

framework. Indeed, some authors criticize this skill-oriented approach to socio-cultural diversity training and discuss the importance of choice of terminology that goes beyond semantics when defining culture and socio-cultural diversity training (1-5). Variations in the way these terms are defined lead to socio-cultural diversity training serving very different purposes and, consequently, requiring very different curricular and pedagogical approaches; these variations also imply different learning outcomes.

Theoretical and terminological divergences notwithstanding, the literature consistently and increasingly states the need to better prepare medical residents to serve a socio-culturally diverse population. The aim of such training should not only be about improving physician-patient communication and health outcomes for all, but also about providing residents with the knowledge and skills needed to understand the historical factors and power dynamics that lead to health disparities, and the physician's role in the maintenance or change of the status quo.

Methodology

The search strategy included the identification of target articles (6-8) on the theme of socio-cultural diversity medical resident training. From these, target terms^b were extracted, which were then used to formulate a list of keywords and/or related MeSH subject headings (where applicable) for searching on MEDLINE, EMBASE, and ERIC databases. Search results were limited to postgraduate health professions education, publications in English or French, and from the year 2000 to 2010. The combined results of the database searches yielded 823 different entries.

The search results included international publications, as well as other health professions publications on socio-cultural diversity training, to incorporate insights offered from other health professions' challenges and best practices on this issue. Given the abundance of publications on this topic, we limited the review to peer-reviewed scholarly work.

The titles and abstracts of the 823 entries were reviewed to exclude all entries that were not relevant (e.g., entries pertaining to undergraduate education; entries relating to how to improve student and faculty diversity within health professions schools without any reference to cultural diversity training; articles focusing on training international medical graduates (IMGs)). The remaining 335 entries were divided into two lists, with 25 entries repeated in each list for inter-coder reliability control^c. Two independent reviewers scored each list by reading titles and abstracts. A fifth reviewer scored the entire list (i.e., 335 entries). Reviewers marked each entry with a score of 2 for very relevant, 1 for relevant, or 0 for non-relevant. When disagreements of more than 1 point occurred (i.e., one reviewer scored 2 and another reviewer scored 0 for the same entry), or when the three reviewers presented three different scores for the same entry, the cases were reviewed by a fourth reviewer, in order to allow a final decision based on majority scores. For all cases of differences of less than 1 point, decision was made based on majority scores. All cases in which decision by majority scores could not be made were included in the final list of papers to be reviewed in full.

^b The target terms used were: Cultural approaches to health and illness; Cultural care; Cultural competency; Cultural competency assessment; Cultural competency education; Cultural competency training; Cultural curricula; Cultural diversity; Cultural education; Cultural efficacy; Cultural humility; Cultural identity; Cultural perspectives; Cultural reflection; Cultural safety; Cultural sensitive care; Cultural sensitivity; Cultural training; Cultural understanding; Discrimination; Health care delivery bias; Health care disparities; Hierarchy; Income disparity; Institutional discrimination; Low income; Marginalization; Needs assessment; Poverty; Power; Self-reflection; Social determinants of health; Social exclusion; Social vulnerability; Socioeconomic diversity; Transcultural; Tricultural interaction.

^c Agreement among all five reviewers for inclusion or exclusion of papers was 83%, and for absolute scores (i.e., 0, 1, or 2) on each item, 72%.

The full papers for the 142 selected entries were divided equally among four reviewers, with a fifth reviewer reading all of them. At least one reviewer read all the papers in full and synthesized them according to a structured protocol, including: (a) type of publication (e.g., research report, literature review, editorial, commentary, letter); (b) purpose of study or main topic of publication; population (specific information about the target population of the study); (c) methods used (e.g., case study, quantitative survey, argumentative paper, focus group); (d) conclusions (including main findings and insights particular to the theme); and (e) references that should be verified for inclusion in our literature review.

From this list, 23 entries were excluded because they were either off topic (e.g., reports on cultural barriers faced by IMGs in the United States and Canada, which is a topic addressed in commissioned paper 5: International Medical Graduates – current issues) or focused exclusively on undergraduate education. Among the remaining 119 papers, some were only marginally related to this theme, but they were maintained because they focused on topics closely associated to our theme, such as increasing diversity of residents in various health professions as a way to ensure culturally effective care, and reports on international exchange programs and placements, which claimed increased cultural competence among the benefits of such experiences. Also maintained were articles that reported on curriculum development and/or implementation focused on training residents to care for socioeconomically challenged populations, such as homeless and low-income populations, or rural populations. Articles focusing on curriculum development or recommendations related to health care disparities were also included in our sample, as the elimination of health care disparities are considered by some authors to be the motivation behind socio-cultural diversity training in postgraduate health professions education.

From the reference lists of the 119 papers reviewed, 82 additional references were selected; the titles and abstracts of these were reviewed following criteria described above, and 52 of these were included in the final literature review. These were synthesized using the same structured protocol described above. We also included in our final bibliography the target articles we used in our search strategy. Thus, a total of 173 papers were included in this literature review.

Each complete protocol was revised and a qualitative thematic analysis of the papers was performed, following the six analytical steps described by Braun and Clarke (9). The analysis was guided by the overarching goal of generating a list of issues and trends on socio-cultural diversity training in postgraduate health professions education. The issues and trends identified through this procedure were then combined to generate the discussion topics presented in the next sections of this paper. Moreover, all reports of curriculum initiatives were synthesized in a table containing detailed information related to the theoretical framework used, the content of the curriculum, the teaching and assessment strategies used, and the evaluation of the curriculum implementation (when available). A summary of the table contents is provided in Table 4 below.

An earlier version of this paper was sent out by email to five stakeholders, two of which provided feedback that was incorporated in this paper^d. Feedback received from colleagues working in this project, including the members of the FMEC PG Environmental Scan's Scientific Advisory Committee, was also considered in writing the final version of this paper.

^d We received feedback from an expert on equity studies, anti-colonialist and anti-racist education; and an expert on cultural safety in nursing education.

Results & Discussion

Descriptive Summary

The majority of the articles reviewed were research reports (N=113), but also included were reviews, commentaries, opinion papers, editorials and notes (see Table 1 in Appendix 3).

More than 86% of the articles reviewed were from the United States; among the remaining 23 articles, 12 were Canadian and 11 were from other developed countries in Europe and Oceania (see Table 2 in Appendix 3).

Postgraduate medical education was well represented in the articles reviewed (over 75% of articles), as was nursing education (over 17% of articles), but our review also included articles from several other health professions (see Table 3 below). Among the medical residencies, Psychiatry was particularly prolific in terms of publications related to cultural diversity issues, followed by Paediatrics and Family Medicine (see Table 3 below). Canadian universities were also well represented in our review, particularly McGill University, the University of Toronto, and the University of British Columbia.

Table 3: Distribution of 173 Reviewed Articles per Discipline

| Medical Disciplines | N | Other Health Disciplines | N |
|------------------------------|----------|---------------------------------|----------|
| Medical education in general | 64 | Nursing | 30 |
| Psychiatry | 21 | Psychology | 4 |
| Paediatrics* | 20 | Dentistry | 2 |
| Family Medicine | 11 | Audiology | 1 |
| Surgery | 4 | Counseling | 1 |
| Primary care* | 5 | Marital & Family Therapy | 1 |
| Internal Medicine | 3 | Physiotherapy | 1 |
| Emergency Medicine | 1 | Psychotherapy | 1 |
| Ophthalmology | 1 | Social Work | 1 |
| Urology | 1 | | |

*These include Family Medicine, Internal Medicine, Pediatrics, and Obstetrics/Gynecology

A total of 53 articles were reports on curriculum development and/or implementation (see Table 4 below for summary of strategies used). Another 48 articles focused on curricular recommendations or theoretical discussions about socio-cultural diversity training. Twenty-one articles reported on quantitative surveys aimed at identifying students' and/or faculty's perceptions of various issues related to cultural competency, such as preparedness and barriers to provide cultural competent care, attitudes and knowledge about particular socio-cultural groups, and barriers to integrating cultural competency in the curriculum. It is interesting to note that only four articles focused specifically on patients' perceptions of culturally effective health care delivery. Table 5 (in Appendix 3) presents the distribution of the reviewed articles in terms of their topic or main focus.

Table 4: Summary of Curricular Strategies Used in the Articles Reporting Curricular Initiatives

| | | |
|--|--|--|
| Curricular Approaches | Anthropological/ Sociological Approach to Culture, with focus on self-reflection and Cultural Humility (attitudes) Focus on Cultural Competence (knowledge and skills), especially communication skills | |
| Teaching Strategies | <p>Didactic Sessions:</p> <ul style="list-style-type: none"> ○ Lectures ○ Demonstrations ○ Interview training ○ Seminars ○ Conferences <p>Structured Exercises:</p> <ul style="list-style-type: none"> ○ Simulated patients ○ Role plays ○ Group discussions ○ Case discussions/ PBL ○ Readings discussions ○ Video discussions ○ Clinical rotations ○ Workshops ○ Self- assessment questionnaires | <p>Alternative Methods:</p> <ul style="list-style-type: none"> ○ Panel presentations by community members ○ Reflective writing/ journaling ○ Poetry/ music <p>Field Experiences:</p> <ul style="list-style-type: none"> ○ Home visits ○ Community Site visits ○ Community work/ service ○ Community based clinical rotations ○ Field trips ○ Site immersions (short or long term) ○ International Exchanges (short or long term) |
| Student Assessment Strategies | <ul style="list-style-type: none"> ○ Self assessment (structured or unstructured) ○ Written evaluation (Likert scale point format) ○ Multiple choice exam ○ Questionnaires ○ OSCEs ○ Analysis of video recorded interactions ○ Portfolios (including quanti and quali evaluations) ○ 360° evaluations (including interdisciplinary team and patients) ○ Surveys of patients ○ Participants' feedback (including students, faculty, patients) | |
| Course/ Program Evaluation Strategies | <ul style="list-style-type: none"> ○ Students' feedback (on Likert point scales or open-ended questions) ○ University Standard Course Evaluations ○ Surveys of patients ○ Randomized control trials | |

Issues and Trends in Socio-cultural Diversity Training in Postgraduate Health Professions Education

The literature on socio-cultural diversity training in postgraduate health professions education presents a variety of approaches to this topic, ranging from descriptions and evaluations of program and course implementation, to surveys of residents' and faculty members' attitudes and knowledge about this issue, to curricular recommendations based on several different

conceptual frameworks. Whereas there seems to be satisfactory evidence in the literature for the benefits of socio-cultural diversity training, not every educational initiative is equally effective, and many challenges must be overcome when designing and implementing these initiatives (10). Of special notice is the discussion on the theoretical foundations of pedagogical and curricular initiatives, with emphasis on the need for defining culture and socio-cultural diversity in ways that avoid stereotyping of societal groups and include a critical analysis of medical knowledge and practices, while also fostering student and faculty critical and self-reflection.

The majority of the articles reviewed focused on issues related to curriculum development or implementation. Most of the educational interventions described or suggested approached socio-cultural diversity from an *othering* perspective (11), whereby a group is considered different from the group that is taken as the norm (10) — in most cases, the norm is the prevalent culture within medical schools (Western-White-upper middle class background (2, 12) and the biomedical explanatory model (10)), and the *others'* culture is delimited by ethnicity (race), country of origin or first language spoken.

Congruently with this approach to culture, in terms of content, most courses or programs included lectures on characteristics of specific ethnic groups that made up the patient population the residents would most likely encounter in their practice. Generalizations are almost inherent in this teaching approach, insofar as socio-cultural groups need to be broadly defined to allow for their cultural characteristics to be covered in a few hours time (13). In fact, some authors warn against this model, which more often than not results in stereotypical perceptions of particular ethnic groups (14), in detriment of a more individually based appreciation of socio-cultural diversity (what Daniel and collaborators (15) suggest should be called *ICD— Individual and Cultural Diversity*). Most importantly, these types of *culture in medicine* models (i.e. where professionals are not encouraged to examine their own practices from a socio-cultural perspective (7)) continue to rely on an overarching framework that takes the biomedical perspective as standard against which other ways of perceiving the world are measured up, and do not provide opportunities for residents to discuss how this perspective is in itself *a culture*. The privileging of certain cultural practices is implicitly reproduced in these curricular models, in which the roots of health disparities and the role of physicians in working towards eliminating health disparities are not explored.

Indeed, several authors urge curriculum designers and instructors to pay special attention to how they define and apply the concept of culture, explicitly and implicitly (2-4, 10, 12, 16-18). Most articles reporting on curricular initiatives employ definitions of culture from earlier anthropological writings, which usually conceive of culture as a static construct (16), which can be taught and learned in terms of fixed characteristics and immutable facts (10). More recent theoretical approaches to culture, however, consider it to be dynamic and always in flux, and being influenced by several social and environmental factors (10, 16). Moreover, many of the approaches to socio-cultural diversity training reported in the literature fail to acknowledge the sources of inequality in society (2) because they essentialize groups of people and treat culture as fixed individual traits that physicians only have to be aware of in order to properly interact with patients from *other* socio-cultural backgrounds. The danger in these simplistic and reductionist conceptualizations of culture is that they might contribute to rather than reduce cross-cultural misunderstandings (4), inadvertently placing the blame for challenges in physician-patient interaction on the patients' socio-cultural background (18), thus, also reproducing and perpetuating marginalization, oppression, social inequality and health disparities.

Some authors take issue with the terminology most frequently used to discuss socio-cultural diversity training: *cultural competency*. This is said to refer to an end-product approach to socio-cultural diversity training, oftentimes related to general knowledge about cultural characteristics

of specific ethnic groups, essentializing them and failing to address the sources of health and social inequalities (2). The same critiques apply to the multicultural and cross-cultural approaches suggested in the literature. As an alternative, the term *cultural proficiency* has been proposed. Cultural proficiency is defined as the ongoing, life-long, inter- and intra-disciplinary process of becoming aware of one's own cultural predispositions and how these affect our interactions with people from different cultural backgrounds (19, 20). This approach is also more closely related to *cultural humility*, which is another term advocated as more appropriate to refer to the type of socio-cultural diversity training needed in PGME. Cultural humility emphasizes the need for self-reflection to acknowledge one's prejudices and culturally driven worldviews; it is a process that requires "humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communications" (21, pp. 97-98). This approach to socio-cultural diversity training requires the recognition of the culture of biomedical sciences in general and medicine in particular, and how it influences health practitioners' behaviors and attitudes. Much has been written about the professional culture of medicine, which encompasses "the language, thought processes, styles of communication, customs, and beliefs that often characterize the profession of medicine" (10, p.108). This culture is usually not acknowledged in socio-cultural diversity training initiatives. Medical educators do not apply the concept of culture to analyze how their own values, attitudes and behaviors are integral to patient care (3), and medical knowledge is usually understood as *real* knowledge or *timeless truths* (16) rather than cultural knowledge, a view that is reproduced in training successive generations of physicians, mostly through hidden curriculum and role modeling (10).

Other terms have been proposed. "Transnational competency" (1), a term which encompasses five dimensions of skills: analytic, emotional, creative, communicative and functional, emphasizes a view of socio-cultural diversity that avoids *othering* and encourages physicians to consider all factors that contribute to health variability, resilience and vulnerability, moving beyond narrow approaches that look only at race or ethnicity. The use of the terms "cross-cultural efficacy" or "cross-culturally effective care" (12) implies that the caregiver is capable of effectively interacting with patients from different cultures, also emphasizing that no culture is superior or preferable to another. "Cultural awareness" and "cultural sensitivity", although also common in the literature, have been criticized for holding a naïve view of the role of individual attitudes in relation to social change, specifically in terms of racism (2). The notion that exposure to socio-cultural diversity is enough to foster understanding and respect on the part of trainees underestimates the huge amount of work that goes into identifying and analyzing the sources of inequalities and health disparities. Indeed, authors also warn against the use of race and ethnicity as part of the concept of culture; they suggest race and ethnicity are concepts that need to be critically explored and historically and culturally situated (4). "By subsuming race under the rubric of culture, racism and discrimination become part of 'cultural differences' and are thereby more palatable and easier to ignore" (18, p. 545).

Almost all the articles that focused on curriculum development, implementation or curricular recommendations suggested that residents be exposed to some form of self-reflection, as this is considered to be an essential first step to developing socio-cultural awareness or competency (10, 22); this contrasts with residents' view of self-reflection curricular activities as least useful (23). Deep self-reflection on socio-cultural aspects of one's identity and practices necessarily passes through and leads to a reevaluation of power relations in the physician-patient encounter and a redefinition of culture, as discussed above.

Several studies report on residents' attitudes and views on socio-cultural diversity training. Student resistance is mentioned as one of the main challenges in implementing educational initiatives on this topic (10); students might consider socio-cultural diversity training as "soft medicine" (24), and, therefore, less important than other knowledge and skills they need to learn

(25). However, residents acknowledge the importance of addressing cultural issues when providing health care (26). Students have identified a lack of formal instruction, evaluation and role modeling on socio-cultural diversity training (26-29), and some residents find that what has been formally taught in their residency is not what they need to learn to be able to effectively serve socio-culturally diverse populations (23). Importantly, some studies report that residents tend to blame patients for difficulties in the physician-patient encounter (18, 23, 25), which, as discussed above, may be connected to the type of socio-cultural diversity training provided.

Time is another often cited barrier to implementing socio-cultural diversity training initiatives in the articles reviewed; this may be due to the fact that socio-cultural diversity training is seen as one more area to be mastered, and, therefore, an *add on* to the curriculum, requiring extra time in the residents' daily schedule. Also important for the success of curricular interventions is timing; if the timing of the introduction of educational interventions on socio-cultural diversity training is off, residents might not see the relevance of this topic to their practice. Thus, it is specially important that instructors reflect on the implications of when to introduce socio-cultural diversity training to residents (30).

Duration of programs and type of exposure to socio-culturally diverse populations are cited as important factors in obtaining positive outcomes in postgraduate training. Programs that provide residents with direct daily contact with underserved and socio-culturally diverse populations, fostering resident-patient interactions beyond clinical time, reported positive outcomes in terms of residents' attitudes and behaviours in relation to socio-cultural diversity training and socio-culturally diverse populations (31-34). Specific strategies used in these programs include supervised home visits with non-medical purposes, volunteer community work, inclusion of community leaders and minority group representatives in the teaching of the curriculum (mostly through presentation of their negative experiences in health care), and resident and faculty immersion in different cultures, through fieldtrips, short- and long-term placement in specific communities (particularly rural and Aboriginal communities), and international exchange programs in poor countries (35, 36).

The use of books, poetry and films has also been reported as valuable aids in generating discussions about socio-cultural diversity and the associated concepts of health disparities, marginalization and oppression (37). These curricular materials not only provide a window into socio-cultural perspectives that might be different from that of the medical residents and faculty, but they also often portray the discrimination and feelings of powerlessness experienced by marginalized and oppressed populations. Care must be exercised, however, to ensure that the aids used are not stereotypical portrayals of particular socio-cultural groups. The issue of stereotyping socio-cultural groups extends also to traditional curricular materials, such as textbooks and lecture presentations, which need to be closely reviewed to make sure they are rid of socio-cultural stereotypes. Thompson (38), for example, commenting on Halperin's analysis of the *Anatomical Basis of Medical Practice*, reminds us that, at the time of the publication of this textbook, the very denigrating tone and images used to describe women's anatomy were accepted and even reproduced in the form of jokes during lectures. Whereas nowadays such an approach is indisputably unacceptable, the author wonders whether we are capable of recognizing our generations' cultural *faux pas*. She reminds us that, "medicine not only exists in the context of social mores and customs, but helps create them. Physicians often share the biases of their times and culture, for better or worse, and impart those biases to their students, overtly or as part of a hidden curriculum" (38, p. 157).

Another strategy commonly used is role playing or simulation-based education (including specifically designed culturally challenging scenarios and case studies, with or without the use of standardized actors), which is advocated in the literature as an effective instructional tool to train

residents and assess their performance in relation to socio-culturally effective care (39-41). In most cases, trained simulated patients and interpreters are used, but in other cases faculty and residents themselves play the role of the patients in these case scenarios. The latter approach, in addition to being more economical, is reported to also provide opportunities for faculty and residents alike to develop insights into culturally related issues (20). However, the risk of stereotyping socio-cultural groups is also present in this approach; thus appropriate preparation time for faculty and instructors and sufficient discussion time after the role playing activity is crucial for the effectiveness of such approaches. Role playing and case scenarios could also be used to introduce residents to several types of diversity, going beyond the mostly prevalent religion and language examples of diversity. Moreover, these case scenarios should also include institutionalized forms of discrimination (15) as examples of socio-cultural challenges in health care.

Faculty development is cited as an essential component for the successful implementation of educational initiatives in socio-cultural diversity training. Time is needed for faculty to adequately prepare for teaching and facilitating discussion. Faculty retreats and workshops are among the faculty development strategies used. Oftentimes, faculty and experts from outside the field of Medicine lead these activities, bringing innovative theoretical and methodological perspectives that challenge taken-for-granted assumptions that faculty may have on socio-cultural diversity training (42, 43). Programs that have reported positive outcomes also emphasize the need to expand efforts to include socio-cultural effective practices at the institutional level (44, 45); the creation of committees, centres and even departments focused on promoting socio-cultural safe environments and practices is deemed an important strategy to ensure success of educational initiatives in this area.

Evaluation of programs and courses and assessment of residents' learning outcomes are frequently debated topics in the literature reviewed. Many authors recognize the need to develop evaluation and assessment tools, but they diverge about what these might be. Whereas some authors envision a quantitative, reliable and generalizable evaluation tool (46), which does not rely exclusively on case studies and individual perceptions, others argue that research may perpetuate socio-culturally dominant views of the world by privileging certain methods over others, many of which may not be the most appropriate to pursue research on cross-cultural interaction or to evaluate courses and programs (47). There is also disagreement about whether practitioners should be assessed in terms of changes in attitudes or behaviors; proponents of the first argue that attitudinal changes reflect changes of value systems, which need to occur if learning is to be life-long and affect social structures; whereas advocates of the latter (46) claim that the observation of behavioral change is a more definitive way of evaluating the outcomes of educational interventions. The lack of formal evaluations in socio-cultural diversity training has been pointed out as a strong message to residents: "if it is not evaluated, it must not be important" (48, p. 500).

Interestingly, few articles considered patients' perceptions and opinions as part of the evaluation of educational initiatives or assessment of residents' learning outcomes. Most evaluations of courses and programs was performed through participants' (residents, faculty and, when applicable, simulated patients and interpreters) perceptions of the success of these initiatives in teaching residents to communicate with patients or to become more aware of socio-cultural issues. Formal evaluations have also been proposed (e.g., various questionnaires, objective clinical structured examinations (OSCEs)); however, the issue of what type of evaluation is the most appropriate given the purposes of the educational intervention, as discussed above, should still be taken into consideration when developing or adopting these evaluation strategies.

Some authors suggest that increasing diversity of the workforce may improve socio-culturally effective care (49, 50). Authors argue that socio-cultural diversity among students and faculty increases opportunities for multicultural interactions and promotes knowledge, acceptance and respect for different worldviews; indeed, residents who are more willing to work with underserved populations tend to be women, from minority groups, and/or non-US citizens (51).

Summary: Directions for Postgraduate Medical Education in Canada

Most courses and programs reported in the literature conceptualized socio-cultural diversity training as learning *about the culture of others*, which, in most cases, was actualized through the delivery of stereotypical bits of information about largely delimited ethnic groups, such as Asians, Latinos, African Americans and Aboriginal Peoples. There are very few articles in the literature reviewed that acknowledged the need to move beyond this tokenistic model and deal with diversity at the individual level, considering more than differences in first language spoken, skin colour, and country of origin of individuals or their parents. Whereas these are important aspects of one's identity, so are education, socio-economic status, religion, gender and sex orientation, among others, all of which vary tremendously within communities otherwise seen as very homogeneous.

The focus in socio-cultural diversity training in medicine should be on learning how to understand an individual's culture and how to include it in the physician-patient interaction, in ways that are respectful to the patient and that aim ultimately at improving health outcomes (health, here, seen as a holistic construct). Whereas practical information, such as how to use an interpreter and how to interview a patient properly must be provided, socio-cultural diversity training in postgraduate medical education needs to go well beyond the development of these technical skills. There needs to be a deeper, more encompassing discussion at the institutional level, so that *role modeling of socio-cultural competent care* at all levels of training (including faculty, staff and administration personnel, all disciplines, and all activities in the curriculum) becomes an inherent part of medical education.

To achieve this, a different understanding of culture needs to take place. The majority of the articles reviewed present culture as static and stereotypical, framed within the "us versus others" model of socio-cultural diversity. Very few of the articles reviewed actually considered the culture of the physicians and their own identities, and fewer still considered the culture of medicine, in which the practices of becoming and being a physician are seen as cultural practice that shapes physician-patient interactions. Also important to recognize are the differences between the American and the Canadian models of socio-cultural diversity (52). Historically, Canada has experienced the forces of colonization and immigration differently from the United States, and this *historicity* also needs to be acknowledged when developing and implementing curricular approaches for preparing residents to care for socio-cultural diverse populations in the unique Canadian context. Understanding the sources of inequality in Canadian society and the challenges individuals face when attempting to access health care should be an integral part of socio-cultural diversity training in PGME.

A clear theoretical framework for the development and implementation of curriculum on socio-cultural diversity is rarely provided in the articles reviewed, and yet it is a crucial component of educational interventions, something graduate students seem to recognize (27). According to Cross (53), "the goal is to ensure that the implementation and integration of cultural competence concepts are not academic exercises but should serve as opportunities to reduce the [health care] gap that presently exists" (p. 153). The discussion, thus, needs to move beyond theory and definitions, without ever ignoring the important assumptions underlying the particular definitions of culture and socio-cultural diversity training we employ when designing curricular initiatives and

teaching residents about professional medical conduct. Instructors must ask “are there features of the culture of medicine that might tend to lead those who inhabit it to think of ‘culture’ as a static set of ideas and beliefs that only other people possess?”(16, p. 556). The culture of medicine must be acknowledged and critically analyzed, on a par with any other culture. This brings us to a conundrum: we train medical residents to *become* physicians, and this training involves purposeful *enculturation* into the practices associated with being a physician. However, physicians also must understand what it is that they are learning to become, and how this stacks against other ways of seeing the world (including their own different socio-cultural backgrounds and that of their patients). The few articles that reported on an attempt to enlighten medical residents on this perspective described how residents *defended* the medical culture, which they felt was under attack, or else became emotionally exhausted from the destabilization of their own identities in view of new insights into the intersectionality of culture, power, marginalization and oppression. Curriculum developers and course instructors must employ strategies that, on the one hand, help residents become aware of the relational nature of the physician-patient interaction and their roles in reproducing marginalization and oppression in and through this interaction; while, on the other hand, also providing the support needed for residents to further develop their identity as physicians. This is especially important as these types of discussions will likely challenge and indeed transform the process of professional identity formation, as residents are encouraged to embrace their roles in eliminating health disparities and social inequalities.

Thus the difficult but important task of crosscultural education in medical settings must now be not only to effectively communicate the ways that culture affects health and health care, but also to make clear the limits of cultural analysis and the unfortunate contributions of social and structural factors in maintaining health disparities by race, ethnicity, and social class. (4, p. 546)

Curricular initiatives for the cultural training of residents need first and foremost to foster professional identity formation that is respectful of difference, mindful of the role of history, privilege and marginalization in the lived experiences of patients and families, and inculcating of a sense of thoughtful inquiry into the systems of meaning that matter to patients.

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Appendix 1: About the Authors



Dr. Saleem Razack (MD, FRCP(C)) is an Associate Professor of Pediatrics and Core Faculty at the Centre for Medical Education at McGill University. He practices as a pediatric critical care physician. He is the Assistant Dean of Admissions, Equity, and Diversity in the Faculty of Medicine. His current research interests include core competencies training, equity issues, and social accountability in health professions education. Dr. Razack is the lead in this paper.



Dr. Farhan Bhanji (MD, MSc (Ed), FRCP(C)) is an Associate Professor of Pediatrics, working in the Pediatric Intensive Care and the Pediatric Emergency Department, where he is also the fellowship program director. He is a graduate from the Masters of Health Professions Education (MHPE) program at Maastricht University and he is an active member of the Centre for Medical Education at McGill University. His teaching activities span the curriculum from pre-clinical to Continuing Medical Education and range from the teaching of professionalism and communication skills, to the implementation/integration of High-Fidelity Simulation at the McGill Medical Simulation Centre. He has been awarded the Kaplan Award for clinical teaching from the Pediatrics residents at MCH in 2007 and was honoured with the New Educator's Award from the Canadian Association for Medical Education (CAME) in 2009. Dr. Bhanji is the co-lead in this paper.



Dr. Lilian Pozzer Ardenghi (Full Licenciante Biological Sciences, MA, PhD, Postdoctorate) is a Research Assistant in the Centre for Medical Education, Faculty of Medicine, McGill University. In the course of her academic career in Science Education, she has published extensively in the field of learning sciences. She is interested in meaning-making and multimodalities, and communication and interaction in teaching and learning settings. Recently, her research explored students' identity development and agency during classroom interactions. Dr. Ardenghi is a co-author of this paper and she was responsible for the literature searches, synthesis and thematic analysis of the articles reviewed and co-writing of the paper.



Dr. Marie-Renée Lajoie (MDCM) is a family medicine resident at the CLSC Côte-des-Neiges, McGill University. On the board of directors of Médecins du Monde Canada for 3 years, she has developed a strong interest in humanitarian and development work in Canada and abroad. Acting as co-chief at her multicultural family medicine unit, she is motivated to improve resident training, demonstrated by her work with the Association of Residents of McGill as vice-president family medicine pedagogical affairs. Dr. Lajoie is a co-author of this paper, participating in the selection of papers for inclusion in the literature review and revision of the various drafts of the paper. She is honoured to be part of this project to bring a trainee's voice to the process.

Appendix 2: Annotated Bibliography

Boutin-Foster C, Foster JC, Konopasek L. Viewpoint: Physician, know thyself: the professional culture of medicine as a framework for teaching cultural competence. Acad Med [Internet]. 2008 Jan [cited 2011 Jan 10];83(1):106-11. Available from: http://journals.lww.com/academicmedicine/Fulltext/2008/01000/Viewpoint__Physician,_Know_Thyself__The.17.aspx

In this article, the authors propose the professional culture of medicine as a framework to socio-cultural diversity training initiatives, which may help mitigate some of the challenges commonly encountered when implementing these initiatives. The authors discuss four main challenges associated with socio-cultural diversity training in medical education: (a) learners' resistance, which may be characterized by students' view of socio-cultural diversity training initiatives as "soft medicine" and as a less important add on to the curriculum; (b) a narrow conceptualization of culture, which usually generalizes a group's attributes and presents culture as static and composed of immutable facts that can be memorized; (c) the process of *othering* socio-cultural groups, which promotes the notion of "us versus them" in physician practice in relation to socially and culturally diverse patients, by defining groups as different from a norm, and, therefore, subjecting these groups to labeling, marginalization and exclusion; and (d) a lack of focus on the learner, with curriculum that usually fails in motivating students to embrace their own culture while also embracing that of their patients. To overcome these challenges, the authors suggest that curricular initiatives focus on (a) cultural humility, with emphasis on understanding the biases of the biomedical culture; and (b) critical reflection that has the potential to question prior assumptions about culture and how perceptions of health and professionalism were formed. The authors discuss the culture of medicine in terms of examples (the white coat, doctor talk, and the physician explanatory model) and suggest strategies to use the professional culture of medicine as a framework to teach about socio-cultural diversity to medical students and residents.

Committee-on-Pediatric-Workforce. Ensuring culturally effective pediatric care: implications for education and health policy. Pediatrics [internet]. 2004 Dec [cited 2010 Sep 17];114 (6):1677-85. Available from: <http://pediatrics.aappublications.org/cgi/content/abstract/114/6/1677>

This is a policy statement from the American Academy of Pediatrics, which reviews current educational and policy efforts to ensure socio-culturally effective health care. The authors acknowledge the imbalance existent between physicians and patients, and propose that physicians (a) learn the language of the population they will be working with and learn how to use a translator during patient-physician interactions; (b) learn about barriers to health access and how to minimize these through culturally effective interactions; (c) learn about how low health literacy, low literacy and low language proficiency can affect access to health care; (d) become child care advocates and learn about their patients' communities and the resources available and that otherwise should be available to them; and (e) learn about their own value systems and how they affect the medical encounter. The authors also propose that courses on socio-cultural diversity should (a) focus less on individual minority groups characteristics and behaviors/customs and more on social barriers and inequities at the institutional/ systemic level; (b) provide practical experience, mentoring, role models, and evaluation tools; (c) incorporate issues related to cultural sensitivity/competence within all courses during all years of the program, including premedical education and clinical presentations, rather than teaching this topic during lectures or seminars only; (d) focus on intracultural diversity, to avoid stereotyping; and (e) focus on the disparities and diversity between care givers and the population they serve. Finally, the authors also emphasize the need for external funding to promote training and the

need for research to provide concrete results that will promote cultural effective training strategies.

Daniel JH, Roysircar G, Abeles N, Boyd C. Individual and cultural-diversity competency: focus on the therapist. J Clin Psychol [Internet]. 2004 Jul [cited 2010 Sep 17];60(7):755-70. Available from: <http://onlinelibrary.wiley.com/doi/10.1002/jclp.20014/abstract>

This is a review of literature on ICD: Individual and Cultural Diversity issues in Psychology education, focusing particularly on ageism, racism, and homophobia. The authors argue that most program training content on socio-cultural diversity has been based on Eurocentric perspectives and European American research subjects, which is, therefore, considered the “normal” view in health professions education. Health professionals who are trained in this model are highly likely to have been exposed to socio-cultural stereotypes and may subscribe to them, consciously or unconsciously. Moreover, negative stereotypes result in discriminatory practices in the workplace and elsewhere, and residents are rarely exposed to the fact that the reality of discrimination and prejudice in the lives of marginalized people impacts their access to institutions such as health-care resources. Therefore, a crucial first step in preparing health professionals to care for socio-cultural diverse population is the development of self-awareness; this requires an understanding of the interface between care giver and patient’s worldviews, the care giver self-examination of reactions to race, sexual orientation, and ageism (among other prejudices), along with issues of defensiveness, racial-identity attitudes, White privilege, and differential power status in the care giver-patient encounter. Care giver-patient encounters are a subsystem of society and, therefore, are influenced by societal values, attitudes, and practices. Clinical work that endorses interventions in which manipulation, persuasion, and assimilation into the Caucasian-dominant society are used shows a lack of knowledge of the patients’ worldviews and is inherently flawed. Specific curricular and pedagogical strategies that may be effective in preparing health practitioners to serve a socio-cultural diverse population include role-plays with direct feedback and examples of institutionalized forms of discrimination; direct contact with marginalized individuals, which has been shown to decrease negative feelings towards them; and role modeling, insofar as educational interventions may prove ineffective unless a trainee or supervisee believes that socio-cultural differences are important to them and to the clinical encounter. Self-awareness assessments, as well as expanded instruction about persons who are marginalized are important for both faculty and students. Self-assessment may include self-report standardized measures, journaling, process notes, self-reflection skills, and critical incidents. Other important sources of feedback are patients, supervisors, peers, faculty members, and collateral colleagues.

MacDonald ME, Carnevale FA, Razack S. Understanding what residents want and what residents need: The challenge of cultural training in pediatrics. Med Teach [Internet]. 2007 Jun [cited 2010 Sep 1];29(5):464-71. Available from: <http://informahealthcare.com/doi/abs/10.1080/01421590701509639>

In this research report of a two-phase project developed at the Pediatrics unit at McGill University, the authors report on the results of a needs assessment study using focus groups, and a 2.5 hrs workshop on socio-cultural diversity training, which included a brief lecture, small group and large group discussions. The workshop leaders introduced two theoretical models grounded on sociological and anthropological traditions: (a) *The culture in medicine*, which is the prevailing framework in clinical teaching and mentoring; it retains scientific medicine as an overarching framework, and acknowledges the role of culture on health and the many different dimensions of cultural identity; however, it does not challenge the culture of medicine; and (b) *The culture of medicine*, which does not retain scientific medicine as the overarching framework; emphasis is placed on the identification of the components that make medicine “cultural”

(routines, values, rituals, traditions). The authors concluded that using a lecture to present the theoretical models of culture (Culture IN medicine and Culture OF Medicine) was not the best way of dealing with this complex issue; longer exposure to and discussion of these ideas is needed, as students tend to be defensive of their culture, instead of questioning it, approaching the lecture as another block of knowledge to be mastered. Reconciling the reductionist perspective of traditional education in medicine and the cultural humility framework proposed by the authors “requires a paradigm shift in how medicine itself understands cultural training” (p. 470).

Appendix 3: Tables Describing the 173 Articles Reviewed

Table 1. Distribution of 173 Reviewed Articles per Type of Publication

| Type of publication | N |
|--|-------|
| Research Reports (including brief reports) | [113] |
| • Case studies | 60 |
| • Surveys | 29 |
| • Qualitative studies (including focus groups and interviews) | 12 |
| • Experimental design (including pre- post-test designs and clinical trials) | 3 |
| • Mixed methods studies | 4 |
| • Other | 5 |
| Literature Review | 16 |
| Commentary | 9 |
| Editorial | 7 |
| Theoretical/Argumentative paper | 28 |

Table 2. Distribution of 173 Reviewed Articles per Country* of Origin

| Country | N |
|-------------|-----|
| USA | 149 |
| Canada | 12 |
| US & Canada | 1 |
| UK | 4 |
| Australia | 3 |
| New Zealand | 2 |
| Italy | 1 |
| Switzerland | 1 |

*per population studied or authors' affiliation for articles that did not specify population

Table 5. Distribution of the 173 Reviewed Articles per Main Topic or Focus of Article

| Main Topic or Focus | N |
|---|----------|
| Descriptions of development and/or implementation of courses or programs or specific pedagogical tools on socio-cultural diversity training | 53 |
| Proposed curricular models, frameworks or conceptual tools for socio-cultural diversity training | 16 |
| Curricular Recommendations and general discussions about socio-cultural diversity training | 48 |
| Assessment or evaluation of socio-cultural diversity training programs, courses and/or tools | 9 |
| Surveys or reports on status of courses and/or programs on socio-cultural diversity training | 6 |
| Development, validation, or pilot testing of research instruments related to socio-cultural competency | 4 |
| Barriers or challenges in implementing socio-cultural diversity training initiatives | 6 |
| Barriers or challenges to, or assessment of quality of care provided to socio-cultural diverse populations | 3 |
| Health Practitioners', faculty, or students' socio-cultural awareness, competence, or proficiency; or their attitudes, perceptions, or knowledge about; or preparedness or willingness to care for culturally and/or socio-economically diverse populations | 21 |
| Specific socio-cultural group's perceptions of socio-culturally effective health care | 4 |
| International exchange programs (fostering or improving socio-cultural diversity awareness and socio-culturally effective care) | 3 |