Cultural Competence in Medical Education: A University Case Study

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Abstract

Medical educators have embraced cultural competence as an initiative to address disparity in health care outcomes. In New Zealand, this disparity in health outcomes is most clearly visible in the health outcomes for Māori people. This study goes beyond describing initiatives in implementing cultural competence curricula in schools of medicine, to examining the relationship between perceptions and practice. This research applies Argyris and Schön’s (1978) conceptual framework of ‘Theories of Action’ in a rich and nuanced case study of one medical school to analyse the congruence between perceptions and practices of cultural competence curricula, and to investigate approaches to organisational learning. Argyris and Schön’s framework is augmented with Hafferty and Franks’ (1994) taxonomy of curricula – the formal, informal and hidden – to describe the range of curricular practices. The research finds that if there is to be congruence between perception and practice, educators need to be aware of the governing values and variables that influence their practice. Existing models of cultural competence initiatives may be theoretically underdeveloped and under supported, and have the potential to further marginalise the very population that they are designed to serve. The thesis proposes a reconsideration of the role and place of medical humanities as a core and essential foundation on which to build efforts in cultural competence. Further, it also proposes that approaches to organisational learning and reform in cultural competence would benefit from a coordinated and strategic approach, and, therefore, a model of a Cultural Competence Community of Practice is outlined. It is a model that can be applied regardless of the meaning a school of medicine attaches to the notion of cultural competence, and can build on existing strengths within the organisation.
Declaration

This is to certify that

i. the thesis comprises only my original work towards the EdD
ii. due acknowledgement has been made in the text to all other material used,
iii. the thesis is approximately 55,000 words as approved by the RHD Committee.

Shaun Ewen
July 2011
Preface

As a medical educator with the responsibility in an Australian medical school for developing and delivering Indigenous health content, I was increasingly aware of the perceived overlaps between Indigenous health and cultural competence. From an Indigenous perspective, the language of ‘cultural competence’ raised alarm bells. For a profession that had, for many years, supported both implicitly and explicitly the social norms of the day (including assimilation of Indigenous peoples) to now become ‘competent’ in, for example, Indigenous culture, seemed incongruous and potentially dangerous (by reinforcing the paternalistic attitude of ‘we know best’, an attitude that has done so much damage to many individuals and communities). I was also wary of the apparent reification of the concept of cultural competence in medical education, and the way it was/is being described as a potential panacea to disparity in health care outcomes. All too often, when I raised my (then) under-theorised concerns about the concept, I was met with agreeable nods. Yet, like me, many people seemed unwilling or unable to articulate the unease that accompanied the otherwise apparent ready embrace of the term by medical schools.

Further, in a multicultural medical environment, how was I to theorise the teaching of Indigenous health, so that transferable principles could be identified and Indigenous-specific approaches highlighted? What was the role of the other 99% of the faculty in contributing to the education of the future medical workforce in regards to disparity in health care outcomes, not just in a colonial context, but for a globalised medical workforce?

The literature is awash with examples of cultural competence programs in medicine, and many of the programs are likely to be influencing in some way the knowledge, skills or attitudes of those at whom the programs are directed. Most educational initiatives have some impact, although not always the desired or intended outcome. The research reported in this dissertation has contributed to the understanding of the perception/praxis nexus at one clinical school. By doing so, a judgement can be made by participants at the case study site as to whether the aims of teaching cultural competence are being met through the practice. As a medical educator, the findings are of use to me in my own practice, as I continually strive for excellence and ponder...
the lingering question about the impact of medical students’ experiences on their future professional practice.

Shaun Ewen, July 2011

Publications related to this work:


Acknowledgments

To my whānau in Christchurch, my most heartfelt thanks. The fieldwork for this research was undertaken at a time of great disruption due to a series of devastating earthquakes. Your support, encouragement and friendship in your own time of need was a wonderful lesson for me and gift from you.

The completion of this study would not have been possible without the timely and insightful support and comments from my supervisors, Professors Richard James and Geoff McColl. Thank you.

The support provided by the Endeavour Research Fellowship for Indigenous Australians, awarded through the Department of Education, Employment and Workplace Relations, Commonwealth of Australia, made the time in New Zealand financially possible.

To my friends and colleagues at the Melbourne School of Population Health, who have eagerly awaited the completion of this work, while at the same time supporting my academic career – this finally marks a line in the sand.

To Cathy Edmonds, who has copy edited this dissertation in line with the Australian Standards for Editing Practice, your editorial support has been most appreciated.

Finally, to my own family, whose unquestioning support is never ending (despite the strange and sometimes hidden workings of academia). Thank you.
**Abbreviations**

AMC  Australian Medical Council  
FP  faculty participant  
MIHI  Māori Indigenous Health Institute  
MOSCE  Māori Objective Structured Clinical Exam  
OSCE  Objective Structured Clinical Exam  
PASAF  Professional Attitudes and Skills Assessment Form  
SP  student participant  

**Māori words used in this dissertation**

hauora Māori – Māori health  
iwi – tribe  
ahapu – sub-tribe  
mana – charisma, power, influence  
marae – a cultural meeting place, which provides a focal point for Māori community and whānau to gather.  
Ngāi Tahu – tribal group of the South Island  
Pakeha – name for a New Zealander of European descent.  
whakawhanaungatanga – to build relationships  
whānau – extended family
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Chapter One: Introduction

Racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities, even when access-related factors, such as a patients’ insurance status and income, are controlled. The sources of these disparities are complex, are rooted in historical and contemporary inequities, and involve many participants at several levels, including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals, and patients (Smedley et al. 2002:1).

Cultural competence is now an established part of the medical education lexicon, yet there is little shared understanding through the published literature of how it is perceived and practised. Medical educators have historically taken seriously their role and responsibility to produce physicians who contribute to the greater good, and are esteemed as healers in our societies. They also have an important role in developing the future health workforce. As evidence of disparities in health care outcomes has grown, one response from medical educators is to embrace the concept of cultural competence. This has been particularly driven from a North American context, and has gained substantial traction in New Zealand over the past decade. There are many definitions in the literature of cultural competence, but little published research undertaken to identify the relationship between the perceptions and practices.

As will be shown, commitment to graduate culturally competent clinicians requires pedagogical approaches and theoretical foundations that support the stated aspirations. This includes coherence between the formal, informal and hidden curricula, and an approach to reflection-on-action that is cognisant of the governing values and variables of the school. The research argues that without adequate evaluation and assessment of students, it is difficult to ascertain whether the aims of the school, as articulated through its graduate profile, have been met. Further, it argues that the uptake of emerging concepts, such as cultural competence, face certain internal barriers and challenges, which are described.

This study establishes the utility of Argyris and Schön’s (1978, 1996) approach to organisational learning in a medical school environment. It shows that sustained curricula changes have been affected through influence of the governing values and
variables, highlighting the value of taking a ‘double loop’ learning approach to curricula reform.

This study also draws upon the taxonomies of curricula defined by Hafferty and Franks (1994), and further developed by Hafferty (1998), the formal, informal and hidden curriculum.

Some of the barriers to curricula reform in cultural competence were identified as technical and logistical in nature, which presented themselves as a product of the complexities of a School of Medicine. A coherent, organised and structured approach to cultural competence in the medical curriculum can capitalise on the hard work and goodwill of many medical educators to graduate students who will help reduce disparity in health care outcomes.

This research suggests that the practices of cultural competence at Christchurch School of Medicine are theoretically truncated, if the aims are to address disparity in health outcomes. This finding can be applied by medical educators at the case study site as an opportunity to reflect on their visions and aims in relation to cultural competence. The findings also provide opportunity for comparative reflection at other sites. And, finally, the methodological approach employed provides a model and a framework for educators and researchers to adapt in their own institutions.

**Background**

The right to health has been described as a fundamental human right (both in the Universal Declaration of Human Rights and more explicitly in the International Covenant on Economic, Social and Cultural Rights (1966)), a corollary of which is the right to the best possible health and medical care. In New Zealand, Article Three of The Treaty of Waitangi has been interpreted as meaning that Māori and European New Zealanders should be accorded equal rights, with both enjoying the benefits bestowed by realisation of their full citizenship entitlements. Inherent is the right to equal health status and equal health outcomes. Specifically, in relation to unequal treatment by health providers, Article 5 of the Convention on the Elimination of All Forms of Racial Discrimination directs States Parties to ‘prohibit and eliminate racial discrimination in the enjoyment of the right to public health, medical care, social security and social services’ (UN General Assembly, 1969:222). Despite these treaties
and covenants, evidence of unequal treatment continues to emerge in New Zealand, seen particularly in health outcomes for Māori and Pacific peoples (Ajwani et al. 2003; Bramley, Herbert et al. 2004a; Bramley, Riddell et al. 2004b; Chan et al. 2008; Reid et al. 2000; Te Roopu Rangahau Hauora a Eru Pomare 2000). This disparity in health outcomes is seen when New Zealand Māori receive care that is not commensurate with their burden of disease, nor equivalent with the care that other New Zealand people receive.

The most obvious approach to dealing with health disparities related to Indigenous peoples in Australia and New Zealand has been the Indigenous Health Curriculum Framework (Phillips 2004a). The framework is not pedagogically prescriptive, but does provide suggestions regarding the content to include and consideration of institutional reform strategies, and was developed with the aim of reducing health disparities for Indigenous people:

a better informed medical education sector regarding Indigenous health issues
will translate into better educational outcomes for medical students, which may, in turn, contribute to better health outcomes (Phillips 2004a:6).

The Indigenous Health Curriculum Framework has been endorsed by Medical Deans Australia and New Zealand, and forms part of the accreditation requirements for medical schools. Most cultural competence initiatives in Australia and New Zealand have been closely related with Indigenous health curricula. This study is built upon the premise that while there may be some overlap between Māori health and cultural competence curricula, the two are not the same. As Jones et al (2010:113) point out:

Māori health is an educational domain in its own right with distinct learning objectives and educational approaches.

The literature describes two discretely identifiable approaches to cultural competence. The first, located in constructions of the Other, has a focus on learning about cultures of minorities to optimise the doctor–patient relationship, and thus patient outcomes. The second, often described with the prefix of ‘critical’, takes into account the social processes that shape both the doctor and the patient, and their cultures, and the influence this has on the doctor–patient relationship, and ultimately on patient outcomes. This important difference is discussed in greater detail in Chapter Two.
The study: Perceptions and practices of cultural competence

This dissertation presents one clinical school’s approach to cultural competence and is a case study of the University of Otago, Christchurch, School of Medicine. A case study approach has been chosen because a rich and in-depth investigation is required to discover and unpack the nuances that surround the complex perceptions and practices of cultural competence. An educational case study is the approach that will elicit the best, richest information to understand and, in turn, inform the educational processes. As described by Bassey (1999:23):

[The] peculiar strength [of case studies] lies in their attention to the subtlety and complexity of the case in its own right. [They]…recognise the complexity and ‘embeddedness’ of social truths.

In New Zealand, the development and embeddedness of cultural competence in medical education is related to the construction of an Other, which is particularly relevant in a school located in a colonially constructed context. A case study approach is the most appropriate avenue to answer the research questions, and to provide an opportunity to fully comprehend the nuances of the conclusions reached.

At Christchurch School of Medicine, cultural competence is understood as a utility to complement communication with patients, especially patients who are seen to be (ethnically) culturally different from the clinician. This was most often constructed as the Māori patient, and cultural competence teaching was strongly linked with hauora Māori teaching by most participants. Despite the espoused view that cultural competence is a very important part of the education of their medical students, it is not explicitly assessed at the clinical school. This study concludes that if cultural competence is being used as a tool to contribute to the reduction of disparity in health care outcomes, then it may be theoretically underdeveloped in the way it is practised.

By applying the principles of the conceptual framework used to inform the methodology, the research concludes by arguing that the very structure of medical education itself needs to be questioned, and an approach that includes relevant medical humanities in the clinical years provided. To do this, a model for progressing reform of the cultural competence curricula within a school is described, called a Cultural Competence Community of Practice. It is a model that is not dependent upon a definition of cultural competence, and could be applied regardless of what the
school itself decides are the ultimate aims of teaching cultural competence in its context.

The University of Otago medical school was a rich site for this study. The School opened in 1875, and sent its first trial class of students to Christchurch in 1924. The medical course (Bachelor of Medicine, Bachelor of Surgery, MBChB) is a six-year undergraduate program, with the first three preclinical years undertaken at the Dunedin School of Medicine (including a first year of health sciences). The final three clinical years are undertaken at one of three clinical schools, located at Dunedin, Christchurch or Wellington, which take an approach of shared graduate attributes and common exams, with the learning opportunities determined independently at each site. The University of Otago, Christchurch, was formally established in 1972, with its first students arriving in 1973. The school currently supports approximately 80 students in each of the three clinical years. Having initially developed as an undergraduate clinical medical school, the research focus of the University of Otago, Christchurch, is evident by the significant numbers of postgraduate students in the health sciences, with more than 70 PhD candidates enrolled in 2010 (University of Otago n.d.a).

The case study focuses on the three clinical years of a six-year undergraduate medical teaching program. It does not ignore the experiences of the preclinical years: key informant interviews were undertaken to identify any significant differences in approaches between the early learning years and the clinical school; however, the focus of the study is the clinical school. As a case study, a wide range of views and perspectives were sought to create the rich picture that follows. Specifically, final-year students and the faculty responsible for coordinating and delivering the curriculum were invited to an in-depth interview. The resultant findings are a rich, detailed snapshot in time. However, medical schools are always changing and evolving, and, for example, the reported experiences of current final-year students may not match the experiences of final-year students in years to come. Indeed, the study does reveal that the school has plans for a more cogent approach to cultural competence in the future, and a repeat of this research in several years would be expected to reveal different, albeit related, findings.
Christchurch itself is a small city of some 390,000 people (Statistics New Zealand 2010:7) and is the capital of the Canterbury region, which in 2010 had an overall population of 565,800 people (Statistics New Zealand 2010:7).

The fieldwork for this study was book-ended by two devastating earthquakes. The first at 4:35am on the 4th September 2010, a week before my arrival, changed the architectural face of the city. The other, at 12:51pm on 22nd February 2011, a week after my departure, claimed over 180 lives, and changed the soul of the city.

**Table 1: Canterbury Population Census 2006**

<table>
<thead>
<tr>
<th>Ethnic Identification</th>
<th>Number of residents</th>
<th>Percentage</th>
<th>Median Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>European or other</td>
<td>483,300</td>
<td>90</td>
<td>38.9</td>
</tr>
<tr>
<td>Māori</td>
<td>40,100</td>
<td>7</td>
<td>22.6</td>
</tr>
<tr>
<td>Asian</td>
<td>32,800</td>
<td>6</td>
<td>26.6</td>
</tr>
<tr>
<td>Pacific</td>
<td>12,100</td>
<td>0.2</td>
<td>21.5</td>
</tr>
</tbody>
</table>

(Adapted from Statistics New Zealand Table Builder 2011

Table 1 displays the demographic make-up of the province in which the medical school is located. Seven per cent of the population identify as Māori, and 6% as Asian; ‘European or other’ constitute 90% of the population.1

New Zealand is a colonised country, with the relationship between Māori and non-Māori framed by The Treaty of Waitangi, signed in 1840. The University of Otago has developed a Māori Strategic Framework for ‘meaningful effect to be given to its Treaty obligations’ (Māori Strategic Framework 2007:1), which requires, ‘among other things, that health outcomes should be the same for Māori and non-Māori’ (Dowell et al 2001:243). Despite this, Māori health status lags behind the rest of the population in New Zealand. The reasons are multi-factorial, but have their roots in the impact and ongoing effects of colonisation. Of particular salience for this research, Māori experience disparity in outcomes from health care and carry a greater burden of disease than the non-Māori population, and have a shorter expectation of life (Bacal, Jansen and Smith 2006). DeSouza (2008:127) describes an overview:

1 In New Zealand, people are allowed to choose more than one ethnic identifier
Health disparities between Māori and non-Māori are thought to be strongly linked with health professional behaviour... Māori are likely to experience fewer referrals and diagnostic tests than non-Māori. In primary care, Māori are seen for a shorter time, offered less treatment and prescribed fewer secondary services.

Māori are also significantly underrepresented in the medical workforce, comprising 2.6% of the workforce (Ministry of Health 2007:10). This figure is little changed since 1997, when Māori were reported to be 2.4% of the health workforce (Ministry of Health 2007:37). Māori medical student enrolments across the two New Zealand medical schools is almost double this, constituting 5% of medical students at Otago in 2009 (Poole et al. 2009:91).

This local context – with significantly poorer health outcomes for Māori, and a history of colonisation and the Treaty - provide the context for the inquiry of this study, which poses the following research questions:

• What are the perceptions of cultural competence among faculty and students?
• What are the practices of cultural competence of faculty?
• What is the relationship between the perceptions and practices?
• In what ways has the concept of cultural competence infiltrated the school’s praxis?

By reflecting upon the literature and application and relevance to the case study, the following question is considered:

• Is cultural competence, as it is perceived and practised, the best concept to be working with as a tool for medical educators to address disparity in health care outcomes?

There were multiple reasons for selecting Christchurch as the case study site. As a comparatively small school, it provides good accessibility to many key informants. It is the institutional home to well-known medical educators who are well credentialed, and well published in the local and international literature. The Māori health team is also well regarded in the Australasian Indigenous medical education community, being recognised for its achievements in Indigenous curriculum leadership, and its development and delivery through the awarding of Leaders in Indigenous Medical Education Awards. I have existing excellent collegial relationships with the school,
having contributed to its teaching program in Indigenous health. This provides the unique vantage point of both emic (insider) and etic (outsider/observer) perspectives.

Each medical school has its own unique structure, culture and personalities that contribute to the learning experiences of the students who enter it. Comparisons are best made by those who know their own school, and whose areas of interest intersect with the range of perspectives and findings evident in this study. Logistics and pragmatics also contribute to the choice of a case study of one. A comparative approach would be a very different approach. As there are no published findings on the relationship between the perceptions and practices of cultural competence at a medical school, this case study offers both a methodological approach and a set of findings and conclusions that are relevant to this site, and which provide a point of departure for other investigators.

**The structure of the study**

The study utilises the theoretical framework of Argyris and Schön’s (1978, 1996) Theories of Action. Argyris and Schön’s Theories of Action state that the people’s espoused theory (how they say they will act when asked) is often different from their theory in action (what they actually do). Argyris and Schön’s Theories of Action are enriched by incorporating Hafferty and Franks’ (1994) taxonomy of curricula – the formal, informal and hidden curricula. Consistent with Argyris and Schön’s framework, Hafferty and Franks argue that what medical schools say they will teach (through the formal curriculum) is often in contrast to what is taught (through the informal and hidden curricula). By analysing and comparing espoused theories with theories in action, the research uncovers the extent to which there is a consistent approach to cultural competence at the school. Analysis of approaches to organisational learning at the study site also provides insight into strategies that have enabled the uptake of cultural competence curricula, as well as uncovering the barriers, by describing examples of single loop and double loop learning (single loop learning is where actions are modified to try and achieve specific outcomes without reference to the overarching values and assumptions. Double loop learning takes into account these values and assumptions before modifying activities. This model is described on page 28).
This thesis is organised across nine chapters, and the dissertation structure reflects the study structure, with descriptions of the governing values and variables, actions and consequences, followed by analysis of learning approaches, discussion and recommendations. **Chapter Two** provides a critical literature review, which sets the scene for an understanding of the development of cultural competence in medical education. Each following chapter integrates the relevant literature as it relates to the emergent findings.

**Chapter Three** outlines the methodological approach taken, and the methods used, to undertake the case study. **Chapters Four, Five Six and Seven** mirror the structure of the conceptual framework used to shape the analysis of the research. **Chapter Four** describes the governing values and variables of the school related to the teaching and learning of cultural competence, which includes the personal and professional values, legislative and regulatory variables, and self-stated values and variables. **Chapter Five** describes the curriculum as it is practised, including the hidden, formal and informal curricula, and **Chapter Six** describes the consequences of the actions from the perspective of what students describe they have learnt about cultural competence. **Chapter Seven** presents an analysis of what were described as barriers and enablers to the uptake of cultural competence at the school. **Chapter Eight** presents discussion emerging from the findings and analysis, utilising an approach that encourages taking a ‘bigger picture’ view of the values and variables shaping the nature of the future medical workforce. The dissertation ends with **Chapter Nine**, a conclusion, which reflects on the case study, its findings and implications.
Chapter Two: Cultural competence and medical education

This chapter provides a critical review of the literature, describing the emergence of cultural competence in medical education in a theoretical, geographical and socio-historical perspective. The concept of cultural competence is analysed, and the development of models upon which cultural competence have built are described, and this provides a context and foundation for the study.

Cultural competence

*cultural competence* has become a byword endowed with almost religious significance, a panacea for the multiple and interwoven problems in health care communication (Perloff et al. 2006:835).

The literature related to cultural competence has increased significantly in number, particularly from the late 1990s to the present day. ‘Cultural competence’ was included in the National Library of Medicine’s MEDLINE subject heading in 2007 – superseding ‘culture’ as a medical subject heading. (National Library of Medicine 2010) Saha, Beach and Cooper (2008) report that by May 2007 there were more than 1000 articles in the medical and nursing journals which mentioned ‘cultural competence’ (or competency) in their titles or abstracts. The numbers of publications related to cultural competence have continued to increase apace since then until the time of writing (early 2011).

One of the first appearances in the literature of the term cultural competence, and the most widely cited definition, is by Cross et al. (1989:7), who define cultural competence as:

\[
\text{[A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enable the system, agency, or those professionals to work effectively in cross-cultural situations.}\]
\]

The purpose of this study is not to develop, support or reject any specific literal definition, but, rather, to seek an understanding of perceptions and practices at one site. An understanding and familiarity of the range of perspectives in the literature provides a grounding to analyse the relationship between the perceptions and practices. There are two distinct theoretical approaches to cultural competence, which are outlined below.
Cultural competence consists of constructions of *culture and competence*, which will now be described as they apply in the medical education context.

**Culture**

The definition given above was developed to provide ‘a philosophical framework and practical ideas for improving service delivery to children of color who are severely emotionally disturbed’ (Cross, T. 1989:7, emphasis added). This early definition of cultural competence was building upon a static approach to the culture of *children of color*, and by implication, essentialising the culture of ‘children of color’. Taylor (2003:555) warns against a too simple definition and understanding of culture. She notes the emphasis of thinking about culture in anthropological terms in earlier descriptions of cultural competence, as static rigid stereotypes, and as groups of people who share similar beliefs, values, experiences and expected ways of behaving and responding. Perloff et al. (2006) includes the debate about the constructs of ‘race’ in his discussions of defining culture, and the problematic stereotyping that can follow this approach. He discusses the overlap between biological factors, and their contribution to health factors, and socio-cultural factors, and how clinicians and health care systems respond to this. In contrast, Dunn (2002:105) describes culture as ‘dynamic…constantly changing, evolving and being created’.

Reviewing the literature on cultural competence shows that definitions of culture have evolved from being used to describe the culture of the patient, applied in ‘static’ anthropological terms, to more recent applications of culture within cultural competence literature, which have taken the approach that culture is fluid, transacted and relational, and that clinicians also bring their ‘culture’ as part of the medical relationship with their patients: ‘The point has also been made repeatedly that not only patients and the communities have cultures, but that there is also a “culture” of medicine’ (Taylor 2003:556). Boutin-Foster, Foster and Konopasek (2008:106) have argued strongly for cultural competency frameworks to begin with ‘Physician know thyself’.

Because interest in approaches to cultural competence has emerged most noticeably from North America, and more recently related to evidence of disparity of health care outcomes for ethnic ‘minority’ groups, the concept of culture has been almost
exclusively applied to contexts of ethnicity and race (Kumaş-Tan et al. (2007). Much less often has culture been applied to cultural groups not defined by race and ethnicity, such as those defined by gender, age and sexuality.

**Competence**

Competence (or competency) in medical education has, as its focus, outcome-based medical education, often defined through graduate attributes. Competencies are assessed and defined at particular points in time, such as examinations and graduations. Competence describes an end point, ‘a mastery of a body of knowledge and skills’ (Hixon 2003:634) implying action – that ‘someone’ is competent at doing ‘something’. Tilley (2008:63) describes competency-based approaches as ‘an exciting and challenging concept in education that may address gaps between education and practice’. Reflecting the diversity of views in the literature, Brooks (2009:90) describes it as ‘possibly the most prevalent buzzword in medical education today’, and continues his strident critique of competency approaches in medical education, stating that ‘competency is not what we want to use when trying to determine if someone is a good, or even an adequate, physician’ (Brooks 2009:91).

Driven by increased awareness of disparity in health outcomes for different ‘cultural’ groups (mostly ethnically described), and based on a model of a ‘competent’ standard to practise, the language of cultural competence emerged, in itself, as a problematic and cumbersome term. Taken at linguistic face value, to be competent at culture is confusing. Definitions within the literature abound, based on varying degrees of divergence from Cross’ (1989) initial description. Nevertheless, despite the absence of a shared meaning, and the lack of clarity about the term(s) – and through repetition, reification through accreditation and mandatory inclusion in many curricula across North America, much of Europe, Australia and New Zealand – cultural competence has embedded itself as part of medical education’s lexicon.

From an Indigenous perspective, cultural competence has the potential to reinforce the professional culture of medicine’s imperialism. The health professional not only seeks to be competent in his or her discipline, but will seek to be competent in someone else’s culture. Indigenous peoples have been subject to exploitation and expropriation of land and self for centuries. The notion that Indigenous peoples will allow
Indigenous culture to be expropriated by health professionals so that they can become ‘competent’ has the potential to further alienate and widen the chasm between the culture of the health professions and the cultures of ‘minorities’ or Indigenous peoples. Combined with the fact that Indigenous Australian and New Zealand Māori are significantly underrepresented in the medical and health care workforce, an uncritical approach to cultural competence that emphasises the Other has potential for unintended consequences in graduate attributes and understanding, by further embedding Indigenous people (and other minorities) on the margins.

**Locating ‘culture’ in medical education**

The positioning of ‘culture’ in modern medical education has a long history. In part as a response to the Flexner report (1910), a scientifically based biomedical approach took predominance in modern medical education. As is further discussed in Chapter Eight, Flexner himself noted in 1925 the need for a cultural background in medical training, to complement and inform the scientific approach. Over the past four decades, the development of a patient-centred approach and biopsychosocial models of health care have provided the foundation on which more recent cultural competence curricula have been constructed. As mentioned, patient centredness and the biopsychosocial model have not always been (some would argue they still are not) a central tenet in medical education. The hegemony of the scientific and biomedical approach to the practice of medicine was challenged by Flexner himself as described, and more recently through the advocacy of a patient-centred approach beginning with Balint (1969). I trace that history here as the foundation for the current cultural competence movement.

Enid Balint (1969) first described patient-centred medicine in 1968, when, in papers presented at New Orleans and later in Melbourne, she said:

> [T]here is another way of medical thinking which we call ‘patient-centred medicine’. Here, in addition to trying to discover a localizable illness or illnesses, the doctor also has to examine the whole person in order to form what we call an ‘overall diagnosis’. This should include everything that the doctor knows and

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understands about his patient; the patient, in fact, has to be understood as a unique human-being.

To understand the patient as a human-being means to strive to understand more than just the biomedical context of the disease presentation. It has become accepted that the social and cultural context of the patient is important in many ways, including how the patient understands the disease, and how the disease manifests as an illness. Levenstein et al.’s (1986:26) description of patient centredness provides a succinct and non-formulaic approach, emphasising the unique worlds in which each patient lives:

The essence of the patient-centred method as it relates to the patient's agenda is that the physician tries to enter the patient's world, to see the illness through the patient's eyes. He does this by behaviour which invites and facilitates openness by the patient.

In the same article, Levenstein et al. (1986:26) point out that ‘we stress again that the patient-centred method includes the disease-centred whenever this is appropriate’, emphasising that the physician comes to the therapeutic relationship with professional skills and biomedical knowledge that are important to optimal patient outcomes. The physician has an obligation and responsibility to provide health care to the best of his/her ability, not just respond to what the patient may naively demand. An understanding of the social processes that shape the patient’s and clinician’s social and cultural context is important. Physicians do have specialised biomedical knowledge, which at times may clash with some patients’ cultural beliefs, understandings and their social context. Excellent communication skills and an acute awareness, integration and application of cultural and social factors into clinical reasoning are critical. Where understandings and expectations between doctor and patient clash, negotiation of different ways of proceeding needs to be considered, from both the patient and physician’s perspective.

Almost a decade after Balint proposed a patient-centred approach, Engel published his seminal paper proposing a move away from a ‘reductionist biomedical model’ through consideration of an ‘ethnomedical perspective’ (Fabrega 1975) and towards a biopsychosocial model of medicine.
To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model (Engel 1977:132).

The biopsychosocial framework was a challenge to the hegemony of the biomedical model. It should be noted that the reason for Engel’s paper is often overlooked. He was writing about the relationship between the discipline of psychiatry and the wider medical fraternity. Nevertheless, his paper is described as the genesis of the biopsychosocial model for medical practice.

The biopsychosocial perspective fits comfortably with a patient-centred approach. The two concepts, while introduced a decade apart, have a natural affinity and were developed and applied in medical education contexts in parallel with each other. Mead and Bower (2000) propose five conceptual dimensions to patient centredness, which includes the biopsychosocial perspective as one of the dimensions. Their five dimensions are “biopsychosocial perspective; “patient-as-person”; sharing power and responsibility; therapeutic alliance; and “doctor-as-person”’ (Mead and Bower 2000:1087). This is an important linking of the biopsychosocial model and patient centredness. Mead and Bower discuss the biopsychosocial perspective further, and argue that, a ‘biopsychosocial perspective alone is not sufficient for a full understanding of the patient’s experience of illness’ (Mead and Bower 2000:1088), urging consideration of all five dimensions they outline.

Based on her own team’s work, and that of Little et al. (2001), Stewart (2001:445) argues there is a growing consensus for a ‘global’ definition of patient centredness:

- Patients want patient centred care which (a) explores the patients’ main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patients’ world – that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationship between the patient and the doctor.

4. Drawing on research based in Great Britain, Canada and South Africa.
Building on the definition of Mead and Bower, Stewart adds ‘prevention and health promotion’ as a key element. This inclusion of prevention and health promotion as a key concept of patient centredness is important in regard of health care provision for a population group that has a very high burden of preventable and chronic disease (as is the situation in this case study site).

Development of curricula that promote and facilitate a patient-centred approach, the biopsychosocial model and, more recently, cultural competence in medical education has been driven by a desire to graduate excellent clinicians who can better ‘see the illness through the patient’s eyes’ (Levenstein et al. 1986:26). These efforts and intent in medical education are very much bound by the sentiments of the Hippocratic Oath, the essence of which is still captured by the phrase, ‘First, do no harm’.

The coming together over the past three decades of patient-centred medicine, the biopsychosocial model and an acute awareness (if not complete understanding and acknowledgement of) cultural and ethnic disparities in health care outcomes has provided the main impetus to the development of cultural competence initiatives in medical education.

The primary impetus for the cultural competence movement of the last decade has been the demonstration of and publicity surrounding widespread racial and ethnic disparities in healthcare (Saha, Beach and Cooper 2008:1278).

As will be seen in the case study, pedagogical approaches for developing cultural competence curricula have built on the foundation of patient centredness, in particular, cross-cultural communication skills. The patient-centred approach, which incorporates a biopsychosocial model (as advocated by Mead and Bower), provides an existing and well-understood framework in medical education in which to locate cultural competence initiatives. Engebretson et al. (2008:176) goes as far as saying, ‘patient-centered care is consistent with cultural competence or proficiency at the individual patient level’.

If we remove, for the moment, the bio (assuming that biological explanations of disease are similar across humanity) from the biopsychosocial approach, we are left with the need to understand the psycho and the social aspect of a patient’s presentation. Learning opportunities that could aid health professionals to develop a
greater awareness and understanding of the complexity of social processes that may shape a patient’s psychological, or social context, would need to include (in a settler colonial context) multiple perspectives of the impacts of history, including colonisation, dispossession, and the power relations that manifest in the patient being the patient and the doctor having the opportunity to be a doctor. Engel argued for the adoption of a biopsychosocial model of medicine. He did not argue for a biocultural model. Culture does influence a patient’s psychological and social presentation, but culture is only one of a range of influences that contribute to a patient’s presentation. As mentioned above, cultural factors have been mostly simplified to race and ethnicity in the cultural competence literature (Kumaș-Tan et al. 2007; Ewen 2011). Socio-economic, political, gender, sexuality and educational status (to name but a few) all have a bearing on the patient’s worldview and presentation. For medical education to overly focus on one area risks ignoring other significant and salient influences at play, while also potentially overlooking the root causes of disadvantage and health disparity.

Cultural competence has thus evolved from assumptions about patients on the basis of their ethnic background to the implementation of the principles of patient-centred care, including exploration, empathy, and responsiveness to patients’ needs, values and preferences. Culturally competent providers expand this repertoire to include skills that are especially useful in cross-cultural interactions (Betancourt 2004). Cultural competence, in the main, has drawn on the pre-existing skills and strengths of clinicians and medical educators, in terms of relating it to existing notions of the biopsychosocial model, and patient-centred care. As shown below, and also in the findings of the case study in the following chapters, educators need to associate cultural competence with the social processes and forces that shape the different worlds of the doctor and the patient. This was evident in Engel’s 1977 quote above, extracts of which are worth repeating:

> a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system.
Theoretical approaches to cultural competence curricula

The literature describes two main approaches to cultural competence (and a plethora of names). These two approaches are best described by Gustafson and Reitmanova (2010) in a review of Canadian medical school curricula to address ‘cultural diversity education’. They name the two approaches as the cultural competence approach and the critical cultural approach, and characterise each approach with 10 criteria from their own review of the literature. Notwithstanding the arbitrary naming of the two approaches, the hallmarks of each approach and differences between the two approaches are important to describe here. In essence, they describe the aims of the cultural competence approach as being able to:

- interact successfully with patients from various ethnic and/or cultural groups…The concept of culture is assumed to be a fixed set of beliefs, traits, values and practices common to all members of a group (Gustafson and Reitmanova 2010:817).

In contrast, they describe the critical cultural approach as having:

- a focus on understanding the relational aspects of culture…How is the concept of culture influenced by political, historical and socio-economic factors, and therefore, power-laden (Gustafson and Reitmanova 2010:817).

In attempting to differentiate the ‘critical cultural approach’ from the ‘cultural competence approach’, they have used yet another term. This may be appropriate for the Canadian context that they describe; however, others would describe the ‘critical cultural approach’ as fitting in with what they understand as cultural competence. As indicated earlier, there are many definitions for cultural competence, and the labels can become confusing. Still, Gustafson and Reitmanova’s taxonomy is a useful distinction between approaches to address cultural diversity and disparity in health care outcomes, and one that emerges in the case study and subsequent discussion.

Historically, Gregg and Saha (2006) describe the initial drivers for cultural competence curricula as being to close the ‘cultural distance’ between patient and provider, particularly in a United States context of high rates of immigration and a very ‘White’ health workforce. This approach had a focus on examining and describing the (often exotic) Other, and can be seen in Cross’ (1989) initial definition,
which was developed to improve communication with ‘children of color’. The
development of cultural competence curricula, which emphasised an understanding of
the Other, represents the greatest weakness of this approach – the impossibility of
knowing all cultures. While Cross himself is a Native American and an enrolled
member of the Seneca Nation, his monograph did not overtly draw upon an
Indigenous standpoint. Much of the rationale for curriculum development and
delivery, and accreditation of cultural competence efforts, has been based on training
health professional students to provide effective services to the Other. Cultural
competence was developed from the perspective of a clinician trying to work out how
to best serve ‘the Other’ – children of color – with ‘few cultural competence
curricula…specifically designed to foster an awareness of the student’s own cultural
background’ (Boutin-Foster, Foster and Konopasek 2008:106).

The cultural competence approach of understanding the Other found a natural and
comfortable link within a patient-centred approach, described by Betancourt
(2006:500):

[C]ultural competence is no longer seen as a set of skills necessary for physicians
to care for immigrants, foreigners, and others from ‘exotic’ cultures, but instead
as a central tenet of patient-centered care, effective communication, and the need
to be responsive and deliver quality care to all.

Gregg and Saha (2006) describe the evolution in the arguments from bridging the
cultural distance to now applying cultural competence education to address
population-level health disparities for ethnic and ‘minority’ groups. The knowledge of
this population health disparity is not new. In 1944 Swedish economist Gunnar
Myrdal published An American dilemma: the Negro problem and modern democracy, in which he commented, ‘Area for area, class for class, Negroes cannot get the same advantages in the way of prevention and care of disease that whites can’ (cited by Geiger in Smedley et al. 2002:417).

Gregg and Saha (2006) argue that the design of earlier cultural competence curricula
focused on learning about cultural elements which could reduce ‘cultural barriers’ in
the doctor–patient interaction. They suggest that this is different to curricula designed
to educate practitioners about the social and economic forces which combine in a
complex way and contribute to disparity in health care outcomes for some different
ethnic and ‘minority’ populations. This is consistent with the approach Gustafson and Reitmanova presented to highlight differences in aims and methods of curriculum development.

The critical cultural approach described by Gustafson and Reitmanova has also been echoed from different perspectives and with different names. Kumagai and Lypson (2009) describes it as developing a critical consciousness, and Wear (2003) names it as insurgent multiculturalism. All of these perspectives take the view that if cultural competence is about addressing health disparity, its location and relevance with a wider ‘social justice’ initiative needs to recognised. Consideration of how power relations are embedded within the very fabric of society, including medical schools and universities, should not be ignored.

Mohammed (2006:100) provides a post-colonial framework to discuss power in health, and observes that:

> The role that history and structural inequalities play in producing health disparities is often ignored…Essentially, ‘culture’ becomes a shorthand, a euphemism that eradicates history and the continuing mechanisms of colonial injustice.

Chapter Eight revisits and expands upon the theme that aims and understandings of cultural competence need to be supported by pedagogical approaches that are cognisant of, and consistent with, these aims and understandings.

**Pedagogical approaches to cultural competence curricula**

> There appear to be as many strategies for providing cultural competency training as there are cultural competency training programs. These vary in length, skill, and knowledge of the trainer, as well as in emphasis (Perloff et al. 2006:848).

Pedagogical approaches to cultural competency, as described by Perloff, are multiple. The development of any new curriculum is a compromise and negotiation between curricular aspirations, and optimal pedagogical approaches, and the practicalities of competing priorities in a complex organisational environment, the medical school. Kripilani (2006) categorises training approaches to cultural competence in the classic domains of knowledge, skills and attitudes. These range from ‘anthropological’ approaches to the acquisition of knowledge about different cultural groups (Crawley
et al. 2002; Eiser and Ellis 2007), skills-based approaches, with the focus on communication across cultures (Kai et al. 1999), and reflective skills, based in the domains of professionalism (Boutin-Foster et al. 2008; Carrillo et al. 1999). Kai et al. (1999) describes an integrated approach to inclusion of culture within the curriculum.

A caution should be noted here about the language of vertically integrated curricula. In reality, what is often being described are vertically located curricula. To be vertically integrated, the content needs to be meaningfully integrated with some other curricula content, not just co-located for purposes of convenience or timetabling practicality. An integrated approach to cultural competence requires a whole-of-school approach, including shared teaching and assessment opportunities. Without a meaningfully integrated approach, cultural competence curricula is at risk of being perceived by students and faculty alike as an ‘add-on’ to the important core curricula. Further discussion of pedagogical approaches is incorporated into Chapters Five and Six, where the teaching and learning at the case study site are described, and related to the relevant literature.

It is expected that insights gained from this case study will contribute to understanding the perceptions and practices of this important and growing concept in medical education, which is driven by the intent of medical educators to reduce the extent of disparity in health care outcomes, identified by Myrdal in 1944.

**Evaluation of cultural competency initiatives**

In 2000, in a review of the literature, and conceptually linking cultural competence with improved health outcomes, Brach and Fraser (2000:203) concluded:

> there is little by way of rigorous research evaluating the impact of particular cultural competency techniques on any outcomes, including the reduction of racial and ethnic disparities.

This finding was echoed by Anderson, L. et al. (2003:74) in a systematic review of five initiatives to improve cultural competence in health care systems, and Chen et al. (2004:955) reported a review of 600 articles related to medical education research (with only four reporting on clinical outcomes for patients), with the focus on educational, rather than clinical, outcomes.
Beach et al. (2005:356), in a systematic review of health care provider cultural competence educational interventions, found that the link between cultural competence training and health outcomes and equity of services was lacking, as did Thom et al. (2006) and Ho et al. (2010). Betancourt (2003:568) describes the complexity of research linking health professional education and health disparity outcomes, and cautions on the ‘complexity of linking cross-cultural curricula to health outcomes in a simplistic way…The challenge of this type of evaluation cannot be overstated.’

Most cultural competence literature describes curricula initiatives – some describe evaluations of those curriculum initiatives as educational outcomes, and a few describe the theoretical perspective that informs the approach. Almost none has been able to show improved patient outcomes due to inclusion of cultural competence curricula.

There are no case studies that describe how cultural competence is perceived and practised at an institution (using search terms including ‘cultural competence’, and/or ‘medical school’, and/or ‘case studies’); one study at the Lund School of Medicine describes the hidden curricula that inform the cultural competence curricula (Wachtler and Troein 2003). Despite its ‘almost religious significance’ (Perloff et al. 2006:835), or maybe because of it, cultural competence has been embraced, almost reified, as a critical component of medical education programs. As described, there is little to no evidence of its impact on disparity in health outcomes, reflection of how cultural competence is perceived within a School of Medicine, or how the concept has developed and infiltrated a School of Medicine (other than by being mandated by accreditation boards). This case study aims to provide one in-depth example of the relationship between perception and practice within a clinical school, and how the perceptions and practices have been taken up.

Conclusion

Cultural competence has grown and developed, primarily as a response to evidence of disparity in health care outcomes. The concept has evolved from an understanding of the culture of the Other, to sometimes taking a more critical approach to the role of culture in shaping the life course and experiences of doctors and patients. As it has
been applied in medical education, cultural competence has built on pre-existing models, the biopsychosocial model and a patient-centred approach being the two most relevant. The evidence linking cultural competence curricula and improved health care outcomes is not strong, and little research has been undertaken to inform the relationship between perceptions and practices of cultural competence in medical education.
Chapter Three: Methodology and methods

This chapter describes the methodological approach taken, the conceptual frameworks drawn upon that have shaped the case study, and the methods used. The conceptual framework of Argyris and Schön (1978, 1996), while also providing the conceptual framework for the research, provides the logic for structure for the dissertation.

Study design

Despite the significant literature describing cultural competence initiatives in medical education, there is little in the way of relating perception to practice. This research fills this void through the use of a case study.

Due to the complexity of medical education, explorative studies will typically be a wise first step before moving on to any other type of study (Ringsted 2009:58).

A case study design has been chosen to best explore and describe how cultural competency is practised and perceived at a medical school. I have chosen a case study for the research design, as I need to ask ‘how’, ‘why’ and ‘what’ questions, which, as described by Yin (2009:2, 9), lend themselves to a case study approach. Cultural competence is a social construct, which has been applied within a professional culture of medicine. As perceptions and practices of cultural competency are contemporary questions still under development and evaluation, I need to pursue the following type of questions: How do you perceive cultural competency? Why do you do x as a method to teach cultural competency? What is the ‘espoused theory’ at this school about cultural competency? The contemporary nature of the inquiry lends itself well to a case study approach.

While case study approaches are widely used in the field of education (Merriam 1998:26), and for clinical patient presentation and clinical analysis, the approach is rarely apparent in medical education (Cook, D. et al. 2008). Case study provides for ‘in-depth study of instances of a phenomenon in its natural context and from the perspective of the participants involved in the phenomenon’ (Gall, Gall and Borg 2003:436), and is concerned with ‘development of educational practice and policy’ (Bassey 1999:62). Common principles of case study are ‘boundedness or singularity, in-depth study, multiple perspectives or triangulation, particularity, contextualization
and interpretation’ (Duff 2008:23). The boundedness in this case is the University of Otago, Christchurch, School of Medicine (the Christchurch School of Medicine).

**Case study site**

The Christchurch School of Medicine was selected as the case study site because it is the medical school in Australia or New Zealand that lends itself optimally to a case study of this type. It is accessible and large enough to support a spectrum of views and perspectives, yet not too large as to be impenetrable in terms of gaining access to key informants and seeking the deep, rich and nuanced information required to inform the research questions.

The first criterion should be to maximize what we can learn…we need to pick cases which are easy to get to and hospitable to our inquiry, perhaps for which a prospective informant can be identified to and with actors (the people studies) willing to comment on certain draft materials…[a] good instrumental case study does not depend on being able to defend the typicality of [theta] (Stake 1995:4).

What Stake importantly illuminates here is that the selection the University of Otago, Christchurch, has as much to do with how accessible and fruitful the case study site will be, as any claims to it being typical of medical schools in Australia and New Zealand. While the University of Otago, Christchurch, may have claims as being at the fore in some areas of medical education, it was not chosen because it is typical of any of the other 19 medical schools in Australia or New Zealand. Rather, as a site, it provides the best opportunity to investigate and elicit rich insights into the complex area being researched. Each of the 20 medical schools across Australia and New Zealand is different. The differences include their structures, their modes of teaching, the size and composition of the student body, entry requirements, articulated mission and vision statements, and their internal cultures, values and norms.

As an academic with pre-existing relationship with the school, I have excellent access to the people and programs at the University of Otago, Christchurch, while being able to optimise the advantage of detachment, should that be required. This dual position provides a wonderful – and privileged – vantage point to be able to undertake a rich and in-depth case study. As an academic whose area of responsibility (Indigenous
health) overlaps with cultural competency curricula, there are vested professional interests in how others perceive and practice cultural competency curricula.

**Conceptual framework**

This research draws upon the conceptual framework of Argyris and Schön’s Theories of Action (1978). Theories of Action were developed and evolved from research by Argyris on the relationship between individuals and organisations, and organisational change.

It is this background to the framework that lends itself so well to this research, as medical schools are organisations that educate and cultivate emerging doctors.

Organizations function in several ways as *holding environments for knowledge*…Such knowledge may be held in the minds of individual members…But knowledge may also be held in an organization’s files, which record its actions, decisions, regulations, and policies (Argyris and Schön 1996:12, emphasis in original).

Medical Schools have trained clinicians who have contributed to disparity in health care outcomes previously described, and medical schools in many places are now required to integrate cultural competence initiatives within their training programs. The research questions outlined in Chapter one aims to investigate and answer questions about organisational change and reform in a School of Medicine, which has its own organisational context, as well as being influenced by the educators and students who spend time within the school. Argyris and Schön argue that:

> When someone is asked how he would behave under certain circumstances, the answer he usually gives is his espoused theory of action for that situation. This is the theory of action to which he gives allegiance and which, upon request, he communicates to others. However, the theory that actually governs his actions is his theory-in-use, which may or may not be compatible with his espoused theory; furthermore, the individual may or may not be aware of the incompatibility of the two theories (Argyris and Schön 1974:6).

Argyris and Schön describe the two elements of their theory as follows:

- ‘By “espoused theory” we mean the theory of action which is advanced to explain or justify a given pattern of activity’ (Argyris and Schön 1996:13) – that
is, how people describe what it is that they do, or would do, to advance a cause, or perspective. In the case of this research, the espoused theory is what participants say they do in relation to cultural competence at the school, and why they think it is important.

• ‘By “theory-in-use” we mean the theory of action which is implicit in the performance of that pattern of activity. A theory-in-use is not a “given”. It must be constructed from observation of the pattern of action in question’ (Argyris and Schön 1996:13). The theory-in-use can be determined by observing what medical educators at the school actually do, evidenced in terms of curriculum and assessment maps, and informed and triangulated from other perspectives including descriptions from learners (students) about actions of medical educators.

The other important elements of the framework are the governing values and variables, the actions and the consequences, an understanding and application of which allows us to consider which type of learning takes place – either single or double loop approaches (Figure 1).

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**Figure 1: Conceptual framework of Argyris and Schön, incorporating Hafferty and Franks’ taxonomy of curricula**
The governing values or variables of an organisation are the ‘dimensions that people are trying to keep within acceptable limits’ (Smith, M. 2001). The example used by Argyris and Schön is that of the automatic thermostat within a room. Activities occur (cooling and heating) to keep the room to the set temperature (the governing variable). The governing value itself (the temperature at which the thermostat is set) is not changed. The governing values and variables in this study constitute personal and professional values, legislative and regulatory variables, and self-stated values and variables. Personal and professional values include faculty perceptions of cultural competence; regulatory and legislative variables are informed by The Treaty of Waitangi, the New Zealand Health Practitioners Competence Assurance Act 2003 and Australian Medical Council (AMC) accreditation requirements; and the school’s self-stated values are seen through its vision and mission statements, and graduate profile. These are described in detail in Chapter Four.

The work of Hafferty and Franks builds upon and focuses Argyris and Schön’s framework by providing an established and useful approach to uncover and describe the actions (espoused theory and theory-in-use), with their taxonomy of curricula (formal, informal and hidden). The application of Hafferty and Franks’ taxonomies of curricula that make-up the action provides an avenue to analyse the congruence of the influences on student learning, to see if the formal, informal and hidden curricula are mutually supportive and reinforcing, or if there is dissonance between them. I have drawn a strong analogy between Argyris and Schön’s Theories of Action and Hafferty and Franks’ work related to curriculum.

Although concept labels and core definitions can vary by author, the notion of a multidimensional learning environment embraces at least three interrelated spheres of influence: (1) the stated, intended, and formally offered and endorsed curriculum (e.g., the ‘this is what we do’ curriculum); (2) an unscripted, predominantly ad hoc, and highly interpersonal form of teaching and learning that takes place among and between faculty and students (the informal curriculum); and (3) a set of influences that function at the level of organizational structure and culture (the hidden curriculum) (Hafferty 1998:404).

The formal curriculum is analogous to the espoused theory. It is, organisationally, what the School of Medicine espouses it will do, and ‘justif[i]es a given pattern of activity’ (Argyris and Schön 1996:13). It is found in the formal school, faculty and
university documents, policies, curriculum maps and responses to accreditation reports. It is also revealed by asking individuals within the organisation to describe what it is they do, and, in the case of this research, their perceptions of cultural competence.

The informal curriculum has its parallels with the theory-in-use. It is what happens at the coalface, the teaching moments with students at the foot of the patient’s bed, or the conversations in the corridor, as well as the observation and modelling of senior clinicians by their students. “The informal curriculum targets learning at the level of interpersonal interactions” (Hafferty 1998:404).

The hidden curriculum is best described by Hafferty and Franks (1994:865):

Most of what the initiates will internalize in terms of the values, attitudes, beliefs, and related behaviors deemed important within medicine takes place not within the formal curriculum, but via a more latent one, a ‘hidden curriculum,’ with the latter being more concerned with replicating the culture of medicine than with the teaching of knowledge and techniques. In fact, what is ‘taught’ in this hidden curriculum often can be antithetical to the goals and content of those courses that are formally offered.

The hidden curriculum is analogous to the organisational theory-in-use. Many individuals within the organisation of a medical school are often unaware of the influence of the hidden curriculum on the consequences, and are often surprised when contradictory elements of the hidden curriculum are revealed to them.

The informal and hidden curricula are different in that the informal curriculum focuses on interpersonal interactions whilst the hidden is more concerned with structural factors that influence what students learn.

By examining and uncovering the theories of action, the research then utilises the single and double loop learning concepts of Argyris and Schön’s framework to reflect on organisational learning at the study site. Single loop learning is defined as learning that ‘changes strategies of action’ (Argyris and Schön 1996:20), but does not address the governing values or variables and their influence on achieving the desired outcome. In examples of single loop learning, ‘the values and norms themselves remain unchanged’ (Argyris and Schön 1996:21).
Double loop learning is defined as learning that takes into account the influence of the governing values and variables themselves, and results in questioning these governing variables and their impact of the range of acceptable actions. Application of the framework facilitates identification of the extent to which single or double loop learning is undertaken, and if the governing value and variables at the school are congruent with the actions to achieve the intended consequences.

Hafferty (1998:406) advocates that organisations should strive to ‘[c]reate structures that allow individuals to reflect upon the larger structural picture of which they are a part’. This is analogous to advocating for double loop learning, when addressing change at an institutional level.

Schön’s work further contributes to this model of organisational learning by describing ways that participants in an organisation can either reflect in, and on, action. Reflection in action – reflecting as events are occurring – is an important element to consider, particularly in relation to how the informal curricula (especially role models) may be influencing the consequences and outcomes of student learning. There are parallels evident between Schön’s work and theories of the reflective practitioners in the health field (Shapiro and Talbot 1991).

Reflection on action – the purposeful reflection on actions and their consequences after the event – is also an important process for individuals and organisations to undertake when critically reviewing their progress. Reflection on action provides an opportunity to reflect, but then also act, utilising a single or double loop approach to organisational learning. The penultimate chapter of this dissertation, the discussion, describes, among other things, a model for implementation that can contribute to the reflection on action in regards to cultural competency curricula.

Drawing on Wear’s (1998) observations, Murakami et al. (2009:np) sum up why this research is important.

The discordance between what formal curriculum intends to teach the medical students and what students perceive to be learned from hidden curriculum is difficult to deal with. It seems to be illustrated explicitly in the example of the white coat ceremony as a curricular event, which was originally expected to symbolize the students’ sense of compassion and humility, but instead serves to
impress care-giving hierarchies and the social privileges of physicians, though this might be one of its functions. If advocates for educational reforms have never been aware of solutions to the problem of reconciling the discordance between these curricula, ‘reform without change’ may occur, as history repeats itself.

If advocates for educational reform to address health care disparity via cultural competency initiatives are unable to take into account the potential for competing or contradictory curricula (formal, informal and hidden), and provide opportunity to reflect upon the impact of the governing values and variables, then history will surely repeat itself. Utilisation of this framework provides an opportunity to show how an emergent concept is perceived and practised, and how the relationship between perception and practice may be influenced by broader governing variables. Recognition of modes of organisational reflection and learning (single and double loop approaches) to support fundamental curricula reform is an important element of this case study. For a whole-of-curriculum approach to integrating cultural competency and achieving the desired outcomes, the formal, informal and hidden curricula need to be aligned with, and informed by, the governing values and variables. As identified by Lempp and Seale (2004:772), ‘[r]ecognition and reform of the hidden curriculum is required to achieve the necessary fundamental changes to the culture of undergraduate medical education’.

**Methods**

The case study was undertaken on location at the University of Otago, Christchurch, School of Medicine for six months, from September 2010 to February 2011. The Māori Indigenous Health Institute (MIHI), an institute of the Christchurch School of Medicine, hosted me as a visiting researcher. Twenty-five formal interviews were undertaken; 15 with faculty participants and 10 with final-year student participants. The formal interviews were digitally recorded and transcribed. I also engaged in numerous informal discussions over the fieldwork period that informed my thinking.

**Selection of participants**

All faculty participants for interview were purposefully selected. Key informants from the faculty invited to participate in an interview included the Dean, the Associate Dean (Medical Education), the Associate Dean (Undergraduate Student Affairs), the
Medical Education Advisor, the Clinical Education Advisor, and module and thread convenors, including those focused on Clinical Skills, Public Health, hauora Māori (Māori Health thread), Ethics and Professional Development (see Appendix A for full list of titles of faculty participants). Final-year students were selected based upon availability (students known to be on rural rotation were not contacted), a mix of international and local students, and gender balance.

In all, 25 formal semi-structured interviews were undertaken, each taking between 45 minutes and an hour. Interviews for faculty participants followed the broad approach of asking them to describe their perceptions of cultural competence, and then their practices (both curricula and assessment) (see Appendix B for the interview schedule for faculty). Student participants were asked to describe their perceptions of cultural competence, followed by where they were taught it, where they learnt it, and also where they were assessed on it (see Appendix C for the interview schedule for students).

All formal interviews were recorded and transcribed, with the transcriptions being analysed and their content coded. Notes taken from informal discussions, conversations and observations were also drawn upon to inform the rich description of the case. Saturation of content was reached with both groups (faculty and students).

Interviews were organised and coding recorded using NVivo (2010). Interviews were coded for content, with emergent themes further coded into sub-themes, and where appropriate, sub-themes coded again into smaller units. The relationship between themes was recognised, and is described in the following chapters. Informant responses have been coded for anonymity, such that faculty participants are identified as FP; similarly, student participants are identified by SP after their quotes. The number following FP/SP indicates the different informants.

Before going into the field I gathered data to inform the study, including medical school accreditation reports from the AMC from 2000–10. These were read for content related to cultural competency. I chose this timeframe because cultural competency in medical education began to appear in the literature from the late 1990s in significant number. It also covers the recent accreditation of most Australian and New Zealand medical schools, providing a bi-national contextual background. The
information from the accreditation reports contributed to an understanding of how the regulatory variables have been constructed and informed over time. I also gathered information about the Christchurch School of Medicine, such as graduate attributes, curriculum maps, mission and vision statements, and strategic plans. Most of this information was publicly accessible, with access provided to the Learning Outcomes Database by the school. This information is also described in the following chapters.

**Governing values and variables**

The regulatory and legislative governing variables, such as the Health Practitioners Competence Assurance Act, the AMC standards for accreditation, and The Treaty of Waitangi, were all accessible in the public domain, as were other written self-stated values, such as the school’s vision and mission statement, and graduate attributes. These documents were accessed and analysed as the governing variables, consistent with the framework described in Figure 1. Personal and professional values emerged through interviews with the research participants, and these values and standpoints reflect, and contribute to, the professional culture of the medical school. Immersion over a six-month period provided the opportunity to observe, note, identify and interpret these governing values and variables.

**Actions**

The actions consist of the formal, informal and hidden curricula, incorporating both the espoused theory and theory-in-action. In an educational setting, both espoused theory (formal curricula) and theory-in-action (informal curricula) contribute to the action (or what the student is taught), even though they may at times be contradictory. Argyris and Schön (1978: 15) describe the potential discord between espoused theory (formal curricula) and theory-in-action (informal curricula):

Indeed, formal corporate documents such as organization charts, policy statements, and job descriptions often reflect a theory of action (the espoused theory) which conflicts with the organizations theory-in-use (the theory of action constructed from observation of actual behavior) – and the theory-in-use is often tacit. (emphasis in original)

Chapter Five describes the formal curriculum, arrived at by drawing upon policies, curriculum maps, assessment maps and the espoused theory of participants (the
indicative range of people which I have described above). By following leads of key academics within the school, the detail of the formal curriculum is described and mapped out.

The methods used to uncover the hidden curriculum follow Hafferty’s (1998:405) guide of areas to investigate, which include policy development, evaluation, resource allocation and institutional ‘slang’. As Martin (in Wear and Skillicorn 2009:451) identifies, a ‘hidden curriculum is not something one just finds; one must go hunting for it’. I have used evidence of the impact of policies, evaluation, resource allocation and slang as data in and of itself. The hidden curriculum is discussed as part of the critical analysis in Chapters Seven and Eight.

Analyzing the hidden curriculum is neither easy nor free from controversy. What is revealed by such an analysis may appear decidedly strange, shocking, or outlandish to insiders. Findings and conclusions will run counter to the group’s prevailing wisdom and therefore will stand a good chance of being rejected out of hand (Hafferty 1998:405).

**Consequences**

Consequences were investigated in a triangulated manner. Medical educators responsible for implementing curricula were asked to make an assessment of what they think have been the consequences of their actions. Questions included: Do they think their programs and curricula in cultural competency have been successful? If so, how have they evaluated this? If not, why not, and what have they changed? The analysis of these discussions considered the extent to which single loop or double loop learning has taken place, and helped identify barriers and enablers to the uptake and implementation of cultural competence initiatives. Students who participated in the study were interviewed with a particular focus on how they perceived the school has practised cultural competence. Given the primary and pressing role of student as learner, formal interviews with students, as opposed to opportunistic informal discussion, were the primary data gathering method for this group.

The opportunity to spend a significant time at the study site enabled follow-up discussions with participants, seeking clarifications of perceptions and practices of particular incidents or events.
Decisions about how case studies should be planned, conducted and reported are as much practical decisions as theoretical, governed by the exigencies of the situation, as well as by general views of education research and evaluation (Adelman et al. (1976) in Simons (ed.) 1980:47).

As described earlier, the pre-existing relationship and access between the researcher and the case study site contributed to negotiating a long stay at the study site, facilitating and supporting immersion into the cultural milieu of the broader school environment.

**Discussion structure**

The discussion section is structured around the theoretical framework (Figure 1). The governing values and variables are described, including accreditation requirements, mission and value statements of the school, the graduate profile, and the personal values and standpoints that emerged from the interviews.

This is followed by a description of the formal, informal and hidden curricula, which constitute the action. The congruence between these three curricular influences is discussed. The consequences of the action is then described, and the way that the consequences are determined and measured (primarily through assessment) is critically analysed.

In Chapter Seven, which reviews barriers and enablers to curricula reform, examples of single and double loop learning are described as they were discovered in the case study. Finally, bringing together the literature with the research findings, propositions for reform in medical education and cultural competence are made.

**Feedback and dissemination**

A critical part of an educational case study, which goes to the heart of ‘Educational research by case study…as the pursuit of professional excellence through academic means’ (Golby 1994:16), is the feedback and dissemination of findings with participants. The very act of participating in in-depth interviews and follow-up conversations related to the cultural competence curriculum at the case study site provides an opportunity for participants to be prompted to reflect on action on their efforts in the area. Formal feedback of findings will be offered to the school following
completion of the research through both presentation of findings and publication of findings.

**Ethics**

The research received ethics approval from the Human Research Ethics Committee, through the Graduate School of Education, The University of Melbourne, application number 1034438.1. Subsequent approval was also received from the Education Research and Quality Committee, approved by the Faculty Curriculum Committee, Division of Health Science at the University of Otago, to include Otago student participants in the research.
Chapter Four: Governing values and variables

This chapter outlines the governing values and variables at the Christchurch School of Medicine. Personal and professional values, including faculty perceptions of cultural competence, are described; regulatory and legislative variables, including The Treaty of Waitangi, the Health Practitioners Competence Assurance Act of New Zealand and AMC accreditation requirements, are outlined; and the school’s self-stated values as seen through vision and mission statements, and the graduate profile, are discussed.

The governing values and variables shape the aims and inform the boundaries and the broader context within which the school operates. There is interplay between the variables themselves, and some will be more influential at times than others. The governing values and variables change and evolve over time, influenced by a diverse range of sources and social processes.

The main findings of this chapter are that the legislative and regulatory governing variables are interpreted through a professional lens of achieving cultural competence through a patient-centred approach to the clinical encounter. This is consistent with the school’s self-stated values, the vision and mission, and the graduate profile.

A schematic model of participant’s perceptions of cultural competence is introduced (Figure 2), which was derived through analysis of the research data, and is original work.

The governing values and variables, interpreted and taken as whole, provide a background and context within which to analyse curricula initiatives in the area of cultural competence.

Personal and professional values and perspectives

Personal and professional values and perspectives of the faculty contribute to the culture of the school in an iterative process. Argyris and Schön (1978:16–17) describe the relationship between individuals and an organisation:

An organization is like an organism each of whose cells contains a particular, partial, changing image of itself in relation to the whole. And like such an organism, the organization’s practice stems from those very images…Organization is an artifact of individual ways of representing
organization. Individual members are continually engaged in attempting to know the organization, and to know themselves in the context of the organization.

At a School of Medicine, the relationship between individual values and the organisational values are fluid, with each informing the other, and reinforcing or modifying the values of the organisation by enacting the personal and professional values through action. From a sociological perspective this is very similar to Giddens’ Theory of Structuration, whereby the structures and rules of a system (organisational culture) are not permanent and immutable, but, rather, are reinforced and modified by the actions of participants within the system (organisation), while, at the same time, the structures of the system itself shape the participants themselves (Giddens 1984).

**Ensuring quality patient outcomes through patient centredness**

The professional value that emerged most strongly from participant perspectives of cultural competence was a commitment to highest quality patient outcomes, through a patient-centred approach to the clinical encounter. Cultural competence was described as a very important concept, and an important element of medical education.

I think it’s hugely important, I think so much harm can be done by not recognising…the lack of awareness, you know… I don’t think any of those people were, you know, ill meaning or bad people, I just think that, you know, if you’re not aware and you don’t do something about the inclusiveness then you actually exclude people. And it doesn’t matter whether you intend to or not, I mean, you might be saying, ‘Come. Come.’ But in actual fact, if you make your practice one particular cultural model, then people just don’t come (FP14).

Figure 2 displays and represents participant’s perspectives of cultural competence. Navigating the clinical encounter and optimising the ‘relational’ aspect was overwhelmingly expressed through the facilitation of a patient-centred approach, a pre-existing and well-understood approach in medicine.

I guess you could say it’s a way of specifying patient centredness. It’s a way of being more explicit about what some of the elements of patient centredness might include. You could say, therefore, it’s a subset of patient centredness (FP2).

This is consistent with Betancourt et al. (2005), who interviewed a range of stakeholders deemed to be experts in cultural competence, including academics, to
find out their perspective on cultural competence. He found those academics involved in education:

[V]iewed cultural competence as the development of a skill set for more effective provider-patient communication. They stressed the importance of providers understanding the relationship between cultural beliefs and behavior and developing skills to improve quality of care to diverse populations (Betancourt et al. 2005:501).

Figure 2: Schematic model of perceptions of cultural competence from research informants

Box 1 represents the emergent themes from the participants’ perspectives of cultural competence, which is that it is framed within the clinical encounter (arrow ‘a’), highlighting the relational aspect of cultural competence as the doctor–patient interaction. This perspective was strongly evident from both educators and students:

I think it describes an approach to clinical interactions (FP11).
I think it’s your ability to just form a relationship with someone so that they have confidence in you and you have confidence and then the communication kind of flows, so you don’t have any barriers up (SP3).

Student perceptions of cultural competence are more thoroughly discussed in Chapter Six, which describes the outcomes of the curriculum on the students (the consequences). However, as agents within the organisational culture of the school, students also contribute in an iterative way to the culture of the school, and their views reflect values transmitted to them as students about the culture of the school.

**Patient centredness through learning about Other**

Arrow ‘b’ represents the approach most participants described to achieving cultural competence, with the emphasis on learning about the patient’s culture:

> Teaching cultural competence to equip medical students to deal competently and effectively with patients from a wide range of cultural backgrounds I suppose (FP11).

> I think it’s understanding another, or having insight in to how another culture works, or how it interacts, and putting that in to medical practice (SP5).

This is consistent with the personal and professional value represented by employing a patient-centred approach, which is to learn as much about the patient, and their culture, so as to optimise patient outcomes. It is consistent, as will be seen later in this chapter, with the regulatory and legislative variables, and is also articulated in the school’s mission and graduate profile. This cultural knowledge was then incorporated by the clinician to help understand the patient as whole (represented by arrow ‘c’).

**Other as Māori**

Learning about the patient’s culture (arrow ‘b’) was most often related to learning about Māori culture: ‘it would be very disconcerting to have a Kiwi doctor who had no knowledge whatsoever about Māori culture’ (FP6). This perspective of linking cultural competence with Māori was a view expressed by most participants. The value placed on learning about the Other recognises that there is, and has been, a dissonance between the professional culture of medicine and some patients from some cultural groups (in this context, Māori). It reinforces the high regard in which the patient-
centred approach is held, as cultural competence, perceived in this context, is a utility that strengthens and reinforces the patient-centred approach.

The discipline coordinator of hauora Māori provided a counter to the overarching faculty perceptions that cultural competence was equivalent to learning about Māori culture:

Even in the latest minutes I’ve had to send back to FCC [Faculty Curriculum Committee] going, ‘No! You either have to put cultural competence as its own thing, Māori health as its own thing, Pacific health as its own thing, you can’t just lump it all together.’ Because otherwise what they do is they, you know, like they’ve done it lots, so now [cultural competence] learning outcomes in our graduate profile is learning about Māori health…So that it’s supposed to be part of my curriculum and nobody else has really taken responsibility for [cultural competence]…that I can see (FP9).

**Professional culture of medicine**

Box 2 (Figure 2) describes a perspective that was only evident from some of the faculty. This perspective included taking into account the role and cultural context of the physician, a perspective that was absent from the students:

Well, I mean, we all have a culture and so how you identify your own culture will clearly inform your view of the world and if you can’t appreciate that you have your own culture influences your views and values, then you won’t be able to identify when they’re impacting on the relationship with your patient and you’re less likely to internalise and more likely to externalise cultural impact and say, well, culture’s something the patient brings, you know, that I don’t have culture, the patient has culture. And so again I think you miss the whole point of what it’s all about (FP6).

So cultural competence, I think, means for the clinician (which I like to focus on) is being able to recognise how the culture of the clinician can interact with the culture of the patient and how best to acknowledge both of those differences and still arrive at the best outcome for the patient (FP4).

The majority of participants didn’t describe this as an element of cultural competence, which indicates a governing value that the professional culture itself was less an influential factor in the doctor–patient relationship than the ethnic culture of the
patients. This is a critical element to pursuing equitable health care outcomes, and is a point of major discussion in Chapter Eight.

Cultural competence and social processes

Box 3 (Figure 2) represents what was completely absent from discussions with students, and mostly absent from discussion with faculty participants, which was the acknowledgement of the broader social, historical and political context that shapes much about the doctor and patient, and thus their relationship. This broader context was described by one faculty member:

understanding the historical context to the background of colonisation, the loss of land, the loss of language and the consequent effects of those on Māori society and health is, I think, really important to then allowing the establishment of hopefully a sort of healthy attitude, because you’re no doubt aware that in some quarters [there’s] a degree of scepticism that there’s any need for cultural competence at all. I think that that can be, you can kind of argue convincingly that there is a need for it if you can show people and demonstrate the historical context and the flow on effects of those. So I think that’s key (FP11).

The general absence of this awareness represents a governing variable associated with a perception of equality between the doctor and the patient within the clinical encounter (from the perspective of the doctor), which may not be matched by the reality of the broader social context that shapes the relationship. It could also represent a lack of reflexivity of unrecognised social privilege from the medical profession, a privilege not shared by many of their patients. Related to this social position, and awareness of social processes that shape the relationship, it was rare for participants to relate the need for cultural competence curricula with disparity in health care outcomes, with just one participant describing the underpinning rationale as:

[So students know] it’s not just warm and fuzzy, it’s not just a political write off to the Treaty, and ‘we’re all being nice’, but they actually see that [cultural competency] actually contributes to health and equality. I think that’s where we come from when I think about cultural safety, cultural competency; that its roots or its genesis lie that there’s inequality. That if we didn’t have the inequality or the inequities then we wouldn’t need it (FP9).
Cultural competence in New Zealand

Participants who were educated and worked elsewhere and migrated to New Zealand described being more aware of the concept of cultural competence since their arrival. This increased awareness in the New Zealand context may be a factor of the passage of time (the emergence of the concept, particularly over the past decade), or the particular emphasis and currency attached to cultural competence in the New Zealand context, and the increasing spotlight on disparity in health outcomes.

I hadn’t really come across the concept of cultural competence at all until coming to New Zealand. My experience previously was all in the [United Kingdom] where the issue of dealing with people from different cultures is a live and pressing one but, it seems to me, very different both historically and politically than it is here (FP11).

In an Australia study in 2007, Johnstone and Kanitsaki (2007:100) interviewed health care providers (not educators) about their understandings of the term cultural competence, and found that ‘few participants had heard of the term “cultural competence” prior to receiving information about the project’. The authors also point out that cultural competence has gained particular prominence in Canada, the United States and New Zealand.

Focus on patient centredness

What emerges from the description of participants’ values and perspectives is the very strong commitment to quality patient engagement and optimal outcomes, based on a patient-centred approach to medicine, which incorporates aspects of the patient’s ethnic culture. Other forms of identity, including sexuality, ageing and gender, were rarely mentioned. There was mostly an absence of acknowledgement of the potential impact of the role that power, colonisation and inequitable social structures play in contributing to the presenting health disparities. Locating the influence on the doctor–patient relationship from a perspective that extends outside of the boundaries of the doctor’s clinic or the hospital ward, and includes broader social issues that contribute to shaping the relationship, was not strongly evident. This resonates with the approach to cultural competence, described in the previous chapter, which does not include the ‘critical’ element.
Overwhelmingly, the professional values represented included a commitment to ensuring excellent health outcomes for patients, consistent with aims of optimising the doctor–patient relationship. The focus of the health outcomes was at the individual patient level and a commitment to best outcomes for the patient. What was less obvious was the impact of the social, historical and political realities that shape the worldview of the doctor, or patient, and this is the focus of discussion and recommendations in Chapter Eight, including re-visiting the role of humanities in the clinical training.

**Regulatory and legislative variables**

This section describes the regulatory and legislative governing variables, and includes consideration of the *Health Practitioners Competence Assurance Act 2003*, The Treaty of Waitangi, and the accreditation requirements for basic medical education, as prescribed by the Australian Medical Council in collaboration with the Medical Council of New Zealand.

*Health Practitioners Competence Assurance Act 2003*

The most explicit legislative governing variable in regards to cultural competence is the New Zealand *Health Practitioners Competence Assurance Act 2003* (the Act), which outlines standards and competencies required of health practitioners. The Act states that the relevant authority in each health profession has a responsibility ‘to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession’ (section 118(i)).

The legislative governing variable is an Act of Parliament and could be described as one of the more immutable variables. However, it is worth noting that the Act came fully into force as recently as 2004, and is an example of how the governing variables change over time. The Act, and explicit reference to cultural competency, has emerged in a global context of increased awareness of unequal treatment, and in New Zealand of a more acute awareness of poor health outcomes for Māori. The Act itself requires interpretation, and this case study shows that the Christchurch School of Medicine interprets the legislative governing variables through a professional lens, and a commitment to clinical excellence and patient centredness.
**Accreditation requirements**

The Medical Council of New Zealand, in collaboration with the AMC, accredits the two New Zealand medical schools and is bound by the standards set by the Act, which demands the Medical Council of New Zealand ‘to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners of the profession’ (section 118(i)). The Medical Council of New Zealand’s Statement on Cultural Competence articulates the requirements for cultural competence in a New Zealand context, including a list of standards covering attitudes, awareness, knowledge and skills (see Appendix D). The Statement on Cultural Competence describes an approach to engagement of patients from different cultures, consistent with perceptions described by faculty (above), rather than the more critical approach advocated for by Wear (2003), Kumagai and Lypson (2009) and Mohammed (2006).

The AMC accreditation standards for basic medical education in Australia and New Zealand\(^5\) state that graduates ‘must be able to work effectively, competently and safely in a diversity of cultural environments, including a diversity of Indigenous health environments’, and, further, that graduates should understand and demonstrate ‘the need to adopt and practise health care that maximises patient safety including cultural safety’ (AMC 2007).

The United States accreditation standards require that ‘schools should be able to document objectives relating to the development of skills in cultural competence’ (Liaison Committee on Medical Education 2008). Most medical schools in the United States now have curricula in place to achieve this requirement (Flores et al. 2000; Champaneria and Axtell 2004).

Review of all AMC accreditation reports for Australasian medical schools from 2000 demonstrates little explicit comment about cultural competence, and it has been mentioned only once in AMC reports since 2000.

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5. In collaboration with the Medical Council of New Zealand, the AMC accredits New Zealand medical schools and uses the same standards as for Australia.
Chapter Two outlines the central importance of the Treaty in New Zealand, as the founding document that describes the relationship between the Crown and Māori. Māori bear a significant burden of disease in New Zealand, and, as mentioned, Article Three of the Treaty obliges parties that, ‘among other things…health outcomes should be the same for Māori and non-Māori’ (Dowell et al. 2001: 243). The further implications of the Treaty as a governing variable is that resources and efforts are required to address this imbalance, and it should also inform the range of policies and procedures that are in place at the school.

**Self-stated governing values and variables**

This section describes the third category of governing values and variables, which are those self-stated values, and are found in the vision and mission statements, and the graduate profile. These self-stated governing variables are influenced by the personal and professional values, and the regulatory variables. They do, however, contribute to shaping the environment and context within which curriculum is developed and delivered to achieve the aims related to cultural competence.

**The vision and mission statements**

The vision and mission statements articulate, for an external and internal audience, the key directions and values of the school. The school’s vision is to be ‘A research-led campus with an international reputation for excellence’ (University of Otago (n.d.b). Research is prioritised and valued at the school, and research performance as measured by the Performance Based Research Fund would indicate that it is meeting that vision, with the university ranking number one in New Zealand, (Tertiary Education Commission 2007) and with Christchurch School of Medicine the top ranking medical campus in the country in 2010 (pers. comm., Professor Tim Wilkinson, Associate Dean Medical Education, 3 December 2010).

The mission statement is broader than the vision, and is a traditionally oriented mission statement, encompassing teaching, research and clinical service in partnership with local community.
MISSION - The University of Otago, Christchurch will advance, preserve and promote the development of knowledge, critical thinking and intellectual independence to enhance the understanding and well-being of individuals and society. It will achieve this by building on a strong linkage with the Canterbury District Health Board and with our community, by enhancing excellent and diverse research and teaching, by promoting clinical excellence, and through its national and international links. (University of Otago n.d.b)

The vision and mission statements of the University of Otago, Christchurch, are a variation of many that are found in schools worldwide. As statements, they do not exclude a wide range of interpretations of culturally competent practice. The strategies for achieving the vision and mission are outlined in the University of Otago, Christchurch, strategic imperative 2007–2012. Key and relevant extracts from this plan include:

(Achieving Excellence in Medical Student Teaching)

…We aim to graduate doctors with outstanding knowledge, clinical skills and professional behaviour ready to serve as leaders in the community, hospital or research. We will review our current curriculum and explore options for diversifying experiences and place of learning…the School will develop a Medical Education Unit and support teaching in areas such as professional development, medical ethics and clinical skills. Research into medical education will be fostered. The School will nurture and support MIHI (Māori Indigenous Health Institute). (University of Otago n.d.c)

Specific mention of the areas of professional development and the nurturing and support of MIHI are areas related to the teaching of cultural competence, as will be seen in the next chapter when describing the curriculum. Recognition of these areas within the strategic plan demonstrates the recognition and intent within the school to support and develop these areas. The message though the strategic plan is that these discipline areas warrant mention within the strategic plan, but are not prioritised to the extent that research is, which is articulated as the Vision of the School.

The strategic plan includes elements of ‘social responsiveness’, which Kamien, Boelen and Heck (1999) describe as a fourth obligation of medical schools, and which Rosenblatt (2010:573) describe as the:
implicit social contract between academic health centers and the broader public, all of our medical schools have an obligation to acknowledge and identify their responsibility to the society at large.

The social responsive element of the strategic plan includes acknowledgement of responsibilities related to The Treaty of Waitangi.

**Contributing to a Healthy Environment, the National Good and to International Progress**

We will build on our relationships with Ngāi Tahu and will extend our partnership with Māori. This partnership will include collaboration in research, as well as efforts to increase the recruitment, retention and achievements of Māori students and staff…

We will undertake a wide range of community service activities, embrace our role as a critic and conscience of society, and act in an ethically and socially responsible manner. (University of Otago n.d.c)

The strategic plan highlights the prioritisation of the relationship between the institution and Māori. Notably, and in the context of the history of New Zealand and the Treaty, the strategic plan does not talk about other ethnic groups. This variable will be shown to reinforce and be reflected by other governing values, such as the personal values, and is also very evident in the practices of cultural competence.

**Graduate profile**

The School of Medicine website states that the graduate profile is ‘designed to be a core statement that helps us plan and refine our course’. (University of Otago n.d.d) As described earlier, the graduate profile is, in part, a reflection of the other governing values and variables, in particular the personal and professional values, and the regulatory and legislative variables. I describe it as a governing variable in itself, because, as a statement, it defines what the expected outcomes are for students. The graduate profile, as a governing variable, articulates and shapes the range of acceptable curricular actions and activities that are utilised.

Extracts of the graduate profile relevant to cultural competence include:
• Respect for, and an ability to respond to the cultural context and aspirations of patients, colleagues, and other health care workers and communities.

• A sense of social responsibility and an understanding of the contribution of doctor, health services, society and political influences to the health outcomes of patients.

• A commitment to the principles of patient-centred medicine.

• Knowledge of factors impacting on inequalities in health outcomes.

• Knowledge of factors impacting on the health status of Māori and other cultures.

• An understanding of and an ability to respond to the obligations of the Treaty of Waitangi.  (University of Otago n.d.e)

Some of these attributes relate to how cultural competence is perceived at Christchurch School of Medicine; others relate to how cultural competence is described in the literature. For example, the attribute ‘A sense of social responsibility and an understanding of the contribution of doctor, health services, society and political influences to the health outcomes of patients’ is more evident in some descriptions of cultural competence within the literature, whereas ‘A commitment to the principles of patient-centred medicine’ and ‘Knowledge of factors impacting on the health status of Māori and other cultures’ are more relevant to the case study participants’ perceptions of cultural competence. I describe all of them here because there is scope within the governing values and variables to develop an approach to cultural competence that incorporates the area described in Figure 2, and absent from most discussions, as the social context and processes that shapes both the culture of the patient and the doctor.

When asked to comment on the extent to which Christchurch School of Medicine graduates reflected the graduate profile, most faculty members responded with an unexceptional view of their graduates – that is, graduates were described as ‘normal’ in comparison to other graduates from other schools, and similar to what the faculty expected.

I doubt very much whether our product is fundamentally different to the Auckland product. I wouldn’t expect an Australian service provider to be able to go ‘Oh, they clearly come from Christchurch’. There are bits within the
This is discussed further in Chapter Six (The consequences), in regards to the extent to which graduates of the school are perceived to be culturally competent.

**Discussion of governing values and variables**

Research shows that medical professionals perceive the primary responsibility for health care disparity is patient and system factors:

Typically, respondents initially named system and/or patient factors, and named provider bias only after the interviewer explained that research controlling for patient and system factors sometimes still yields unequal treatment for patients of different races (Clark-Hitt et al. 2010:392).

This is not to say that all doctors are therefore ‘bad’ or racist, but, rather, that there is a significant and growing body of evidence that demonstrates unequal treatment along cultural lines, which contributes to disparity in health care outcomes for some population groups. As Esmail (2004:1448) quotes from Seth when describing issues of institutional racism in the British National Health Service:

If it is only bad people who are prejudiced, that would not have such a strong effect. Most people would not wish to imitate them – and so, such prejudices would not have much effect – except in exceptional times. It is the prejudices of good people that are so dangerous.

The way the school or faculty perceives cultural competence influences how the requirements of the regulatory and legislative variables will be met. To re-cap, cultural competence is perceived and contextualised within the context of the doctor–patient relationship by practising patient-centred medicine. Culturally competent clinicians are clinicians who are able to successfully work with a patient-centred model of medicine. Cultural difference between the doctor and the patient is dealt with by developing an approach to help the clinician understand ‘the Other’, and is evident through the explicit and close linking of cultural competence with hauora Māori. The underlying social structures and processes that create and reinforce unequal distributions of power and concomitant access to resources, matched with
‘the prejudices of good people’, is not a theme that emerges strongly in participants’ responses.

As will be shown, the actions (curricula initiatives) reflect the interpretation of this legislative requirement, in concert with the professional values and standpoints. The analysis of previous AMC accreditation reports from 2000 has no instructive mention of cultural competence (there is mention of one Australian medical school that has a six-week problem-based learning approach with a cultural competence focus). In many ways, this is not surprising, as basic medical education accreditation requires culturally safe practitioners (although this is also rarely substantively mentioned). However, even the New Zealand medical school reports are silent on cultural competence since the Health Practitioners Competence Assurance Act of 2003 was implemented. As is described in Chapter Seven, one of the significant factors that was instrumental in increasing Māori health input into the Christchurch School of Medicine curricula was instruction from the AMC. The other influence apparent in New Zealand has been the emergence and traction of the concept of cultural safety, a concept that emerged from the discipline of nursing and was championed by Māori academic Irahapeti Ramsden (2002) from an Indigenous perspective in a colonised New Zealand.

Conclusion

Together, the governing values and variables interact to demarcate the boundaries within which the school designs, develops and delivers its curriculum. These values and variables are malleable and flexible, and different values hold sway over others at different times. Taken as a whole, they enable us to develop a picture of the governing value and variables that inform and influence the actions and consequences at the school, which is the focus of the following chapters.

The commitment to ‘embrace our role as a critic and conscience of society, and act in an ethically and socially responsible manner’ and to ‘graduate doctors with outstanding knowledge, clinical skills and professional behaviour ready to serve as leaders in the community’ (University of Otago n.d.c), and an ongoing partnership and relationship with Māori, and more specifically with Ngāi Tahu, provides the framework to meet the accreditation requirements of cultural competence. This is
underpinned and supported by the professional values of the faculty to excellence and optimal patient outcomes (with a sharp focus on the doctor–patient relationship). These values are aligned with patient-centred medicine within the clinical encounter (and, in the main, do not explicitly include issues of race, power and privilege within society) and its contribution to structuring both the institutions of the medical school and society as a whole and the outcomes (such as unequal health). There is little in the regulatory and legislative variables that is inconsistent with these approaches.

The schematic representation of perceptions of cultural competence (Figure 2) provides a model for medical educators to reflect on how their own approaches may resonate with the perspectives of this case study. This responsibility to the community at large needs to be considered more broadly than the doctor–patient relationship, inclusive of the social processes that contribute to health disparity. While parts of the strategic plan resonate with the school’s social responsiveness, the culture of the school, as deducted through interviews with the faculty, was that social responsiveness was to be principally met through the doctor–patient relationship, with little or limited self-reflection on the role and responsibilities that schools of medicine may have in preparing their graduates to locate the doctor–patient relationship within a social context, complete with unequal power relationships and unacknowledged racisms. As shown in the following chapters, the very nature of the structure of the curriculum, an historically departmentally based approach, has little room for linking humanities or a liberal education as a foundation on which to base the excellent skills and approaches to the patient-centred, culturally competent curricula initiatives.
Chapter Five: Actions and practices

This chapter describes the way the school practises cultural competence. It is structured into five sections. The first three sections are a description of the formal, informal and hidden curricula respectively. The fourth section discusses whether these three practices of cultural competence curricula are congruent, and the final section discusses the relationship between the governing values and variables (including perceptions) and practices of cultural competence. The formal cultural competence curriculum (espoused theory) is found in the school’s Undergraduate Curriculum Outcomes Database, and is outlined along with participant descriptions of cultural competence teaching and related pedagogy. The informal curriculum (theory in use) is described from the participant’s perspective, and finally the hidden curriculum is revealed by applying Hafferty’s four areas of investigation.

There are two main findings of this chapter. The first is that the formal, informal and hidden curricula are reasonably congruent in their practice of cultural competence (with some exceptions, which are highlighted). The second is that practices are both consistent and at odds with the perceptions. They are consistent in so far as cultural competence was described as a utility, employed to enhance the doctor–patient relationship, and inconsistent in that cultural competence was described as an extremely important element of the training of medical students, yet it is rarely explicitly evaluated or assessed. Further, that while most faculty participants viewed cultural competence as more than hauora Māori, there is little evidence of teaching cultural competence outside of the hauora Māori domain.

The formal curriculum

In this section I describe where participants (both faculty and students) described cultural competence as being taught. Where students learn about cultural competence is described in Chapter Six.

In 2006 the University of Otago commenced the Undergraduate Curriculum Outcomes Database (the Database) project to ‘articulate the learning expected of students during the…course’. (University of Otago n.d.f) The database was launched in August 2008 following a ‘rigorous and comprehensive’ environmental scan of
teaching and learning outcomes at the school (pers. comm., Anthony Ali Medical Education Advisor, 22 November 2010). These outcomes were discussed and refined with content domain teams from across the faculty, and, as such, the Database can be described as an articulation of the formal curriculum at the school. The Database is accessible to all educators involved with the curriculum at the school, and the maintenance, further refinement and development of the Database remain an ongoing project. The Database constitutes the formal curriculum and assessment map.

To contextualise the rest of this chapter, and to help locate the stages of the curriculum where teaching is described, a meta-map of the curriculum at the case study site is provided below. The curriculum is departmentally structured, and organised around a series of ‘blocks’, which correlate to domains of medical practice and disciplines (e.g. General Practice, Medicine, Surgery etc.). The course has several vertical threads, which are integrated throughout the course, some of which have dedicated teaching time allocated (e.g. Ethics and Professional Development), and others which do not, with the content expected to be learnt within and related to the content of the main discipline modules.
Figure 3: Diagrammatic overview of curriculum (accurate for 2008/9, when interviewed students were being taught)

The Database was searched to identify the formal cultural competence curricula. Searching commenced inductively with the terms ‘cultural competence’, ‘culture’ and ‘health outcomes’. Deductive searching was then undertaken, based on the emergent themes of the interviews, and included the search terms ‘Māori’ and ‘communication’. The full results generated are included as a table in Appendix E. The ‘hits’ returned from the Database were analysed to determine whether they related to cultural competence, taking into account the breadth of understandings within the literature and from the interviews. Hits that were not related to cultural competence (for example, cultures in pathology) were excluded.
Table 2: Summary of 'hits' from the Undergraduate Curriculum Outcomes Database

<table>
<thead>
<tr>
<th>Search Term</th>
<th>Total relevant hits returned</th>
<th>Hits in hauora Māori domain</th>
<th>Hits in other domains</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural competence</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Culture</td>
<td>10</td>
<td>7</td>
<td>3</td>
</tr>
<tr>
<td>Health outcomes</td>
<td>4</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Māori</td>
<td>37</td>
<td>36</td>
<td>3 (2 repeated with hauora Māori)</td>
</tr>
<tr>
<td>Communication</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total hits</strong></td>
<td><strong>57</strong></td>
<td><strong>53</strong></td>
<td><strong>11</strong></td>
</tr>
</tbody>
</table>

Table 2 displays a summary of the relevant hits from the Database, which shows that the great majority of cultural competence-related curriculum outcomes are located within the responsibility of the hauora Māori domain. The significant exceptions to this are those outcomes that emerged from the search under communication. Communication outcomes were described as the responsibility of all ‘blocks’, meaning that as part of an integrated and integral outcome this was the responsibility of all teachers and clinicians, including in hauora Māori.

**Cultural competence and culture**

The one specific return using the search term ‘cultural competence’ was located within the hauora Māori domain (HM036: Cultural competence and cultural safety – when working with Māori individuals, whānau, communities and organisations). The term ‘cultural competence’ did not appear anywhere else in the Database.

The less specific search term of ‘culture’ returned ten outcomes, which included one each in Psychological Medicine, Obstetrics and Gynaecology, Ethics and Professional Development, and seven in hauora Māori (see Figure 3 for location of these blocks across clinical school years).

This reflects participants’ observations that most of the cultural competence teaching is related to the hauora Māori domain, and almost all of the assessment, which is
described in more detail in the following paragraphs. The majority of participants and
the majority of their comments indicated that cultural competency was taught through
hauora Māori, with a reluctance to specifically describe it anywhere else.

Yeah, well, it’s sort of stating the obvious. [Cultural competence is taught] in the
general MIHI program (FP3).

And:

But certainly within the Māori health stream thread, there’s a very distinct focus
on cultural competency, from my perspective, although it’s not necessarily
termed in that way (FP12).

Students also overwhelmingly describe cultural competence teaching in the hauora
Māori domain:

Okay, well, I guess for me…when I think about cultural competence, it’s kind of
probably the stuff you learn…the Māori-related MIHI stuff, which is,
unfortunately, how it’s sort of boxed in my head in some ways. Because it’s so
clear that we’re going to MIHI. The majority of that is sort of around cultural
competence and learning about sort of a lot of Māori historical things and that
whole association and how you’re going to, how you should approach patients
and things (SP8).

This association of formal teaching of cultural competence with hauora Māori was so
strong that several students explicitly responded to questions of teaching cultural
competency outside of hauora Māori in the negative.

I don’t think there’s any. No, no, I don’t think there’s any. Probably when you
have a consultant teaching you in bedside teaching, probably they mention
something about, you know, being aware, you know, about the patient’s culture
and their beliefs, but there isn’t any formal teaching about other cultural
competence (SP10).

**Integrated teaching**

There were three outcomes that were allocated to more than one domain of teaching,
for example outcome PM044.
Table 3: Example of an outcome allocated to more than one domain of teaching

<table>
<thead>
<tr>
<th>Learning outcome</th>
<th>Module</th>
<th>Learning opportunity</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Generic clinical approaches - history, exam, decision making, practical procedures</strong></td>
<td>Hauora Māori Thread</td>
<td>Lectures</td>
<td>Oral Presentation</td>
</tr>
<tr>
<td>PM044: Negotiate a management plan in conjunction with the patient and their carers as appropriate, acknowledging the person’s particular culture and the place of Māori mental health and Health Pacifika services as appropriate.</td>
<td>Tutorials</td>
<td>Oral Presentation</td>
<td>Reflective comments</td>
</tr>
<tr>
<td></td>
<td>Psychological medicine</td>
<td>None identified</td>
<td>None identified</td>
</tr>
</tbody>
</table>

Outcome PM044 was to be met through learning opportunities in hauora Māori, as well as Psychological Medicine (the Alcohol and Addiction block). These opportunities were identified as lectures and tutorials in hauora Māori, and assessed in hauora Māori through oral presentations and reflective comments. There were no identified learning or assessment opportunities of this outcome in the Psychological medicine domain. There were also examples from the interviews where other domain areas were integrating, or planning to integrate, cultural competence. However, the responsibility for this teaching was still seen as the role of the hauora Māori team.

Yeah, so for example in Paeds at the moment I think for next year they are planning some cultural competence component, but that will be coordinated by MIHI (FP4).

And:

I know that [cultural competence] is occasionally in the professional development thread, in previous years MIHI has had a strong part to play in teaching (FP4).

The principle of whether curricula content is ‘integrated’, as opposed to simply vertically ‘located’, throughout the course is described in Chapter Two, and it is timely to revisit that point here. Integrated curricula require meaningful linkages with concurrent other curricula, and implicitly recognises an existing structure that it is being integrated to and with. While the outcome database is dependent upon the extent to which it has been actively populated by the relevant faculty, it also shows a lack of meaningful integration of cultural competence content, with the exception of
the description of communication skills (which were to be completely integrated across all areas of curricula).

**Communication**

As described in the previous chapter, there was a strong perception that communication skills as part of a patient-centred approach was an important element of cultural competence. The hauora Māori thread had a range of outcomes clustered under the sub-heading of ‘Communication and Engagement Skills’; for example, HM002: Effective and culturally safe communication with Māori patients, whānau and communities (see Appendix E), which had associated learning and assessment opportunities described and attached to the outcome. The communication skills thread itself in the clinical years had no specific learning outcomes or assessment described, and, consistent with perceptions, was focused on the doctor–patient interaction; for example, CS027: Adapt communication according to differing patient knowledge and expectations and differing doctor-patient relationships (see Appendix E).

There was significant congruence between the formal curriculum as outlined in the Database and faculty and student descriptions of where cultural competence was taught. This mutual reinforcement of the espoused curriculum from three related sources (the Database, the teachers and the students) provides a rigorous and reliable view of where cultural competence is formally taught.

**Other teaching**

Faculty participants were less confident to describe the teaching of cultural competence outside of hauora Māori, but did hope or expect that it was a stream that ran throughout the course:

There’s more formal teaching and more sort of overt teaching of [cultural competence] when the students come up from Dunedin and they have a trip to a marae and sort of cultural introduction at that stage. I’m wondering if there are any other specific?…there’s the teaching that MIHI provide for the students. They rotate through there and I’m not sure whether there are other courses [that] provide a specific sort of cultural component (FP11).

Strikingly, only twice did students identify cultural competence learning opportunities external to the hauora Māori:
I think more recently I can remember specific kind of days that we’ve done in our professional development courses (SP3).

This was matched by the faculty participant responsible for teaching professional development, who said:

And I used to be responsible for the professional development part of the thread…and so I made an effort to sneak some, what I consider to be cultural competency sessions into the professional development part of the program and so we did it as a sort of formal part of the curriculum. So we had some sessions which, and I don’t think I was the first person to do it, but, it was just that I inherited that part of the curriculum. So we had some sessions where we tried to introduce the concepts and the definitions but we also invited some speakers who had different cultural backgrounds to come and share just some of, you know, how that impacted for them or what it meant for them (FP6).

Another student had a less positive recollection of the teaching of cultural competence in professional development:

We learn [cultural competence], like, I mean – most of the time they try to emphasise it in professional development. But it doesn’t, if I am to be honest, it doesn’t really work. I slept most of the time (SP6).

The next section describes the pedagogical approaches adopted to teach cultural competence within the formal curriculum, as described by the participants.

**Where is the formal curriculum taught?**

Although the focus of this case study is the clinical school of the Christchurch School of Medicine, students were able to recall some teaching before their clinical years, during what is called Early Learning in Medicine (some of the relevant content of Early Learning in Medicine is discussed in Chapter Eight). Their views of the teaching of cultural competence in the preclinical years was limited, but what they did recall was that it lacked relevance and was moderately well received, at best:

in second and third year we had a bit of teaching, sort of didactic teaching, lecture type stuff, which probably wasn’t that well received. And we came up here with that sort of in the back of our minds, going, ‘oh, here’s some more cultural stuff’ (SP5).
Even though the preclinical context may not have been so well received by students, they were aware of the relevance and importance of having some teaching in the introductory weeks of clinical school, and then subsequently being able to apply it:

once you hit clinical school obviously you’re going to be exposed to the patients and exposed to situations in which it is important. And I think having had that at the beginning of the clinical years, you sort of learn as you go through the clinical years (SP5).

Consistent with the perception that cultural competence is a skill to be utilised as part of the clinical encounter, the rationale for teaching and practising it in a clinical context was described as follows:

it has to be a patient–doctor interaction and that tells me therefore, it might be best done in a situation where students interact with patients (FP2).

However, it was also acknowledged that if cultural competence is a skill, students should have a chance to learn about it and practise it before they ‘actually do it’, similar to a technical skill, such as suturing or administering an injection, which may be practised on the skin of an orange before the skin of a human is perforated.

you could make the argument that before students can do it in real time, they have to be able to rehearse it in non-real time. So they might have to think about it and write about it for a start, before they can actually do it (FP2).

Students describe the integrated approach as important, and, again, the clinical perspective ‘validates’ the time allocated in the curriculum:

it only really becomes valid when you’re put in the clinical situation and you can actually see the importance of what you have learnt. So I think it’s quite good in the way that we have had it (SP2).

Kai et al. (2001:250) supports the notion of an integrated across-curriculum approach, stating that ‘training needs to be integrated across the different stages of the medical curriculum, and that locating training only in the early undergraduate years will be inadequate’. Vega (2005) also argues for cultural competence curricula to be best located in the clinical context, and then goes on to make the link between cultural competence and disparity in health care:
By making cultural competence training more focussed and operationally valid for clinical care, its value will be more readily perceived, as will the intimate relationship between cultural competence and the remediation of disparities in care (Vega 2005:448).

Discussion with the faculty and students about where they described cultural competence as being taught is remarkably consistent with the formal curriculum, as mapped through the outcomes database. The inclusion of formal curricula related to cultural competence in the preclinical years has changed significantly since the final-year students who participated in this research undertook their preclinical training.

The practices of cultural competence are all clinically based. There are few formal curricula that engage with the ‘critical’ approach described in Chapter Two. The supporting curricula for cultural competence are linked with communication skills and knowledge about Māori. This is discussed in greater detail in Chapter Eight, but, for observation and comment here, the foundation content and theoretical underpinnings for cultural competence are in the clinical sciences, or the learning about another ‘static’ culture. There is little humanities or sociological foundation for the teaching of cultural competence, and even the hauora Māori thread is conscious to include a clinical element to its teaching.

Knowledge and skills

Faculty participants were asked to ‘unpack’ cultural competence in terms of knowledge, skills and attitudes. Most described the three domains as inter-related and interdependent, similar to the literature that draw upon the three-legged stool analogy to describe the relationship between knowledge, skills and attitudes (Betancourt 2003; Sue et al. 1992). Knowledge is most aligned to the formal curriculum, and as described in the next section, attitudes and skills are most aligned to the informal curriculum. Communication skills, for example, while well described and outlined in the formal curriculum database, were described by students as being learnt as applied skills through the informal curriculum.

The informal curriculum

The informal curriculum targets learning at the level of interpersonal interactions…The concept of the informal curriculum also allows us to better
address and assess the importance of role models in the learning that takes place at all levels of medicine (Hafferty 1998:404).

Both faculty and student participants described elements of the informal curriculum, most strongly in terms of the impact of role models and the notion of learning by *osmosis*.

I always think a lot of medicine is sort of by osmosis. If you’re there and you’re around, you’ll pick stuff up all the time, even if you don’t really make, you know, well, you make an effort (SP8).

The informal curriculum was most often described as influential in the clinical context:

I think this is probably a really powerful part of how students learn about this. That we know that the most influential things on students is just what they see happening. So, for example, students coming in, sitting in consultations and taking part in consultations, observing our interactions with Māori patients, Pacific Island patients and so on. How they differ from how we interact even maybe subconsciously with *Pakeha* patients and then the brief discussion that goes on around patients on a sort of individual case-based approach after seeing patients together. I suspect that students pick up a lot of what we’re thinking and what we’re doing and how we’re behaving and interacting with patients and just as they progress through their clinical attachments without us really thinking much about it. Now that’s potentially a good thing because they might see some good practice. It might be a good thing because they see and recognise some bad practice and maybe challenge it and even if they don’t maybe reflect on it, but it is not necessarily considered and overt but I think important (FP11).

The consistent theme of the relationship between cultural competence and hauora Māori continued to be evident in the informal curriculum, where it was a Māori patient that provided a trigger for clinicians to consider cultural competence teaching (see also previous quote):

The more powerful bits are then in the clinical settings, that approximately a third to half the patients on the medical wards, when you look in the charts, do identify as Māori and from time to time I can address this. So we do clinical teaching on how to find specially breath sounds and then sort of almost casually mention,
‘And what did you notice on the bedside which tells you this patient had a Māori record?’ It’s normally there. It’s normally there loud and clear. And students often fall over backwards, because if you don’t look, you don’t see (FP3).

The impact of role models was highlighted by both students and some educators, with a senior clinician describing:

And it tends to be very powerful when I mention, amongst many other issues, students need to think about as they learn to take a history and to examine patients, integrate the findings, to say, ‘And don’t forget, there are also cultural aspects’. It tends to be very powerful if it comes from me in a clinical environment (FP3).

And a student commenting:

I think having really good mentors. I don’t think they even realised they were really good mentors. They gave really good examples and it’s just seeing how it’s done in different ways. I suppose that would be the informal part of how I was taught (SP4).

Other examples of the informal curriculum were when the teaching of cultural competence was included because of the personal or professional interest of the teacher.

So that was kind of the formal part of the curriculum but the more informal part is that whenever I’m doing the tutorial or we’re having a case discussion in either ethics or PD [Professional Development], if there’s something that is relevant to cultural competence I tend to try to highlight and discuss it. So it would be discussed quite a lot when the topic might be something like, I don’t know, ethics around end-of-life care. You know, that’s a perfect example where we know that cultural views and values around death and dying can vary substantially as well as personal ones and so I would try to sneak it in if it was relevant where I could, just because I think again ideally, while it’s got its own core formal curriculum if you want to call it that, we really want it integrated as part of what we do day to day in terms of how we interact. So it was just sneak it in when you could kind of thing (FP6).

The informal curricula input based on personal or professional interests of clinicians and educators can be both a reinforcing and an undermining influence for students. At
the level of the professional, Schön’s (1987, 1995) notion on reflection in action and reflection on action can be applied in relation to clinicians being aware of their influence on medical students. As mentioned in Chapter Two, there is a strong similarity between Schön’s approach to organisational learning and the role of the reflective practitioner in the health science literature. The reflective practitioner is most often applied in a context of the doctor–patient relationship, and is relevant to this study. However, the reflective practitioner is also important in relation to how the practitioner reflects on his or her influence on the learning experience of the students – the informal curriculum.

The lack of identified responsibility for teaching or leading cultural competence curricula was also an emergent theme:

I don’t see it as being my ownership, you know, I am quite happy to contribute (FP14).

A reasonably expected outcome from lack of explicit allocation of responsibility for teaching is either repetition of content or no content because of a perception that the content is being delivered by someone else.

The awareness of the presence of the informal curriculum, especially when thinking about the ‘patient’ part of patient-centred medicine, was put in a historical context by a faculty participant, who reflected on the teaching of behavioural science, which he called the precursor to cultural competence:

And you sort of learnt it in clinical, yes, as well, but it was never taught, you sort of learned it in the informal curriculum rather than the formal curriculum (FP1).

Immersion

The students perceive that the teaching of cultural competence is in the hauora Māori thread, and highlighted the pedagogical approach taken, which was an immersion experience.

we had a great session that must have been beginning fourth year, we spent one or two nights out at the marae down in Akaroa. And I think those sort of block courses that we do here are really effective because it’s sort of intense learning
and it helps you – things stick as opposed to go to a tutorial every other week (SP2).

This teaching takes place at Onuku marae, which is a 90-minute drive from Christchurch, and is located a short distance from Akaroa township. Faculty (hauora Māori and some others) and all students spend two days and nights cohabitating at the marae at the beginning of their three years at the clinical school. It is a world away from the more oft used teaching environments in the hospital, at the bedside or in the medical school lecture theatre. Compared to the usual teaching environment for medical students, it is an exotic location, and generally a noteworthy experience for the students.

I guess formally, when he held that camp for us at the start of fourth year, that was awesome. That was really, really good. That was better than, they kind of sat everyone down and just talked to us, and that was better than any other formal teaching session I’ve had actually (SP4).

Cultural immersion teaching in medicine is described in other contexts such as Hawaii, New Zealand and North America as an approach to teaching Indigenous health (Crampton et al. 2003; Kamaka 2001; Kai et al. 2001; Dowell et al. 2001; Kreitzer et al. 2008; Zink et al. 2008). As Dowell et al. (2001:243) describe:

Cultural immersion has been used as an educational approach to enhance cultural competence. Its basic premise is that immersion in culture and language is the most effective way to learn about oneself and about another culture.

Zink et al. (2008:354) describes a rural location as the immersion site to engage students in a rural experience:

Immersion learning expands the definition of clinical education and, as a result, students extract value and meaning and synthesize content and professional role behaviours from the breadth of experiences.

Kamaka (2001: 512) describes a cultural immersion program for Native Hawaiian physicians, with the aim to:

teach community physicians how to become more culturally competent and to see whether adding an intense cultural immersion experience would increase the success of the curriculum.
Interestingly, the notion of ‘immersion’ in this case study, and in the literature described, has been applied to teaching and learning environments outside of the traditional teaching and learning environments. It should not be overlooked that students are ‘immersed’ in medical school and hospital environments for significantly much longer periods of time than the exotic immersions into a rural, Indigenous or other environment. It appears that the identification and naming of ‘immersion’ is only undertaken when the program is exotic to the ‘normal’ medical school environment. Consistent with criticisms related to cultural competence as potentially reinforcing the Other, the description of teaching at Onuku marae as immersion teaching, without acknowledgement of the obvious paradox – which is that the much longer ‘immersion’ takes place for the other 750+ days (minus the two days offsite) – is instructive. The description of block teaching modules offsite as immersion is revisited in a discussion of slang later in this chapter.

This hauora Māori immersion learning opportunity modifies and pauses for a few days some of the governing values and variables and norms usually experienced as the culture of medical school. The structures, expectations and day-to-day rules are different. On the marae, Māori is normal, and medical students are a welcomed Other, if still a curiosity. Faculty and students share the sleeping quarters in the marae, they eat together, there are no white coats. Māori beliefs, values and experiences are engaged with in a Māori context. The usual informal curriculum is perturbed, with students being welcomed into the whānau. The traditional medical hierarchies are paused, with senior clinicians and heads of department sharing meals with students on the same table, in an environment not ‘normal’ for either of them in the context of medical education. The immersion program is scheduled at the beginning of the clinical training years, and includes patient simulation activities to provide a clinical scenario and to help students make the links to clinical relevance.

The coordinators of the hauora Māori teaching program on the marae describe elements of what they teach as cultural competence, but that cultural competence is only a part of what they are teaching.

Well, I think that hauora Māori has components of cultural safety and cultural competency in it, I don’t think it is cultural safety and cultural competency but it...has components of cultural competency and cultural safety (FP9).
**Attitudes**

Attitudes of clinicians are most evident through the informal curriculum, unlike the transmission of knowledge and skills, which, as described in the previous section, was most obvious in the formal curriculum. If the analogy of the three-legged stool remains true, the attitude displayed and learnt must be consistent with the knowledge and skills. The following quote demonstrates the link between knowledge and attitude:

> And then in terms of attitude…there’s been a lot of debate about whether you can change attitudes. I think you can but I think it’s an output or an outcome of being able to ‘do’ the knowledge and skills…we have never ever set a goal that says we will change attitudes, I think that’s too complex…I don’t try and change their attitude, I just try and change their, you know, teach them skills so that it will change their behaviour and what happens from the students that I’ve interviewed is that when they do it and act the skills we have taught them they freak out about the response from the patient and therefore it changes their attitude towards doing it. So like, at first, they will say, ‘oh, whakawhanaungatanga is a waste of time’ and then they are trying to interview a patient and they don’t get anywhere, and then they go, ‘oh, I am going to try whakawhanaungatanga’ and then they do it, and then they’re shocked about what happens. And so it reinforces their behaviour and then they get to see another side of the patient that they couldn’t see using a biomedical model. Therefore it changes their attitude and they become a stronger advocate and they stop believing stuff they see in the media. They stop, you know, the social political environment has less of an influence on them. And so, yeah, that’s how I see it fitting in to, so we don’t focus so much on attitude but we have noticed it’s a natural by-product of the skills and knowledge (FP9).

**The hidden curriculum**

I have drawn upon Hafferty’s (1998) work in terms of directions to take in revealing the hidden curriculum, including describing relevant evaluation, resource allocation, institutional slang, and policy and policy development as areas to explore to uncover the hidden curriculum.
Evaluation

What is evaluated and where is a significant element of the hidden curriculum. ‘Layers’ of evaluation will be discussed, including AMC evaluation, and evaluation (through assessment) of student learning. Evaluation of the medical school by the AMC reflects important messages back to the school in regards to what the accrediting body observes during its visit, and of what the school itself values. The University of Otago, Christchurch, School of Medicine, in its accreditation visit in 2008, received the longest possible re-accreditation of six years. There was no mention of cultural competence specifically in the report, but it did acknowledge the strength of the hauora Māori teaching team, and made two critical points. There is a recurrent strong theme of encouragement and support for the efforts that the faculty makes with regards to hauora Māori, and the report recommends that:

the Hauora Māori domain remain distinct and that responsibility for broader aspects of cultural diversity is dispersed more widely among Faculty so that the few Hauora Māori staff are not expected to take the lead role for cultural diversity as well as their own area of Hauora Māori (AMC 2009a:245).

The AMC does not specifically report on the efforts and progress to meet the graduate attributes as they relate to cultural competence, except in the context of cultural diversity curricula.

Student evaluation and assessment

By and large, cultural competence is assessed in relation to the hauora Māori domain, with very little explicit assessment anywhere else. If student learning is driven by assessment, then it follows that what a school values in terms of learning outcomes will be reflected as part of a program of assessment. There are two reasons for this. The first is to evaluate the effectiveness of teaching on student learning, and the second is to evaluate whether the school is on track to graduate junior doctors who meet its graduate profile, and thus ensure its actions are consistent with the governing values and variables.

An overview of assessment of cultural competence within the curriculum was provided by a faculty member, who said:
I think it tends to be predominantly within the hauora Māori component and as we know, that is not equivalent to cultural competence, but I think that’s sort of where we’re at. Is it assessed anywhere else? Probably not. Not explicitly anyway (FP2).

This was echoed by student perceptions of where they were assessed in cultural competence:

we had to look at the statistics, the difference between health outcomes in particular of Māori versus Pakeha, things like that. So sort of different ones but it [cultural competence assessment] is mainly through hauora Māori. We don’t get assessed from anyone else on cultural competence (SP2).

It was observed that assessment within hauora Māori included knowledge (such as health outcome data, as described above) and application of knowledge and skills in what is named the MOSCE (Māori Objective Structured Clinical Exam).

I think our Māori OSCEs that we had…They weren’t pure cultural competence assessment, but the medicine side of it was fairly straightforward and it’s nothing that should’ve worried any of the students, if you know what I mean? So it was more a matter of, ‘Are you able to communicate? Are you able to communicate in a way that’s culturally competent?’ So I guess they were our main sort of assessments (SP8).

The MOSCE was carried out in the students’ fifth year, and included the learning outcome, ‘Demonstrate the principles of cultural safety, competency and literacy with the health environment’ (University of Otago, Christchurch 2010:np). The marking criteria for this MOSCE specifically focuses on communication skills and knowledge relevant to Māori. A student recollection of the focus of the MOSCE was:

The [aim of the MOSCE was an] ability to create rapport, especially before you get down to the nitty gritty of what they’re there for, getting a bit of background and a bit of… ‘Right, this is my name. This is where I’m from. What’s your name? What’s your iwi or are you from around here? Where’s your family from?’ (SP7).

The literature on assessing cultural competence through Objective Structured Clinical Exams (OSCEs) is limited. Green et al. (2007:348) cultural competency OSCE station at Harvard Medical School is described as a ‘powerful teaching tool’. They discuss
the advantages and disadvantages of having just the one cultural competency OSCE, which, by implication, further marginalises where and how cultural competence is taught rather than having elements of cultural competence in many more OSCE stations. The parallel for the Christchurch medical school is the use of the MOSCE, and the potential that this has to lead students to think that cultural competence is only therefore assessed with Māori patients. This is reflected in the student comment below, that students mostly saw ‘stereotypical New Zealanders’, which by implication meant that they have no culture, or at least no cultural dissonance with the medical students and clinicians.

Several participants described as implicit the attitudinal assessment of cultural competence.

It’s implicitly assessed… I think the attitudinal part is probably the most important at the end of the day with this, and that’s a hard thing to assess other than for somebody who’s maybe spent some time with a student, observe the student, particularly interacting with Māori patients, Pacific Island patients (FP11).

In 2001 the school developed and implemented the Professional Attitudes and Skills Assessment Form (PASAF) (see Appendix F). The PASAF provides a tool for clinical supervisors to measure and monitor professional attributes including, “Clinical Skills, Tutorial Performance, Communication and Teamwork Skills and, Attitudes and Behaviors’ (Fontaine and Wilkinson 2003:130). This includes areas described as relevant to cultural competence by participants, such as ‘communication skills towards patients’, and ‘demonstration of appropriate cultural, religious and ethical sensitivity’ (PASAF see Appendix F). However, this is not described by participants in this study as a tool that has been used to explicitly assess cultural competence.

There’s also a part of our assessment of student performance in every module…it’s called a PASAF form. There’s an attitudes…section to that form and students are marked on pass, fail, distinction…And in the attitudes of behaviours we give certain areas that any module convenor can use…So one of those areas is sensitivity, cultural sensitivity and I don’t know the actual term…but if there were some issue with students they would be brought under that category. So by default, module convenors are assessing in that category. Theoretically they are [assessing cultural competence], it doesn’t come up as a
term that they have…It doesn’t come up in every form that they say, you know, culturally sensitive and whatever. So while not specifically highlighted in terms of comments, it is implied that it is one of the areas that is being looked at and the students are being assessed on (FP8).

This implicit assessment was recognised by students:

In other cases, I don’t think it [cultural competence] is assessed at all really…By the time you get to the end, or by the time you get to the clinical years, a lot of your work is clinical and a lot of your assessment is based on, I guess, impressions from senior staff. So how well does this person go in a number of areas including, you know, procedures? And one of those areas is, say, communication, which I guess could include aspects of cultural competency. In practice, I don’t think it necessarily does, unless you were particularly good or particularly terrible (SP9).

Limited formal and explicit assessment of cultural competence sends a strong hidden curriculum message about its relative importance. Both students and faculty can perceive it as less important than other parts of the curriculum that are assessed, as described by a faculty participant, who said:

you can’t assess everything and you’ve got to assess sort of things that are representative of the things you think are important (FP2).

This differs to how the faculty described the importance of the presences of cultural competence within the curriculum, which was that it was very important. The small amount of the current cultural competence assessment is in the hauora Māori domain, reinforcing the view that cultural competence is something that is required only when dealing with patients who are ‘different’ and, in this context, ‘Māori’.

One of the effects of having cultural competence teaching and assessment so strongly associated and linked with the hauora Māori domain is that the message students receive is that only Māori patients have a culture. Further, that patients of similar ethnic or cultural background to themselves do not have culture. This was revealed by a white, male, local student, who said:

I mean, we’re getting assessed with our communication skills right the way through fourth and fifth year and I think that if you were found wanting with that,
then that would be picked up along the way sort of more…I’d be loathe to say that we have that much cultural competence assessment during that period, just purely because the amount of patients we get are generally stereotypical New Zealanders (SP5).

This is contrasted by a student who will often occupy the place of Other in Christchurch: a female, hijab-wearing Muslim, who, when asked about assessment of cultural competence, replied:

> Usually every time that I have my viva or my OSCE because…like I mean at the end of it, they even have the patient feedback, ‘How likely are you to come back to the doctor?’ So I guess that’s obviously cultural competency. Yep. So, like, I mean, every time, so basically I can say that every time that I have my OSCE or viva I was being assessed for my cultural competency as well (SP6).

This positioning of ‘minority’ student or health provider as the Other was also described in Canales and Bower 2001 where Latina nurses were more likely to describe broader constructs of disadvantage, rather than just describe some ‘cultural characteristics’ of a ‘different’ group:

> The ‘point’ for these Latina faculty participants was an understanding of teaching that focused on broader constructions of the Other and the phenomena of ‘Othering’ (Canales in Canales and Bower 2001:107).

Lypson et al.’s (2008:1081) experience of multicultural education to medical students shows that unless students recognise formal assessment, student perceptions arose that the non-formally assessed areas were ‘not essential to their education’. The influence of this part of the hidden curriculum is that, without formal assessment, and left to the non-specific, albeit related assessment of communication and cultural sensitivity on the PASAF form, cultural competency was not essential. Van Der Vleuten and Schuwirth (2005:315) describe the importance of a programmatic approach to assessment: ‘What really matters is that the assessment programme should be a integrated part of the curriculum.’ What is apparent through a review of cultural competence assessment is that it is not programmatic, and not a whole-of-curricula approach, consistent with the findings of the Database, which also showed an inconsistent approach to cultural competence assessment. The one Database outcome that specifically included cultural competence is assessed, within the hauora Māori
domain, including the use of OSCE and written assessment. Very few of the other proxies for cultural competence were explicitly described as being assessed.

**Resource allocation**

There are several perspectives on how to ascertain resource allocation within a medical school. One of the most obvious, and perennially debated and discussed, is curriculum time, regardless of the domain. The cry is often heard that there isn’t enough ‘x’ content in the curriculum, and that ’y’ gets too much time (most often heard from surgeons, in relation to a perceived lack of anatomy).

The structure of the Christchurch medical course into domain blocks (related to departments) is one way to allocate time (see Figure 3). Each ‘block’ is allocated a certain number of weeks, while other content, such as Ethics, Radiology or hauora Māori, is vertically integrated across the three years. Some vertically integrated modules are allocated specific time within the existing blocks (for example, Thursday afternoons from two o’clock to five o’clock), whereas other threads are not allocated any actual curriculum time, but are expected to ensure their learning outcomes are met through experiences that are expected to arise throughout the clinical years. For example, the Learning Outcomes Database indicates that the ongoing development of communication skills is vertically integrated, with faculty expected to fully integrate, interweave and identify ongoing opportunities for development of those skills within the existing blocks that the students experience. According to the Database, cultural competence gets very little explicit (either independent or integrated) curriculum time.

Curriculum time was described as a barrier to provision of cultural competence learning opportunities by many faculty participants (this is discussed in more detail in Chapter Eight); however, it is important to note that the structure of the course, and the allocation of resources, can create the perception for students and faculty alike about the relative importance and privileging of some content over other content. There are pedagogically based rationale and strengths to pursuing an integrated approach to teaching some material. Integration per se does not indicate that content delivered this way is secondary in importance to content delivered in a block.

Nevertheless, the content and associated learning outcomes need to be visible to students and faculty. An integrated curriculum isn’t analogous to an invisible one.
External to the MIHI, there are very few Māori staff, including Māori clinicians, with whom students come into contact as part of their learning. The reasons for this are multifactorial, including the significant underrepresentation of Māori doctors in the health workforce (described in Chapter Two). External to MIHI there are only four Māori faculty members, none of whom has a role as a clinical supervisor or mentor for the medical students. The AMC in its most recent (2008) visit stated, ‘The Team encourages the Faculty to act on its intentions to continue to recruit [Māori] staff and provide support to sustain and grow the development of the Hauora Māori program’ (AMC 2009a:17). The small number of Māori staff outside of the hauora Māori unit is an important part of the hidden curriculum. It reinforces the view that Māori are patients, or, at least, they are not clinicians. Māori are primarily represented through the curriculum as patients, or as the few faculty members who teach hauora Māori. Very rarely are Māori seen as doctors. It follows for learners that, with the focus of cultural competence in the hauora Māori thread, Māori patients have an extra element for the medical student to grapple with – not only the biomedical demands of the presenting complaint, nor even just the biopsychosocial or patient-centred elements to make sense of, but also the cultural. It reinforces the view of Māori as patient. If the teaching and learning of cultural competence is interchangeable with Māori, a reasonable learning outcome that follows is that only Māori have culture.

The underrepresentation of Māori clinicians and staff more generally within the school, unacknowledged, reflects and reinforces the surrounding social structures, with roots in the effects of the ongoing processes and realities of colonisation in New Zealand. Without due acknowledgement, and a visible, articulate strategy and plan to match the vision of more Māori staff within the school, the impact of unequal power relations as a consequence of colonisation continues. This message is reinforced and reflected in perceptions and aims of cultural competence training, which was to improve individual patient outcomes, with little relevance to the issues of racism, class and social forces that shape disadvantage, as described and represented through Figure 2.

Where Māori doctors were present and recognised, students were moved to comment on their interaction with patients, and thus provide a potentially powerful role as mentor and role model.
The ones that I’ve seen…paediatric surgeons… they sort of have quite a cultural background, one of them is almost certainly Māori and one of them is sort of Pacific Island background and the interactions they have with the Māori or the Pacific people is quite different to what you see with some of the other consultants (SP5).

**Student cohort as hidden curricula**

An interesting exercise is to consider the impact of the student demographic and its impact on curriculum. Consider this: if all the medical student cohort was Māori (perhaps with a couple of special entry Pakeha students), how would this shape the teaching of cultural competence? Would the focus move to understanding Pakeha culture as the conduit to deliver cultural competence curricula?

One influence of the hidden curriculum in relation to the ethnic demographic of the student body is that cultural competence becomes a proxy, slang possibly (see following paragraphs), for teaching non-Māori about communicating and treating Māori. With the curricular focus on cultural competence closely related to hauora Māori, the impact of the presence of even a couple of Māori medical students became noteworthy in this study.

Yes, there has been a couple of occasions where the influence of culture has come up early. And sometimes it’s not even the Māori students themselves, but I think having the Māori student in that group influences the other students’ attitudes and awareness of this (FP4).

The role and impact of the demographic constitution of the student cohort is discussed in detail in Chapter Eight, with a focus on its impact on the professional values of the future professional culture of medicine, and as an approach to address disparity in health care outcomes.

**Institutional slang**

The most obvious example of institutional slang is the use of Māori for cultural competence. If students are competent at issues ‘Māori’, then they are culturally competent. This can be seen in the interviews and the formal and informal curricula, and much of the governing values and variables, including the approach of the AMC.
There are several issues associated with this, including that other cultural groups (including non-ethnically defined groups) may become invisible in the shadows with the spotlight on Māori cultural competence. Being culturally competent in contexts other than Māori relies on transferability of skills into other domains. It also places a significant burden on the hauora Māori teaching team (recognised by the AMC and described above) to deliver curricula outside of its area of responsibility. Cultural competence is slang for ethnic competence (Kumaş–Tan et al. 2007) or Māori competence. This was stated by one Māori academic, who said:

I’m not overly keen on using the word cultural. If it’s Māori, it’s Māori. If it’s aboriginal, it’s aboriginal. If it’s, you know, your sexual connotations, that’s what it is. It isn’t a cultural thing. This is what it is. So I’m kind of a bit definite about that (FP15).

However, many other identities experience disparity in health outcomes, including those relating to ageing, sexuality and gender.

Competence is also slang. Linking competence with culture can be misleading, such that students and faculty stereotype individuals, and that displaying competence with one patient who presents as ‘cultural’ may become the baseline learning experience, a hurdle jumped, and a competence achieved. Competence is also contradictory to lifelong learning.

As previously discussed in this chapter, the description of offsite block learning was often described by students and some faculty participants as an immersion program, notwithstanding the fact that the majority of teaching and learning time is located within the hospital or doctors’ clinics in a range of clinical rotations.

The other two phrases that appear to be used as slang are ‘patient-centred approach’ and ‘communication skills’. While these are well understood and generally accepted elements and attributes of a proficient physician, the patient-centred approach, taught independently and not related to broader social processes, obfuscates and diverts attention from the root causes of health disparity. Racism and discrimination are terms rarely found in medical curricula documents, despite the evidence of unequal treatment.
**Policies and policy development**

The ‘Welcome from the Dean’ web page highlights the vision of the Christchurch campus to be a research-led campus. (University of Otago n.d.g) This, of itself and in isolation, isn’t instructive to the study. However, consideration of what is not included in the vision is instructive. To be engaged with research, and to be in a position to compete in a competitive grants environment, requires a significant level of opportunity of access to education and support to complete the research. The vision statement, innocuous as it is, places a value on research above many other things. In contrast, The University of Pennsylvania, an Ivy League university and rated as one of the top five medical schools in the United States, has the following as its mission statement:

Our mission…is to train medical students, residents, and physicians to provide culturally effective and appropriate healthcare. This includes the ability to understand the language, culture, and behaviors of diverse individuals and their families. We aim to increase self-awareness and the potential cultural factors that affect interactions with patients (University of Pennsylvania n.d.)

The involvement of Māori voice and perspective in policy development was highlighted in the 2004 AMC visit to the faculty, where the accreditors stated, ‘Hauora Māori is underrepresented at the deanery level and an appointment at Associate Dean level could be considered’ (AMC 2004:20). This was acted upon by the faculty with the appointment of an Associate Dean (Māori) across the faculty. The self-stated governing variable, described as the strategic imperative to focus on the recruitment of Māori staff, in not a policy: rather, it is a strategy. This was commented upon by the AMC, in 2004, which recommended ‘improved staff resources in relation to Māori health, particularly Māori staff members’ (AMC 2004:2).

The University of Otago has a Māori Strategic Framework, the thorough and meaningful implementation of which has been overlooked as a vision for the school. This is in contrast to the focus on research, in the self-stated values articulated through documents such as the Dean’s welcome web page.
**Congruence of practices**

The relationship between the three practices of the formal, informal and hidden curricula is complex and inter-related. With regards to the importance placed on teaching cultural competence with a focus on Māori, some elements of the formal and informal curricula are well aligned. However, the hidden curriculum, as seen in terms of resourcing faculty through staffing and curriculum time, and evaluation of students, is inconsistent with this approach, and indicates a lower priority placed on it.

The formal curriculum describes cultural competence primarily in the hauora Māori thread, whereas the informal cultural competence curriculum is taught in the context of a clinical environment (mostly using Māori patients as a trigger). Hauora Māori, as a thread, has limited curriculum time, and the evidence from the Learning Outcomes Database raises questions about the extent to which it is meaningfully integrated, as opposed to vertically located, across all teaching blocks.

The formal curriculum describes only limited assessment in cultural competence and related areas, which is consistent with the hidden curriculum finding about the extent to which cultural competence is evaluated or assessed, and the way this reflects its prioritisation within the faculty. There are existing opportunities to evaluate and assess cultural competence through the PASAF, and this implicit assessment would reinforce what is learnt from the informal curriculum; however, it is reported that this is not done. Hafferty (1998) describes the importance of aligning different elements of the curriculum to send a consistent message to students about what is valued and what is core to learning as a medical student.

**Congruence between governing values, variables and practices**

There is some incongruence between the perceptions and the practices of cultural competence. This chapter shows that the practices of cultural competence at the Christchurch School of Medicine are both consistent and at odds with the perceptions. The structure of the section is consistent with the description of the governing variables, and refers to each of the described governing variables and its relationship with the practices:

- personal and professional values
- regulatory and legislative variables
• self-stated values.

**Personal and professional values**

The perceptions and practices are consistent is so far as cultural competence was described as a utility, employed to enhance the doctor–patient relationship, particularly in the training context in relation to Māori. This may be understood in greater detail by discussing the relationship between a patient-centred approach to medicine and cultural competence. Teal and Street (2009) describe the differences between a patient-centred approach and cultural competence. The Christchurch School of Medicine is at the stage of understanding cultural competence as patient centred, although with some awareness and acknowledgements that it is different. However, there is not yet clarity on what that difference is, and how the difference is best reflected in practice.

There is a tension between a patient-centred approach and an approach that inadvertently locates the patient as the Other (as seen as a potential interpretation of Figure 2). An approach to this tension is offered in Chapter Eight, and includes the role and relationship between the humanities and clinical education.

Patient-centered care emphasizes improving high-quality individualized care for all patients, while culturally competent care stresses equitable distribution of quality care among diverse and disadvantaged groups (Teal and Street 2009:534).

Given the longer history of patient-centred medicine, a model that many of the clinicians would have been trained under, or at least been significantly exposed to in their clinical years, it is an approach that is known. Importantly, Teal and Street include an element of cultural competence, which they describe as situational self-awareness. Situational self-awareness is broader than just the situation of the clinical encounter. In the case study site, situational self-awareness must necessarily include the awareness of the history of colonisation, and its impact on Māori–Pakeha relations. Further, situational self-awareness requires an awareness that most New Zealand-trained doctors are not Māori, and the way this demographic of the health workforce contributes to the construction of doctor–patient relationships in New Zealand. Parallel examples can be described the world over. In the United States, the situational awareness would depend again on the geographical location. In the south
of the United States, it may the relationship with Mexico, the role and socio-economic ethics stratification of the economy, or the history of slavery and the relationships between white and black. The medical profession is comfortable with describing and analysing the doctor–patient relationship within the clinical encounter. But much of the clinical negotiation is shaped by the broader social, cultural and political realities of people’s lives, including the doctors’.

Several participants talked explicitly about the link between cultural competency and patient-centred care. Indeed, one can argue that the generic skills are similar, but that they require content- and context-specific examples to practise and apply those skills. This becomes a recurring theme, which is essentially that race and racism in health care outcomes need to be dressed up as patient communication and clinical skills. Power, social advantage and disadvantage, often conferred by skin colour, are discussed by using the language of cultural competence, and hauora Māori, as slang for these generally unpalatable issues. As Drevdahl et al. (2008:14) describes:

any practitioner who hopes to ameliorate health disparities by providing culturally competent care faces the nearly insurmountable task of overcoming the formidable workings of power that keep structural disparities in play and in place.

The practices are also inconsistent with professional values in that cultural competence was described as an extremely important element of the training of medical students, yet it is rarely explicitly evaluated or assessed. Further, that while most faculty participants viewed cultural competence as more than hauora Māori, there is little evidence of teaching of cultural competence outside of the hauora Māori domain, supported by students’ descriptions of where it is taught.

**Regulatory and legislative variables**

The actions are, from the perspective of the AMC, consistent with the AMC accreditation team members’ perceptions of cultural competence. The AMC has pointed out in the past where it thinks actions are inconsistent with the governing values and variables of accreditation, and it hasn’t done this in regard to cultural competence. It must, however, be noted, that the AMC has rarely in the past decade mentioned cultural competence, and has had a focus more on Indigenous health and approaches to Indigenous health curricula.
**Self-stated variables**

The governing values and variables that capture the school’s social responsiveness, in particular to Māori, are in part reflected through formal curriculum initiatives. How much curricula is required to meet these requirements could best be answered not through a quantum number of curricula hours, but through successfully achieving graduate attributes or learning outcomes. Because of the almost absent assessment and evaluation of students in this regard, this is difficult to measure and comment upon.

The extent of the commitment to building the relationship with Māori, in particular obligations to Ngāi Tahu, by recruiting more Māori staff is a matter of degrees. Clearly, the AMC thought this could have been the focus of more sustained effort and resourcing. As noted, there are very few Māori staff external to the Māori-specific programs. This needs to be considered within the broader workforce demographic and availability of appropriate persons. However, the school, in its mission statement, acknowledges the need for capacity development and a reciprocally rewarding relationship with Ngāi Tahu, not based just on good will, but on Treaty obligations of equity, equal treatment and equal opportunity.

Many elements of the graduate profile can be observed in the curriculum, with the emphasis more apparent on some attributes than others. For example, ‘a commitment to the principles of patient-centred medicine’ and ‘knowledge of factors impacting on the health status of Māori and other cultures’ are represented through the curriculum. The ability to respond to obligations under the Treaty is a graduate profile that is less evident in the curriculum, particularly at the level of the doctor–patient interaction. The model discussed as Figure 2 indicates that perceptions of cultural competence are very much at the doctor–patient interaction. There is, perhaps, some conflict between the governing values and variables themselves, in terms of how the Treaty context may apply within the health setting, in particular with the training of medical students. This was evident through the use of institutional slang, such that cultural competence and hauora Māori are slang for addressing some of the broader social issues such as colonisation, race and power, and are inextricably related to the context and application of the Treaty. The extent to which the graduate profile is being met is a different question and one that will be discussed in the next chapter.
Conclusion

This chapter describes the three different practices of cultural competence by describing the formal, informal and hidden curricula. The discussion describes the congruence and incongruence found in the curricula, as well as the relationship between the governing values and variables, and the actions. The chapter describes the actions and practices, and provides the foundation for the next chapter, which describes what the students perceive they learn. Chapter Eight, the discussion, proposes a model that may assist in reflecting on the different curricula influences on the students, and working towards a congruency between them. Apart from the Faculty Curriculum Committee, there is no identified, dedicated structure or process to assist with this process.
Chapter Six: Consequences

This chapter describes and analyses final-year student perceptions of cultural competence. This is located within the conceptual framework as a consequence of the formal, informal and hidden curricula. The influence of the informal curriculum as a site of learning, in particular the influence of role models, is described. The extent to which the consequences of the teaching and learning (actions) were consistent with the graduate profile is considered in the context of the conceptual framework of the thesis. The main findings of this chapter are that without adequate evaluation and assessment, it is difficult to determine the extent to which the school is achieving its aims in relation to the graduate profile, or the legislative obligations of the Medical Council of New Zealand in relation to preparedness to practise in a culturally competent manner.

Student perceptions of cultural competence – what they have learnt

Having been subject to, and having experienced and interpreted, the curriculum, student perceptions of cultural competence are described as an outcome of their experience at medical school. I describe this as an outcome, although noting the multifactorial influences on student learning, including those factors outside of the broad context of medical school training. There were two major elements to how students described cultural competence. The first was that it was overwhelmingly described as a utility for the doctor–patient relationship. The second is that the ‘patient’ within the doctor–patient relationship had a different ‘culture’ that needed to be understood and responded to within the framework of a patient-centred approach. These perceptions are remarkably consistent with faculty perceptions and practices. I have repeated Figure 2 here (re-labelled as Figure 4).
Most students remarked that cultural competence was strongly linked to the doctor–patient relationship, more specifically a patient-centred approach, and as a utility to improve patient outcomes (as represented by arrow ‘a’).

my understanding is that for me to improve my relation with my patients and therefore I can improve the outcome from my management plans (SP10).

And:

[Cultural competence is] the ability to relate to people from all walks of life without offending anyone and gaining a good rapport, so that you can have a good medical relationship with them (SP7).

And:

And I guess it’s about having a relationship [that] allows you to convey information and get information from a patient, to help you understand them, to
help understand how they go about things and what’s important to them, which can hopefully help you treat them better (SP9).

These three examples are indicative of the student perceptions of cultural competence. Much less common were comments that leant towards a more ‘doctor-centred’ approach, describing the aims of cultural competence as improving patient compliance.

I mean, specific examples…compliance to medications are a biggie and we know that medication compliance is a lot lower than we’d like it to be (SP9).

Only one student made a comment that included reflection and acknowledgement of institutional influences, which was a central plank of Cross’ (1989) early definitions of cultural competence.

Better outcomes for your patients…Based on the fact that if you make hospital or a medical environment a shit place to be, people aren’t going to want to come. If they don’t come then they are not going to get the help they need. If they don’t get the help they need, they’re just going to get sicker. So I guess making it a place where they feel comfortable, where they feel listened to and then they can feel comfortable to come and then obviously we can have the follow-on effects in a positive manner as opposed to the negative manner (SP5).

Students’ descriptions of how they understood cultural competence are consistent with an anthropological approach to culture as static, with a focus on learning about the culture of others (arrow ‘b’). Students descriptions didn’t include any reflection that their professional culture may, indeed, be different:

I think it’s being aware of differences in how different cultures work, and their approaches to things, and how different cultures, their communities, are sort of set up like family structures and that sort of thing (SP2, my emphasis).

And:

And I guess the primary aim for it would be, you want to have graduating doctors who have a good degree of cultural competence so that when you deal with these patients, that you increase people’s, you know, ability to communicate with different groups (SP8, my emphasis).

And:
It’s being equipped and knowing what to do in terms of different cultures, people from different cultures (SP1, my emphasis).

The focus of the student’s understanding and perception of cultural competence was significantly constructed within the doctor–patient relationship (identified by arrow ‘a’ in Figure 4). Taylor (2003:555) talks about medical education, ‘which systematically tends to foster static and essentialist conceptions of “culture” as applied to patients’, which resonates with the findings in this case study. From the student’s perspective, the cultural competence component of this relationship was understood (arrow ‘b’) and practised (arrows ‘c’ and ‘a’) by acknowledging and integrating the fact that ‘some’ patients have a culture that may be different from the clinician’s.

The notion of locating the doctor and his/her culture as part of the relationship was not discussed or raised by student participants (box 2, Figure 4). Kleinmann, in Fox (2005:1316), asks:

If you can’t see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else’s culture?

This apparent lack of reflection on the culture of medicine, and the culture of the doctor, may be something that comes with a maturing clinician, as many of the faculty participants did recognise and describe this as an important element of cultural competence (as reported in Chapter Four).

**Which culture?**

Reinforcing the finding that how students learnt that cultural competence was about integrating elements of the patient’s culture (arrow ‘b’, Figure 4) into the doctor–patient relationship, the related question and critique that emerged was, ‘Why just Māori culture?’ This is best represented by the following quote from a student:

But I think specifically my cultural competence is not very, like, great at all. I haven’t learnt a lot about other cultures other than Māori or a little bit of Pacific Island kind of thing, yeah (SP3).

The other critique about this approach was the potential for it to stereotype patients from the culture being described; in this case, primarily Māori patients.
I’m wondering if the skills we’ve been taught are not transferrable across every Māori person. Perhaps if they don’t see themselves as Māori, if they just, you know, think, ‘I’m just a Kiwi like you, you know, why are you asking about my whānau?’ You wouldn’t ask her about her whānau (SP7).

Everything is really anecdotal and I think everything can be so individual…they seem to stereotype so many cultures and I just don’t agree with a lot of it…When they put such a large emphasis on treating people differently depending on what culture they come from, but because these days, different cultures are brought up in different environments, it doesn’t mean that a Māori person brought up in the middle of Christchurch can act quite differently than someone brought up in South Auckland, so, yeah, that kind of thing (SP3).

Students were aware of the heterogeneity within the cultural groups that they were being taught about, and the implicit conflict between being taught cultural norms and the individuality within that. This was highlighted by a student who indicated the impossibility of teaching ‘Asian cultural competence’, and the inherent paradox in such an approach.

You can’t teach it [Asian cultural competence], cause like, for some people in Singapore, they are quite open and liberal about things. Some older people are more conservative. People from Korea are a bit different. People from China and people from Malaysia are different as well. Like Muslim countries, it’s all really different and it would be very hard to teach (SP1).

**Communication skills**

Students were asked to describe the elements that define a culturally competent clinician. Communication was described as the foremost skill required. This skill was described as central to achieve the articulated aims of cultural competence, which were better outcomes for patients through an optimal relationship with the patient.

Because if you can’t communicate with the patient, then what’s the use? (SP10).

And:

Communication is huge and being able to tailor that communication to who you’re talking to. So, knowing what expectations are of that culture and how they deal [with] or view disease (SP2).
In the previous chapter, communication outcomes were tracked through the Database in relation to participants’ descriptions of communication as an essential component of cultural competence. Some elements of the communication outcomes in the Database were specific to facilitating a patient-centred approach, such as ‘CS010: Elicit and consider the patient’s perspective’. Other communication outcomes focused on specific skills for Māori; for example, ‘HM002: Effective and culturally safe communication with Māori patients, whānau and communities’. This is consistent with what students describe they have learnt. Student descriptions of the importance of communication as part of cultural competence and a patient-centred approach is also reflected in the previous chapter in the discussion regarding the relationship between cultural competence and patient-centred care, as described by Teal and Street (2009:533), who describe ‘communication as central to a successful medical encounter between physicians and patients’.

Knowledge of Other

Students always described knowledge elements of cultural competence as knowledge about the Other (Māori from non-Māori, Muslim from non-Muslim, Asian from non-Asian) and never about self, or the self’s part in reconstructing the professional culture of medicine, and never about learning about New Zealander or Pakeha culture.

For example:

If you have a Muslim woman come in, how to approach certain subjects in the examination and things like that (SP7, White New Zealand student).

And:

But also knowing the sort of protocols around different cultures I think is really important. One of the classic ones that we talk about here is if a Māori patient needs a post-mortem, you know, the importance of returning all body tissue back to Māori patients and things like that (SP2, my emphasis).

This learning about Other reflects what has been taught via the formal curriculum, and the linking of cultural competence with the hauora Māori domain. There were also other specific examples from students describing presenters as being representative of the Other, such as:
And we had, I think, an African registrar come in from psych and I remember a lady with a Muslim background, I forget what she did, came in and they talk about their experiences overseas and here and what the differences are and that’s been interesting (SP3).

There is no parallel comment relating to a presentation from, for example, a White, Christian surgeon and his/her experiences in Auckland delivering a presentation related to teaching and learning of cultural competence.

This is also reflected in the Database, where learning outcomes specifically related to knowledge about Māori were evident; for example, ‘HM016: Apply knowledge of Māori societal structures (e.g. iwi, hapu) to work effectively with Māori individuals, whānau, communities and organisations’.

One of the unintended consequences of this approach may be to increase the perceived cultural gap between the doctor and the patient by constructing Māori patients as increasingly different from their (usually non-Māori) doctors, rather than narrowing that gap with culturally specific knowledge.

**Attitudes**

Students described traits of culturally competent practitioners when asked about relevant attitudes. These include descriptions such as being respectful, being approachable and being aware of difference.

> It’s like, being able to adapt to a different culture without being judgemental, without being prejudice and without being sarcastic (SP6).

Student perspectives of appropriate attitudes can also be gleaned from their observations of their senior colleagues and their patients.

**SP5:** I don’t think that a lot of them have been taught cultural competence or believe in it.

**Interviewer:** And where do you get that impression from?

**SP5:** Probably background chatter. When you say, ‘I’ve got to go and do this assignment, have we got any patients at the moment that are Māori?’ ‘Oh, wouldn’t have a clue.’ [Clinician] That’s probably an
indicator to me that actually, ‘I don’t think that I [the senior clinician] really care about that sort of stuff’.

In the above reflection, the student was alert to the clinician’s attitudes towards an awareness of the presence of Māori patients. The student perspective of learning cultural competence through hauora Māori was that it was important to know if Māori patients were on the ward (an attitude that was not shared by the clinician) and, more importantly, were recognised by the student.

In general, participants had difficulty in describing attitudes that accompany, or identify, a culturally competent clinician, and were much more forthcoming when describing skills or knowledge components.

**Where students learn – the informal curriculum**

The students described the influence of the informal curriculum on their learning, particularly in relation to learning from observation of senior clinicians. This was seen as providing opportunity to learn both positive and negative approaches to cultural competence.

You learn from looking at various encounters, not formally, obviously. But it’s probably a bit unfair to say it’s more often what not to do, but you do get the odd occasion when you see things done in a way that’s not optimal. But at the same time, I think you see the other side. Often I think you remember the poorer or the worst experiences and a lot of the more positive interactions don’t necessarily come to mind as easily (SP9).

And:

I think having really good mentors. I don’t think they even realised they were really good mentors. They gave really good examples and it’s just seeing how it’s done in different ways. I suppose that would be the informal part of how I was taught (SP4).

This highlights the importance of the self-reflective practitioner, because practitioners need to be aware that they are being watched, observed and learnt from. This was introduced in Chapter Three, and Schön’s theory of the importance of reflection in action and reflection on action. In this case, both would be important, but particularly the notion of reflection in action, as the student is watching and absorbing the very
action itself, not the post-event reflection on action by the clinicians and educators. Examples presented in the previous chapter about the influence of role models in this raised the question of the role of faculty training. Cognisant of the influence of the informal curriculum, through role models, and being aware of the emergence of cultural competence as an approach to address disparity in health care through education, the opportunity for faculty training and professional development in the area of cultural competence requires consideration. Faculty training is discussed in detail in Chapter Seven, and noted here as an important omission, in relation to how to shape and influence the informal curriculum so that it aligns with the formal.

**Student cohort**

Students also described learning from their teams, not just from senior clinicians. The team is made up of other students, as well as senior clinicians, and the role of the diversity of the student body, as a potential teaching and learning opportunity, also demands consideration.

It’s not just like, it doesn’t go by theory, it goes by practical. Like, I mean, let’s say if I’m attached to the team and the team really shows [a] good example of how to be culturally competent, then that really works (SP6).

In published literature, Jaye, Egan and Smith-Han (2010) describe a community of clinical practice for students on a fourth-year surgical attachment (at the Dunedin clinical school, one of the three clinical schools of Otago). They show that students:

learn and internalise the normative professional values and behaviours that they witness and experience within the disciplinary block of the medical school and teaching hospital; specifically, the authors suggest, it is through their participation in communities of clinical practice that medical students learn how to ‘be one of us’ (Jaye, Egan and Smith-Han 2010:59).

The extent to which a differently defined and demographically structured student body could impact student learning is presented in Chapter Eight. But students learn from each other, as well as from their senior clinicians. The value that comes from a diverse student cohort is also a major discussion point in Chapter Eight, in terms of how admissions processes are designed to privilege students with certain skills over
other students. This admission process may not be consistent with the aims of developing a future workforce to address disparity in health care outcomes.

The transmission of skills and attitudes can be seen as part of the informal curriculum. It is the site of enculturation for students, the coalface of interaction between doctor and patient. Many of the supervising clinicians in a medical school that students come across are general practitioners, or hospital-based clinicians, who may have only a fractional or an honorary appointment with the School of Medicine. The school has very little formal influence on how these teachers, as the transmitters of attitudes, knowledge and skills, do their job in relation to the informal curriculum. For these clinicians, and the students apprenticed to them, the governing values and variables, which guide clinician’s attitudes, are strongly related to professional culture and norms of the medical profession. This influence on the students is structured through an apprenticeship model of learning. As indicated, this is the site of significant enculturation, and as Hafferty and Franks (1994:865) describe:

The hidden curriculum itself operates along several different but reinforcing dimensions. Within the classroom, a hidden curriculum accompanies formal instructions in a variety of ways…case reports may convey images that perpetuate gender, racial, ethnic, cultural, or disability stereotypes. Stories, jokes and personal anecdotes, whether told by faculty or fellow students, all function as part of the oral culture of medical training and this as an influential part of the educational process.

Assessment-driven learning

The previous chapter presented some of the findings about the role of assessment and this section expands that discussion with a focus on student perceptions about assessment, and how it reinforces and guides elements of their learning. This section is located here because it is related to student perspectives of how they learnt from the informal curriculum. Not only did students describe learning from observation of clinicians, but they were aware of where and how they were assessed on cultural competence. There was no explicit relationship between where students describe learning about cultural competence and where it was assessed (if it was assessed at all).
Students describe little to no assessment of the learning through the informal curriculum:

We have ongoing assessment from the consultants. I don’t think that they look into cultural awareness that much actually. Yeah, so the only time I think I’ll be assessed on cultural awareness is during the exam (SP10).

Students presented differing views on communication assessment depending on their own social and cultural positioning within the field. The Database revealed specific assessment of communication through hauora Māori, which was reinforced by a student who described:

Māori health – that would be probably where they actually test you on cultural competence. There’s not many other places that do that (SP1).

Student performance could be assessed via the PASAF focusing on the following pre-existing assessment criteria:

demonstrates understanding of, and respect for, patients’ and colleagues’ different cultural, religious and ethical beliefs; does not force own beliefs on others or discriminate against others on the basis of culture, race, or religion; acts professionally in situations where ethical issues are prominent (Appendix F, attribute 23). Students described that this was not generally assessed.

In other cases, I don’t think it’s assessed at all really. I mean, the main modes of assessment say in our clinical years, a lot of your work is clinical and a lot of your assessment is based on, I guess, impressions from senior staff. ‘So how well does this person go in a number of areas including, you know, procedures?’ And one of those areas is, say, communication, which I guess could include aspects of cultural competency. In practice, I don’t think it necessarily does, unless you were particularly good or particularly terrible (SP9).

Overall, consistent with faculty perceptions of assessment, student experiences of assessment of cultural competence was that where it did exist, it was related to hauora Māori content, and that although much learning was through the informal curriculum, this was not supported nor reinforced with assessment of cultural competence.
Student self-assessed level of cultural competence

The student participants were asked for their own assessment on their levels of cultural competence. Of the range of views expressed, the most widely shared view was that students thought they were more culturally competent than many of their senior clinicians, but also that they had some way to go.

I think that we’re probably almost better than more senior, you know, getting very senior, because some people are stuck in the old way. And I think we are increasingly being told to treat everyone differently. Whereas I think there’s that saying, ‘Treat everyone the same’. And I think that’s the old kind of way of thinking, that if you treat everyone the same then you get the same outcome. But they’ve tried to kind of send us away from that, kind of, thoughts and stuff. So we’re probably better than the senior people in a way (SP3).

And:

When I see my colleagues taking, if I see a Pakeha from my year taking a history from a Māori, for example, I think they can get more information compared to a consultant. And they can engage better, because they are aware of things that I guess the consultant is not aware of, you know, such as their beliefs, you know, talking about their whānau. And sometimes making the decision, the consultant sometimes – some consultants, not all – some consultants, sometimes they forget that there are some other people around the patients, their support group or their whānau, who can make the decision for the patient, and they sometimes just neglect that. For them, it’s the patient they are treating and the patient makes all the decision and nobody else needs to care. Yeah, so sometimes I feel that, in that sense, my year or my colleagues are better. But not every consultants do, some consultants are very good, I know, but some are just, to be honest, yeah, not that good (SP10).

Consciously incompetent

With the very reasonable view that the role of the medical school is to develop undifferentiated, ready-to-practice junior doctors, students had a healthy caution about their preparedness to practise.

I’d like to say we have some idea but…I think the majority would probably feel like myself, and they’re not very confident. They kind of know what they’re
expected to do, but probably wouldn’t feel that confident if actually required to do it (SP2).

Specifically in relation to students’ perceived cultural competence with Māori, one student reported:

I’d like to say I’m sort of unconsciously competent and it’s all sweet. But…I don’t think about it all the time, you know. I don’t think about it when I see a Māori patient and say, ‘I’ll do it this way’. And that sort of comes naturally, a reasonable amount of it. But every now and again I think, ‘What could I have done differently? What would’ve been more comfortable?’ and those sorts of things. And probably less so with Māori patients and more so with patients from other cultures that I don’t know anything about, Arabic patients and things and thinking, ‘What do they want? What do they want different?’ (SP8).

Students were also conscious that although they perceived they had quite a lot of knowledge in relation to Māori, when it came to other cultural groups, they felt that they were just at the beginning:

I leave with a little bit more knowledge but still probably in reality only touching the iceberg of, you know, the top of the iceberg of what it is but I have a bit more of a framework to work from. Specifically with Māori population but with other populations I would suggest that I am probably still at that second-year type level but am more aware (SP5).

One participant linked learning about cultural competence to exam and accreditation requirements as the driver for the inclusion and teaching of it:

I think as a group we’re very culturally competent but sometimes we don’t really realise that we are not being competent consciously or unconsciously. But overall I think all the Christchurch, probably most of the medical students in Christchurch are culturally competent because although it’s for just exam purpose, although it is for just evaluation purpose, like we’ve been taught about it for a long time and at least everybody shall have a bit of that in their mind (SP6).

**Areas for further development**

Students were able to describe areas that they considered needed further development, which indicates that students ‘knew enough’ to know what they didn’t know. This is
an important stage of development of self-reflection, and could be described as reinforcing their own perceptions that they were consciously incompetent.

Consistent with how students had absorbed the anthropological approach of learning culture as a static set of facts to be learnt and applied, they most strongly described areas for further development in the context of learning about other cultures, and not just about Māori culture.

I guess I’d probably say the cultural competence of more than just Māori culture. It’s a bit hard with MIHI and things, because that’s their brief. But that’s somewhere where I feel like…I’m sort of let down when it comes to cultural competence. Not let down, but, you know, I haven’t had any training around that and I don’t really know how it’s done in different cultures, what sort of cultural aspects are important. So I guess that’s something that’s difficult to say where it should be and difficult to say who’s supposed to be doing that. And I guess when you asked a reasonable portion of people they’d say, ‘Oh, it’s fine. We do fine and that we carry on and therefore, you know, we don’t have too many issues. Oh, it’s fine. Don’t worry about it. Don’t change it.’ But I think that's probably…somewhere I feel like we’re not quite, yeah (SP8).

And:

Be probably cultures other than Māori, probably sort of maybe some Indian, Asian type flavour to things and maybe a little bit more on sort of Pacific Island…people’s type flavour. I suppose it’s just a by-product of who teaches the Māori stuff. But it’s so good that it would be nice if we had the equivalent [teaching] but I imagine that it would be almost impossible to find time and sort of, yeah (SP5).

This highlights a pedagogical question about the teaching of cultural competence, and the theoretical foundation required for the teaching to meet the aims and outcomes. Importantly, absent from student understandings of cultural competence was box 3 in the Figure 4 (above), the social processes that shape the cultural contexts for both the doctor and the patient and, by definition, the doctor–patient relationship.

One student also provided a challenge to the concept of competence, in terms of a mastery of the skill, and, in describing areas for further development for himself,
described his view that ongoing learning and practice was required outside of the safety of the medical school.

I think it’s really just a matter of doing it, practical experience. I don’t think there’s much substitute for that. As with a lot of things, I think there’s some concerns when you’re in a situation, you’re in university before you start to practice, it’s hard to know how you’ll go. But I think there’s always a learning curve with everything and I think that includes cultural competency. And I guess it’s a matter of remembering things that you’ve learnt and translating them into a way that’s practical, you know, when you actually start working (SP9).

The general view from participants was that Christchurch School of Medicine graduates were not particularly different from any other graduate – and that their skills in cultural competence constituted some kind of bell curve. Students considered themselves generally equipped, but with an expectation that with more experience and exposure to patients, their skills in cultural competence would improve:

But I think there’s always a learning curve with everything and I think that includes cultural competency (SP9).

Reflecting students’ notions of needing more practice, and a learning curve, Tervalon and Murray-Garcia (1998:117), in discussing their notion of description of cultural humility, argues the necessity of a:

lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic, and to developing mutually beneficial and nonpaternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations.

Professional mobility, and the limitation of learning about just Māori health, was the perspective behind the following comment about learning more:

Yeah, it’s something that I do expect to get better at because I’m aiming to work, like, I mean, not just in one place, but I plan to travel around the world as well (SP6).
Koehn and Swick (2006) advocate for an approach to education to address disparity in health care to encompass *transnational competence*, rather than cultural competence, to prepare graduates for a rapidly changing global demographic. They argue for skills to draw from the fields of ‘international relations, cross-cultural psychology, and intercultural communication’ (Koehn and Swick 2006:548).

This focus on ‘cultural knowledge’ reflects how students understand the approach taken of hauora Māori and cultural competence. The explicit concentration within hauora Māori, while useful for the visions and aims of the MIHI team, raises questions about cultural competence learning and scope of purpose of training medical graduates in Christchurch. Medical schools have multi-layered obligations, and there is a range of communities they can serve. There are local, regional, national and international communities, all of which have different needs and demands from health professionals. Christchurch School of Medicine’s mission statement outlines its commitment to the local community, through partnership with the District Health Board, and through its relationship with Ngāi Tahu. As such, the privileging of Māori cultural learning before other cultures is consistent with the school’s governing values and variables.

**Faculty perceptions of graduate competence**

The faculty participants’ perceptions of their graduates’ levels of cultural competence differed from the students’ own assessments. Faculty perceptions were cautious in claiming that their students were in any way particularly different from other medical school graduates, nor different from comparable graduate skills across time. Faculty participants are not the best placed people to ask for this comparison, as their vested interest is unlikely to allow a comment that sheds a negative light on the faculty’s own professionalism as teachers, and, further, they have little opportunity for meaningful comparison (as was acknowledged by many participants). A point that is taken up in the discussion is that of the value of ‘outsiders’ in medical education reform and evaluation (see Anderson, W. 2011).

**Transferability**

Despite no questions being designed to ask about hauora Māori (unless following up a participant’s comment), so much focus from participants was about teaching of
cultural competence through hauora Māori, so participants were asked about likely transferability of cultural competence into other (non-Māori) contexts. Students described transferability within the three domains of knowledge, skills and attitudes. In summary, attitudes and skills were described as transferable, but (cultural) knowledge was not.

Attitudes were described by more than half the students as having an awareness of difference, of cultural dissonance, or a similar sentiment.

I think that being aware of [differences in health status] it would probably, you know, make you learn faster (SP3, my emphasis).

And:

My cultural competence if I had an Asian person would be zilch, but in saying that I think I’d be more aware of it (SP5, my emphasis).

The awareness was an awareness of difference, and different expectations from the patient. Attitudes, as identified through an attitude of awareness, was considered to be transferable across many contexts.

So I feel a little bit like it is applicable to other places, because you sort of have an awareness that there’s a need for cultural competence and that you should think about, or at least have some sort of idea about how you should deal with different people, just the little things (SP8).

One student, who had undertaken an elective in Africa, said:

For example, this year, beginning of the year, I was in Africa on my elective and I was the one well outside my comfort zone – didn’t know what was going on really – but it’s hard to know if I would have had this awareness without having gone through the, sort of the MIHI type stuff. But I did have an awareness of, ‘I’ve got no idea what these people (‘these’ people sounds terrible), what this community would want and expect.’…But I think that it was good that I was aware that there was going to be issues…I think that it helped, and I don’t know what it was that helped, but just the fact that you knew that different cultures work in different ways helped (SP5).

Skills were generally described as being transferable:
but the skills that you learnt when you were learning to be aware of it kind of would be, if that makes sense (SP3).

The skills being described included those related to communication skills, history taking and diagnosis that students had learnt.

In the main, students perceived knowledge elements as learning about culturally specific pieces of knowledge, and as such these elements were described as not transferable:

And as you say before, is it transferrable? Well, yeah, but you still need that knowledge of those other cultures. So I think a few people do get stuck when, yeah, for example, the Muslim woman walks in and you go, ‘Oh, right, um. My Māori skills are not going to help me here’ (SP7).

One international student thought that what he had been taught may be transferable to his home context:

Oh, yeah, definitely, definitely. Because I’m not sure if you’re aware, but back home we also have indigenous people as well (SP10).

This classification by the students of transferability of skills and awareness, but not of knowledge, goes some way to answering the question raised in the previous section about the responsibility to communities that medical schools have. It may be that graduates’ awareness of difference, and awareness of the need to apply culturally appropriate communication skills, is enough in a globalised environment, where the acquisition of knowledge about different cultures in an ongoing pursuit, shaped by changing demographics and a changing work environment. This was acknowledged by a faculty participant who said:

The best we can do is we can live in the hope that by people being bi-culturally competent that there might at least be some spinoff to being multi-culturally competent (FP2).

And another faculty member reflected that there could be more opportunity within the learning environment to apply the skills, with the appropriate attitude, while at medical school:
I think that they have some cultural competency skills what they will be able to transfer which will stand them in good stead, but I also think that there’s an absence of opportunities to develop and explore how transferable these cultural competency skills are in any other setting (FP9).

**Relationship between actions and consequences**

This section discusses the relationship between the consequences (what students learnt) and the actions (what faculty had taught). The primary issue is the lack of assessment and evaluation of student learning in relation to cultural competence. Without clear and adequate evaluation and assessment, it is difficult to make definitive and informed analysis on the extent to which the final-year students meet the expectations of the graduate profile. However, several things can be inferred from the lack of any obvious or overt outcry or criticism from the Medical Council of New Zealand or any of the District Health Boards, where most graduates initially work. As such, it follows that the professional practice of most graduates is consistent with the broad expectation of newly graduated doctors within the health field, which is likely to be consistent with the norms and values of the professional culture of medicine.

Secondly, the fact that the medical school graduates (with pomp and ceremony) most of its medical students each year, and, as such, is confident (perhaps without any hard evidence) that the students are ready to practise safely and competently. Third, student perceptions of their own skills, as measured against those they see as their seniors, is that in the area of cultural competence they are at least as competent in many cases as their senior colleagues.

Nevertheless, for the school to report confidently on its practices of cultural competence, evaluation of teaching and learning is necessary. To apply Argyris and Schön’s framework, and to consider either single or double loop learning to align outcomes with actions, it is imperative that the observed (and evaluated) outcomes are clearly known and understood, in relation to the expected outcomes. If the observed outcomes are not known, then there is a risk of reform without change. Double loop learning requires that the governing values and variables are taken into account, and their influence, through the actions, are considered with respect to how they influence the observed outcomes. Even so, rigorous evaluation and understanding of the outcomes is still required when a single loop learning approach has been applied.
If we consider the relative influence of the three ‘strands’ of curricula – formal, informal and hidden – the hidden curriculum does not appear to have as much obvious influence on student learning outcomes as the formal and informal curricula. Possibly because it is ‘hidden’, it is not easily described by students in this form of data gathering (through interview). Its impact on student learning may be more easily identified through targeted assessment. The processes through which the hidden curriculum influence student learning could be through the faculty and the informal curricula, which transmit these hidden, institutional values and variables to the students. An example of this may be the quote above, and repeated here, which identifies an indifference to the presence of Māori patients on the ward.

SP5: I don’t think that a lot of them have been taught cultural competence or believe in it.

Interviewer: And where do you get that impression from?

SP5: Probably background chatter. When you say, ‘I’ve got to go and do this assignment, have we got any patients at the moment that are Māori?’ ‘Oh, wouldn’t have a clue.’ [Clinician] That’s probably an indicator to me that actually, ‘I don’t think that I [the senior clinician] really care about that sort of stuff’.

The senior clinician may be influenced by the hidden curriculum (such as a possible perception of the relative importance of Māori issues, reflected by the near invisibility of Māori staff outside of MIHI), which may transmit through his/her attitudes to the student, and is recognised here as an informal curriculum influence.

**Conclusion**

This chapter outlines the consequences of the actions, and students’ perceptions of what they have learnt. The students’ perceptions of cultural competence were very similar to the way the faculty perceived cultural competence. There was a focus on cultural competence as a utility to enhance the doctor–patient relationship through a patient-centred approach, and mostly considered within the framework of the patient as Māori. Some students were critical of this approach, highlighting the tensions between learning about one culture and recognising the diversity within one culture. Students also described the informal curriculum as very influential, particularly
through the role and influence of mentors and role models. Without adequate evaluation and assessment, it is difficult to determine the extent to which the school is achieving its aims in relation to the graduate profile or the legislative obligations of the Medical Council of New Zealand in relation to preparedness to practise in a competent manner.

Students learn from the informal curriculum, yet the transmission of knowledge in the formal curriculum comes from the faculty clinicians. There are no training opportunities for the faculty in the area of cultural competence.
Chapter Seven: Permeation of cultural competence

This chapter is divided into two sections. The first section recounts how participants perceived the uptake of cultural competence into the curriculum at Christchurch School of Medicine. Three main areas were described as influencing the uptake of cultural competence; they include professional values (through the professional culture of medicine), regulatory variables (feedback from accreditation bodies) and personal values. Two of these areas were also seen to be influenced by broader contexts; the impact of inter-professionalism and the changing New Zealand demographic.

The second section of this chapter describes perceived barriers to implementation of further cultural competence curricula initiatives. These barriers were described as leadership and ownership of the curricula, a shared meaning of cultural competence, and competition for curriculum time. These barriers resonate with barriers described elsewhere in the literature. These findings are discussed, providing the platform for the next chapter, which outlines an approach to cultural competence reform, based on the findings of this case study.

Permeation of the concept at University of Otago, Christchurch

When asked to describe how cultural competence had been taken up at Christchurch School of Medicine, participants responded by outlining three major influences; professional influences, accreditation, and personal values and standpoints. These three approaches resonate with the governing variables, and are shown in the Figure 5.
Figure 5: Professionalism and the professional culture of medicine

**Professional influences**

Professional values was described by a block convenor, and general practitioner as:

I think it comes from a consensus that this is an important part of the education that we need to include, and then formally include it at various points… I think it’s because people connected and involved in clinical education perceive that it’s an important element of the education, that we’re convinced that to practise safely and effectively in New Zealand, you need an understanding of this area, and that
we’ve probably made some effort to incorporate it into our own practice and we feel that, like anatomy, it’s an important part of the education system. I think it’s such a widely accepted area of practice that it naturally becomes incorporated into our teaching. I suspect that’s the way it runs (FP11).

This analysis follows the longer development of medical practice and the doctor–patient relationship, as described in Chapter Two, about the development of different models of medical practice, from the biomedical through to the biopsychosocial model, and patient-centred medicine. It is analogous to the way that the professional culture of medicine, and professional values and approaches, has developed over time. This participant continued to describe the fact that many clinical teachers are not strongly attached to the School of Medicine and the academy, and the influence of the profession of medicine itself is most important (a theme raised in the previous chapter):

but we have a very clear sense of what our professional expectations are and, you know, we’re kind of held to account on that front, and interested in the literature of research and development in it professionally. So I suspect that that has the bigger influence on clinical teachers’ approaches than university dictates or university policy (FP11).

It was also noted that the influence of non-medical clinicians was an important influence on how the culture of the medical profession was being influenced within the context of the school:

there’s been potentially more voice from non-medics in recent times in the curriculum. Because I think some of the other professions have done this better than us, nursing in particularly would have led more. It may be that individuals…who come from a non-medical background, who’s got a broader picture of things. So it may be partly that, that there are more voices being heard at a faculty level (FP6).

The current leader of the hauora Māori thread at Christchurch School of Medicine is an educational psychologist who did not train at medical school, and Christchurch City has been host to notable non-medically qualified health professionals who have taken approaches to health care disparity that have influenced the medical profession. The late Irahapeti Ramsden, whose conceptualisation and writing around cultural
safety while she was at Christchurch, has provided an alternative dialogue to cultural competence, which was informed from a Māori perspective, and also a nursing perspective. As discussed in greater depth in the next chapter, the influence of people outside of the medical profession has had a significant influence on the profession itself, and Anderson, W. (2011:29) highlights the value of actively seeking the perspectives of outsiders in the quest to evaluate medical education:

> No voices call more loudly for change in medical education today than those emanating from within the arena itself. Interestingly, however, the monumental reforms of the Flexner Report were impelled largely from outside the specific discipline of medical education.

**Accreditation – regulatory variables**

The second enabler for the permeation of cultural competence curricula was related to the accreditation of the school, and the accreditation team’s recommendations with regards to the hauora Māori thread. This is relevant given how the school closely links hauora Māori with cultural competence.

> I think in terms of hauora Māori it was because of the AMC accreditation process. It got really hammered, I think in 2000 or something like that, so in 2001 they developed this job position for Māori health lecturer. Although it was always part of the faculty goals, Christchurch hadn’t overly prioritised Māori health in terms of that level of cultural competency and so it was really directed by AMC, just trashing them (FP9).

Extracts of the AMC report of 1999 describe the following in relation to Māori health.

> Since the 1994 AMC assessment, little in the way of additional staff resources have been directed to improving training in Māori Health through the Faculty of Medicine. Currently, the Otago Faculty of Medicine employs only 1.3 full time equivalent staff for this topic although it is regarded as a priority area by the Government and Ministry of Health.

> [S]tudents at…[Christchurch] did not consider Māori health to be an integrated part of the course but rather a set of separate topics not linked strongly to the students’ other experiences or goals.
Overall, the Team considered that Christchurch has the weakest program in Māori health, relying on two Māori psychologists for input.

At present, the curriculum in Māori health has insufficient academic support and will require a greater level of commitment for the Faculty to meet its stated goals in this important area of medical education in New Zealand (AMC 1999:17).

This is strong language from the AMC, and, as described, is seen to have been influential in making the resources available and supporting the development of the Māori health unit. There has been no such strong language from the AMC in relation to cultural competence in any accreditation report for the past decade. Indeed, the term cultural competence is not mentioned in the most recent AMC report of the Christchurch School of Medicine, although measured acknowledgement of the advances in hauora Māori are made, with an urge to continue to do more.

**Hauora Māori as a Trojan horse**

In this study site, hauora Māori has been the Trojan horse for cultural competence. To describe the analogy, hauora Māori becomes the representation of the horse, which is let into the usually very well-guarded curriculum gate. Subsequent to breaching the gate, hauora Māori staff have been appointed to influential curriculum committees (with an expectation that they will now lead the cultural competence agenda). The success of the Trojan horse in the Trojan War had several important and critically relevant elements. These include the fact that the horse had enough soldiers hidden within it to successfully repel the early attacks from Troy, and that by forcing the modification of the gates of Troy to accommodate the horse’s entry, this had created enough space to allow subsequent reinforcements to follow. These reinforcements were ready to enter the gates from the outside and ready to help the successful invasion. The analogy can be taken further by proposing that if hauora Māori is to be an enabler for the introduction of cultural competency to the curriculum, there needs to be enough soldiers inside the horse (resources for hauora Māori) to continue the immediate curriculum challenges. Hauora Māori also needs to have made enough space, through its championing and advocacy at senior levels, for others with an interest in and responsibility for cultural competence curricula to gain a presence and traction within the faculty. Finally, there also needs to be others ready to enter the curriculum debates. If cultural competency is more than just teaching about Māori
health and culture, those advocating and proposing a more comprehensive ‘critical’ approach need to take the opportunity provided to state their case and make their claims.

**Personal values**

The third enabler was described as individuals acting from their interests and personal values:

> there’s just individuals who have reason to want to get it in there and you kind of find each other accidentally or, you know, it comes up through some other bit of work you’re doing and you think, ‘Oh, I’ll just see what I can do’ and so I suspect it’s just a kind of gradual awareness that’s growing. There’s no particular champion at this point, although I do know that we’re currently looking at trying to get a champion at a faculty level to lead cultural competency within our curriculum. I think probably the other key influence is that New Zealand is becoming a more multicultural society, certainly from an ethnic culture kind of view, and so to some extent that’s influencing us. And definitely our student group is more multicultural than in my day. So those may all be subtle influences as well (FP6).

This was also seen to be influenced by the changing New Zealand demographic, the implications of which could be drawn that in a mono-cultural environment, cultural competence training may not be required. This limits the view of the rationale of cultural competence to that of cross-cultural (ethnic) interaction, and to the presumption of a static, non-mobile workforce or population.

These reflections on how cultural competence has infiltrated the curriculum are all influences of the governing values and variables, as outlined in Chapter Four. This provides an important insight into the influence of the governing variables at Christchurch School of Medicine, although this was not explicitly recognised by the participants. Argyris and Schön’s framework provides a useful tool to analyse the enabling influences. However, this does not necessarily indicate that the organisational learning approaches at the school incorporated a double loop learning approach. Argyris and Schön’s framework as a proactive organisational learning tool would require that these governing values and variables were taken into consideration as the school undertakes reflection on action. These findings from the study do not
indicate that double loop learning was in place; rather, that the governing values and variables, as they themselves evolve and change, have their own influence within the school. What it does show is that as I examine the barriers to the uptake of cultural competence curricula in the next section, double loop learning would be an effective approach to organisational learning.

**Barriers to further reform**

This section describes participant perceptions of barriers to further development and reform of cultural competence curricula. Four themes emerged in discussion about barriers to further development of cultural competency curricula. These four barriers are:

- leadership
- ownership and responsibility of curriculum
- access to curriculum time
- a shared understanding of the term (see Figure 6 below).

Participants’ views of barriers to further reform contrast with their views of the enablers in that barriers were generally described at the operational and technical level, whereas enablers were at the level of the governing values and variables. The focus of perceived barriers was at the practical level of how to progress things ‘on the ground’, within existing structures and processes.

![Figure 6: Barriers identified to further development of cultural competence initiatives](image-url)
Each of these barriers indicated that the faculty was taking a single loop approach to organisational learning and reform. Usher and Bryant (1989: 87) describe single loop learning examples as those with a focus on ‘techniques and making techniques more efficient’, and not taking into consideration the governing values and variables, their influence, impact and how they shape the parameters of the actions.

**Leadership**

As shown in Figure 6, each of the four emergent themes (barriers) was linked, but two – leadership and ownership of curriculum – were more strongly linked in people’s thinking and their responses. Leadership was identified as a prerequisite to implementing curriculum reform.

I mean…we need a leader and we think we’ve found someone and so they’re just embarking on it right now. But I think the fundamental thing is it’s not who, but as long as it’s someone (FP2).

And:

Under good leadership…I don’t actually see there being too many barriers. I think the school is ripe to facilitate [development of cultural competence curricula] under strong leadership. I wouldn’t see there being too many barriers actually (FP8).

Leadership has been cited as a key issue in the literature, both in terms of leadership of the cultural competence agenda itself (Culhane-Pera et al. 2000; Chun 2010), but also as general support from existing leadership within the faculty (Lindsey 2007; Wu and Martinez 2006; Turner 2008). Leadership was also described by Turner and Farquhar (2008), who, when referring to their own faculty initiatives in cultural competence, said, ‘Central leadership from the dean’s office allowed us to see the curriculum as a whole and to coordinate across courses and across years’.

The way that issues of leadership were described in Christchurch School of Medicine indicated that it was required in terms of leading and developing reform related to cultural competence. There was no concern raised about lack of support in relation to existing school leadership (for example, from the Office of the Dean). This suggests that the type of leadership being described as required was understood to be within the broad context and existing culture of the school. Leadership required pursuing an
agenda that was within the boundaries of the governing variables, rather than leadership to reconsider these governing variables and how they may be impacting on consequences and outcomes.

The issue of leadership itself isn’t just located within the realm of single or double loop learning. Leadership would be required to realise organisational double loop learning – to develop structures and processes that took into consideration the governing variables themselves, and the extent to which they supported or inhibited implementation of practices. This is discussed further in the recommendations in the following chapter, but leadership, as it was described in the interviews, was based on single loop learning.

de Leon Siantz (2008:167) argues (in relation to nursing) that leadership is required so that a whole-of-school approach is undertaken to achieve a culturally competent health workforce:

Such leadership must develop a vision that builds on a blueprint for action in partnership with the school's leadership team, faculty, university wide and community partnerships, including support staff, budgetary priorities, faculty governance, and philosophy. A critical need exists to not only focus on culturally competent skill development for patient care, health systems, curriculum, research, recruitment and retention but also to implement an action agendum that schools of nursing must model for a diverse and global health care community. A critical need now exists to transform health care systems beginning with the schools that are responsible for preparing the diverse and culturally competent future health care workforce.

Positioning leadership with a whole-of-school approach strengthens the structures and processes in place, which encourages double loop approaches to organisational learning.

Ownership and responsibility

Linked to leadership is how faculty participants perceive the locus of ownership and responsibility for cultural competency reform.

You’ve either got to have dedicated time in the curriculum and dedicated individuals responsible for it…or you’ve got to say, ‘Well, I’ve got oversight of
it, but actually it belongs to all of us and we all should be sharing it.’ And then, of course, the risk is that it doesn’t happen, or that it happens in an inconsistent and poorly coordinated sort of fashion (FP6).

And:

I don’t see it as being my ownership, you know. I am quite happy to contribute (FP14).

Ownership was described as a challenge elsewhere in the literature, with Turner and Farquhar saying ‘faculty ownership of the curriculum strengthened the project, but when other duties pulled faculty members away…the development and implementation of new material stalled’ (Turner and Farquhar 2008:637).

It is important to have consistent, cogent, coherent curricula, not just of the formal element, but of the informal and hidden as well. Single loop learning, and attention to ensuring the technical elements are attended to, are important in achieving the articulated aims of the school. Delegation of responsibility across curricula domains is a foundation stone of how a complex curriculum is successfully delivered over three years in the clinical school. A cultural competence community of practice, as an approach to dealing with this and other barriers, is described in the following chapter.

Curriculum time

Access to curriculum time, and competition for curriculum time and space was the third barrier described. The issue of curriculum time is a common one in the medical education literature (Litva and Peters 2008; Bloom 1989; Turner 2008), as it was in this case study:

The scientists want their piece of flesh…So freeing up time is very difficult (FP12).

Inclusion of cultural competence curriculum was described as possible with an approach of integration, or ‘tweaking’ existing teaching, learning and assessment opportunities.

So it would be saying, we’re not adding another tool, we’re just tweaking or enhancing an existing tool…Time in the curriculum is always a bit of a negotiated point. And there’s always this tension of the ownership and there’s
also, which is not the same…necessarily as time, ’cause you can have ownership, and this has been one of the things we struggle with. You can have a thread that has elements, but doesn’t necessarily have specific curriculum time, and you can have threads that do have curriculum time. And the ones that don’t have curriculum time, you could say, well, how does that happen? And you could say, well, that’s by making existing convenors alert to the various elements that you think should happen and just pulling those threads together. So that is possible (FP2).

This is reflected in the literature, with Turner et al. (2008:637) describing:

> Recognizing that the curriculum was already full, we added no new material without eliminating existing material; we replaced or ‘tweaked’ existing material to address project objectives.

In this case study, the barrier of an already full curriculum and lack of available time was described with a degree of resignation, and acceptance that curriculum time in medical education is always a competition, especially for the ‘soft’ disciplines (that is, not science).

> Nobody wants to give up curriculum time for the core stuff for what’s seen as the soft peripheral stuff (FP6).

Issues of curriculum time, and the related prioritisation of content, indicate that the professional and self-stated values, which privilege the scientific basis of medicine, were taken as a fait accompli. That these governing values and variables were not going to be questioned, but, rather, cultural competence curricula could be integrated into this existing curriculum foundation and structure, demonstrates a single loop approach to dealing with limited curriculum time as a barrier.

There are many ways to reconsider curriculum time, many of which require a reconsideration of the governing values and variables, such as the length of the course, the priorities of the outcomes, the nature of the graduate profile and the basis of the curriculum itself. Several of these governing values are re-considered in the following chapter.
Shared understanding

Shared understanding of cultural competency within the school was a further barrier to a more comprehensive approach to its implementation.

I think the biggest barrier is actually around a clear understanding of the definition of what is cultural competency for us at the Christchurch School of Medicine within our curriculum (FP9).

Mullholland in Drevdahl et al. (2008:19) also highlight issues of shared understand and myriad definitions:

The culturally competent care literature is ‘saturated with confusions and ambiguities over terminology; such ambiguities constitute an ongoing handicap,’ which may limit the usefulness of cultural competence as a mechanism to realistically address health disparities.

And Chun (2010:616) suggests that ‘Regardless of the term used, it is important to be absolutely clear on its meaning in the context of one’s work’.

Other participants described the impact that the lack of clarity of understanding was having.

I think it is really hard to operationalise something that’s quite nebulous in many ways (FP11).

The shared understanding emerges from the boundaries created by the governing values and variables. A shared understanding of cultural competence will facilitate a coordinated and consistent approach within the curriculum, at all levels. However, that shared understanding needs to be both informed by, and needs to inform, the governing values and variables, and to be a congruent understanding across the curriculum from perception to praxis. The shared understanding needs to be reflected and represented in the school’s mission statement and strategic plan and staffing profile. If cultural competency was something seen to be important and prioritised (as faculty described it as being), in the same way that having a research agenda has been prioritised, then this would be evident within mission statements, similar to the University of Pennsylvania example provided earlier. This in part goes to what may develop as a shared understanding for the raison d’être for cultural competence at the
school. If it is to be understood as related to patient centredness, devoid of the broader context of disparity in health outcomes and issues of unequal treatment, then this too will be reflected in the mission statement. If the shared understanding to be developed was that culturally competent physicians have a role to play in reducing disparity in health care outcomes, then a more significant ‘critical’ edge will be reflected through the governing values and variables. This is also discussed in greater depth in the following chapter, as a comprehensive model is outlined for cultural competence within medical education.

**Hauora Māori**

Hauora Māori was seen as a barrier to the broader cultural competence agenda, because of the perception of the close relationship, even conflation, of hauora Māori and cultural competence.

I would predict that people would say, ‘Yes, [cultural competence], it's really important and we’ve already got time in the curriculum for hauora Māori, let them sort it out’ (FP2).

A further perspective was provided that the linking of cultural competence to hauora Māori may mean that cultural competence initiatives may face some of the same acceptance hurdles as hauora Māori has.

We also have to be careful that we’re not stigmatising because hauora Māori itself at times can be stigmatised, and the association between hauora Māori and cultural competence and the fact that hauora Māori is potentially stigmatised at times, we don’t want cultural competence to be stigmatised as well (FP8).

Hauora Māori as a barrier relates to curriculum time, leadership and a shared understanding of cultural competence. Again, if hauora Māori was understood as the Trojan horse for cultural competence, then it could be seen from a different perspective as an enabler, with further clarification of its place, and a re-conceptualisation of its meaning within the curriculum.

**Faculty training**

One of the case study findings is that faculty participants were not aware of any training opportunities in cultural competence.
I imagine there is some…I’ve never been to one and I don’t perceive that many of my colleagues have been to one either (FP13).

Personal and professional values can be addressed through continuing education through faculty training opportunities, in the same way that training of students can impact on their knowledge, skills and attitudes. What is interesting in faculty responses about cultural competence training was that not only had the participants themselves not been to faculty training, but that they had not investigated, nor sought out, the possibility.

Not that I know of but I’ve never asked to be honest. Never investigated it (FP6).

As described in the earlier chapters, the informal curriculum was an important site of learning for students, where they observed and interacted with faculty, yet in regards to cultural competence there were no targeted faculty training programs. Where participants described training opportunities, these were in hauora Māori:

there are the training opportunities in relation specifically to Māori culture in New Zealand…there were a couple of workshops you can go to around The Treaty of Waitangi and stuff like that…I don’t really consider that cultural competency myself, you know? That’s not what I think cultural competency is. I’m not aware of any [training programs] but then I’ve never looked into it. I’ve not sought it out. It’s kind of a slightly intimidating topic I think for a lot of doctors too (FP6).

As medical training is very much an apprentice model, the apprentices need to be trained by faculty members who are up to date and expert (or who at least are aware of, and can mirror, the values of the school). Training for faculty can also be seen as taking a single or double loop approach to organisational learning, depending on the nature of the learning opportunities and the messages that are transmitted to faculty. For example, if the school shows support in implementing and encouraging faculty to attend the training, it is also sending messages of the value that it places on cultural competence training. To the contrary, if the training opportunities are non-existent, then the governing values and variables are unlikely to change in the short term through the influence of the school itself.
There are many examples in the literature of faculty training programs, which provide the following pointers. Dogra et al. (2009:992) urges for compulsory training programs, arguing that,

People are often scared off by the idea of implementing a compulsory training programme, but there is a real danger that if it is not compulsory then it will turn into a support group for the already converted. While support is very important, we also need to reach those academics that still see diversity and equality teaching as a politically correct irrelevance that is simply common sense. Training and evaluation of faculty and clinicians on cultural diversity issues are very important since they serve as role models and their poor modelling may detract from work done in earlier years at medical school.

Ferguson, W. et al. (2003:1228) describe their faculty training interventions, concluding with a call to action for the profession:

our generations of established clinicians must take ownership of the findings of a growing number of studies on disparities in communication and relationship building experienced by ethnic and racial minorities in this country [United States]. We believe that this is achievable and that cultural competency training can become institutionalized as a critical element of faculty-development training.

Kripalani et al. 2006 also argues that faculty training helps with issues of sustainability and an influence broader than the early adopters. He contributes that broad buy-in from faculty helps ensure consistent messages across the three curriculum areas – the informal, hidden and formal curricula. Describing the impact of training faculty in cultural competence at Harvard, a cultural competence course facilitator reported that ‘After the faculty course was implemented, the course’s rating on cultural competence improved significantly’ (McKee 2009:2). Kamaka’s (2001) work on training faculty was unique, in that it is one of the only reported courses for Indigenous (Native Hawaiian) physicians to be immersed in an Indigenous (Native Hawaiian) context.
Accreditation training

Linked to faculty training programs is the notion of training the accreditation teams in how to accredit in relation to cultural competence – what to look for and how to adequately assess a school’s efforts in meeting the accreditation requirements.

The accreditation of medical education programmes is a way of promoting an appropriate learning environment, and may ultimately impact the quality of medical care provided to patients (van Zanten et al. 2008:930).

This may, in turn, strengthen the impact of the regulatory variables on the processes and practices in place at a school. As referred to earlier, there is no reference to cultural competence in the most recent accreditation report of the Christchurch School of Medicine, and some reference to hauora Māori, although this is relatively cursory. It may be that the accreditors are unqualified to comment on cultural competence, or that cultural competence it is not at the fore of their awareness. Although there are cultural competence accreditation and legislative requirements, they become ineffectual if the body responsible for accreditation does not have the requisite skills and knowledge to adequately evaluate a school’s initiatives in cultural competence.

Conclusion

This chapter outlines how participants perceived that cultural competence had been taken up at Christchurch School of Medicine, as well as barriers to further development. By utilising Argyris and Schön’s conceptual framework of single and double loop approaches to organisational learning, it was seen that those factors that contributed to the uptake of cultural competence were primarily categorised as being part of the governing values and variables. Barriers to further development were principally aligned to technicalities, and related to aligning efforts within the area of the action, including the formal, informal and hidden curricula.

Much of the literature related to curriculum reform in terms of cultural competence takes either a double loop or single loop learning approach – rarely are both considered, nor the relationship between the two. For example, much is made of curriculum time, leadership and ownership and shared meaning of cultural competence. This is often raised with an unquestioning allegiance to the existing governing values and variables. On the other hand, the pragmatics of medical
education and organisational realities at the local level also need to be considered so that the learning outcomes match the learning objectives.

The next chapter offers some reflections and an approach to thinking about and implementing cultural competence curricula. It draws upon the framework of analysis of Argyris and Schön, but offers an approach to organisational learning to optimise outcomes, both within the existing paradigms of medical education and with the reflective action to challenge those same paradigms.
Chapter Eight: Medical Schools as sites of reform

This chapter discusses approaches to cultural competence in medical education that address disparity in health care outcomes by re-orienting the governing variables that inform cultural competence curricula approaches and by applying a double loop approach to the issue. The discussion consists of three sections. The first is a discussion of the disciplinary foundation of medical education, and the role the humanities may have in developing a critical approach to cultural competence. The second section reviews the impact that the demographic make-up of the student body has on the delivery of cultural competence curricula, and as an agent of change in its own right. Admissions criteria and approaches to student selection are critically analysed, and the argument for ‘minority’ seats discussed as a possible approach to reducing disparity in health care outcomes. The third section makes a recommendation for a cultural competence community of practice, operationalised to ensure that practices of cultural competence are cognisant of the governing values and variables, while at the same time offering an approach that supports reflection on action.

Disciplinary basis of Medical Education

Critical consciousness and the disciplinary basis of the medical curriculum

The fieldwork for this case study was carried out in 2010, the same year that there was much reflection on the centenary anniversary of Flexner’s (1910) seminal report about the state of medical education in the United States and Canada. Flexner’s report had a significant influence on the very nature, structure and accreditation of medical schools and medical education. His report was wide ranging, and one of the most extensively embraced recommendations was the ‘strong advocacy of scientific rigor in the intellectual portion of medical training’ (Riggs 2010:1669). What was been noted in the centenary reflective process was that Flexner not only urged a scientific approach, but he also observed that the ‘physician’s function is fast becoming social and preventive…this type of doctor is first of all an educated man’ (Flexner 1910:26).

The history, positioning and understanding of the role of culture in medical education is described in the section in Chapter Two entitled ‘Locating “culture” in medical education’. This case study has described the ways in which cultural competence has
been conceptualised and perceived at Christchurch School of Medicine. I return to the primary finding of my analysis, which is that the focus of cultural competence curricula has been the doctor–patient interaction, consistent with a patient-centred approach, and a focus on communication skills (see box 1, Figure 2). If cultural competence is perceived as a utility to facilitate communication across cultural divides, I suggest that clinicians are, in the main, extremely competent with very many of their patients. Indeed, Christchurch School of Medicine students were very positive in describing the extent to which they thought that they were culturally competent. Commitment to a cultural competence approach that focuses on patient centredness suggests that the activities at Christchurch are consistent with the governing values and variables, and how those values and variables are interpreted at the school. For example, students can communicate well with Māori, and their skills are generally ‘competent’. However, instead of cultural competence being described as skills of communication, and knowledge as knowledge of the culture of the Other, and attitudes of empathy, openness and approachability, cultural competence needs to be reconsidered to also take into account the absent reflection about the social processes that locate the doctor and the patient, identified in Figure 7 as box 4a and box 4b. Kumagai and Lypson (2009:783) describes this as critical consciousness:

The development of critical consciousness involves a reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships – an act that Freire calls ‘reading the world’ – and the fostering of a reorientation of perspective towards a commitment to social justice.
Critical consciousness relates to descriptions within box 4a and 4b, and is the mostly absent discussion within the medical school (in relation to cultural competence). Box 4a reflects the social processes that have shaped the professional culture of medicine. These include the socially shared and shaped common understandings of the role of the doctor, and the responsibilities, obligations and increasing demands of the profession (as referred to above by Flexner). Box 4b represents the social processes that shape and have shaped any one particular culture, and that contribute to creating the social conditions that provide access to opportunity to get into medical school for some people, and the supported pathways to succeed, while others carry a greater burden of disease, ill health and morbidity, and may be more likely to encounter the doctor and health system as a patient. These intersections, or boundaries, help us to understand the relationship between the medical profession and broader society, to understand how citizenship shapes opportunity, and to locate social forces and dynamics that lead to privilege or disadvantage.
As individualized and emotional as doctor-patient communication can be, it always takes place in a larger society, in which institutional norms, economic realities, and sociopolitical forces impinge powerfully and subtly on physicians and patients (Perloff et al. 2006:836).

For the doctor, to understand and apply a patient-centred approach with a critical consciousness requires taking into account the complexity of the human condition, and should draw upon the rich history of human endeavour. This would lead not to a truncated and under-theorised approach to cultural competency, but to a critical approach richly informed by the medical humanities, supported by a liberal education. Cultural competence without a foundation in the humanities is like surgery without a foundation in anatomy. Flexner (1910:25), describing the competing interests within the basic sciences, but which could equally be applied to the humanities and cultural competence, forewarned:

Only at the sacrifice of some essential part of the medical curriculum – and for every such sacrifice the future patients pay – can this curriculum be made to include the preliminary subjects upon which it presumes.

Fifteen years later, in 1925, he lamented, ‘Scientific medicine…[is] today sadly deficient in cultural and philosophic background’ (Flexner in Curry 2010: 283). His comments resonate today, although with the positive observation that there are many initiatives designed and implemented with the intent to address this deficiency. However, I argue that the hegemony of the scientific basis of medicine overwhelms these efforts to strengthen graduates’ ‘cultural and philosophic background’ through the momentum of an historical approach that privileges a science-based curriculum and student admissions processes that are designed to select those best suited to excel in a science-based curriculum environment.

As described, the structure of the Christchurch School of Medicine curriculum, not dissimilar to many other medical curricula, has evolved from being departmentally based to being divided up and delivered according to body system blocks (still related to faculty departments). If cultural competence is to be used as an approach to address disparity in health outcomes, critical reflection of the governing variables that shape the very curriculum itself needs to be addressed. Governing values and variable need to be embraced to support a curriculum that will produce the physicians required to
address needs rooted in social inequity, reflecting Flexner’s comment in 1925, and reinforced by Riggs in 2010:

We now produce physicians with exceptional scientific competence. For our personal medical care, however, we all seek the physician who possesses not only scientific competence but also compassion, empathy, erudition, ethics and humanity (Riggs 2010:1670).

One approach to this dilemma has been the inclusion of social science teaching, as Kleinman outlined in 1978:

Because biomedical science tends to blind health professionals to questions of illness and differing versions of clinical reality, social science teaching is necessary to train professionals to deal competently with these essential, but nonbiomedical, aspects of clinical practice. To be adequately conceptualized, clinical science must be thought of as both a biomedical and social science (Kleinman et al. 1978:146).

Christchurch School of Medicine has produced excellent graduates over many years, but it cannot ignore its contribution to the disparity in health care outcomes within a New Zealand context. Grant (2002:45) states, ‘curricula need to be reshaped to take account of the new requirements’, and I argue that culture competence curricula need to provide learning opportunities that link the root causes of disparity in health care outcomes to the clinical and public health context.

**Revisiting the humanities**

As an outcome of considering the findings of the study, this research proposes that the curriculum pedagogy needs to be revisited, and the role of medical humanities curricula rethought and conceptually linked to cultural competence, with an aim to have critically conscious graduates. Acknowledging that, ‘Despite 50 years of effort, then, the very well intentioned motives for encouraging the medical humanities in medical schools have had far from universal success’ (Cook, H. 2010:4), I counter that neither has the focus on scientific and clinical skills had universal success in delivering equitable health care outcomes.

Grant (2002) describes four reasons for humanities in the medical curriculum:

1. To increase understanding of the human condition
2. To expose students to the critical analysis of ideas
3. To make more allowance for individual differences
4. To provide pockets of expertise and lifelong interests.

On the basis of this rationale, more than a decade ago Auckland medical school (the only other medical school in New Zealand) developed an approach to what it describes as the ‘whole person’ problem, and which is analogous to what I have described in Figure 7 in boxes 4a and 4b. Auckland medical school developed eight humanities subject, with one requirement that they had to be relevant to medicine. Example of the subject titles include ‘Sociology: social issues in medicine and health care’, ‘History: case studies in medical history’ and ‘Political studies: politics of health care delivery’ (Grant, Jackson and Suk 2002).

Most students at Christchurch enter medical school via the first-year health science pathway, before commencing what then becomes their second year in medical school. In the health science year they take seven compulsory science-based papers, before taking an optional eighth paper in the humanities from an approved list, which includes options such as ‘The Silk Road: East meets West’, ‘Interpreting the Old Testament’, ‘Māori society’ and ‘Human development’. The 2010 Guide to the Early Learning in Medicine Curriculum (University of Otago 2010:4) describes the curricula experience (for the students who participated in this case study), and says:

> The Systems Integration Course integrated medical and clinical sciences and the Patient, Doctor and Society Course integrated the psychosocial aspects of medicine with the doctor-patient relationship, healthcare delivery systems and public health.

As reported in Chapter Six, some student participants recalled some of their learning about ‘culture’ in their preclinical years, but generally reported the experience as disconnected and that it was difficult to recognise the relevance. Not one participant, student or faculty, commented on the humanities curricula at Otago, which is provided before the students enter clinical school. There was no conceptual link made between cultural competence curricula and humanities education. The challenge, attempted at Auckland, is to make humanities meaningful for students. Auckland’s approach was integrated, but only to the extent that it found a home in the preclinical years, as is the optional humanities subject at Otago (which is not integrated).
In relation to cultural competence, the challenge is to encourage engagement and, in concert with clinical and scientific skills, to produce doctors ready to contribute to reduction of health inequality for future generations. Curry & Montgomery (2010) uses the description of a liberal education as the foundation on which to base cultural competence curricula, and, in medicine, I argue that select medical humanities (which I describe below) provide an appropriate liberal education for medical students.

Liberal education is an approach to learning that empowers individuals and prepares them to deal with complexity, diversity, and change. It provides students with broad knowledge of the wider world (e.g., science, culture, and society) as well as in-depth study in a specific area of interest. A liberal education helps students develop a sense of social responsibility, as well as strong and transferable intellectual and practical skills such as communication, analytical and problem-solving skills, and a demonstrated ability to apply knowledge and skills in real-world settings (Association of American Colleges and Universities in Curry & Montgomery 2010: 284).

Curry continues and relates this to current-day approaches of cultural competence:

[This definition of a liberal education] identifies the development of social and cultural perspective as the primary goal of a broad disciplinary base – a goal clearly synchronous with current efforts to ensure ‘cultural competence’ in our medical students (Curry & Montgomery 2010: 284).

Curry’s (2010) contribution to the literature is the only one that explicitly links cultural competence with a liberal education, and the humanities. It is an area that requires further thinking and discussion, which I now outline.

**Medical humanities, cultural competence and critical consciousness**

I argue that medical humanities curricula (which can provide a theoretical foundation for cultural competence) not only needs to be relevant, but also be able to be applied and meaningfully integrated (not just vertically co-located) in the clinical context. In the debate about the role of the medical humanities, there is a duality between medical humanities being an ‘add on’, or being ‘integrated’.

The [additive] is concerned with complementing medical science and technology through the contrasting perspective of the arts and humanities, but without either
side impinging on the other. The [integrated] aims to refocus the whole of medicine in relation to an understanding of what it is to be fully human; the reuniting of technical and humanistic knowledge and practice is central to this enterprise (Evans & Greaves 2002:57).

An integrated approach allows students the opportunity to begin to apply their understandings of the social processes that shape the doctor–patient interaction, and to the therapeutic relationship itself. In relation to the case study findings, the overlooked social and cultural milieu that shapes much about the clinical interaction (boxes 4a and 4b in figure 7) would no longer be overlooked, and would become relevant and inform the basis of the doctor–patient interaction.

The humanities have a role in informing the theoretical underpinnings of an approach to medical education that is cognisant of the social processes that contribute to disparity in health care outcomes, at least insofar as clinicians contribute to these outcomes. This is not new, but has been overlooked in the recent blinkered push for cultural competency curricula. Engel described just this approach in 1977:

To provide a basis for understanding the determinants of disease and arriving at the rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system (Engel 1977:132, my emphasis).

The ‘social context in which he lives’ in a New Zealand context includes an understanding of how history has shaped relations between different groups and, as such, shaped the identity of the groups themselves. This requires not just an understanding of Māori culture, frozen in time, but a critical understanding of the bi-directional impact of colonisation between Māori and Pakeha – a critical consciousness, which is not abstract but applicable for students in developing their understanding of what it is to be a doctor, the social standing and responsibility that it infers, and how that is relevant for, and impacts upon, their patients. The development of a critical consciousness does not imply a state of competence, but, rather, an ability to apply acquired clinical skills of cultural competence through a critically conscious lens, regardless of the geographical, socio-cultural and political chasm that may
become apparent in the doctor–patient relationship. In the absence of a critical approach to cultural competence, it is easy to understand Seth in As Esmail (2004:1448), quoted in Chapter Four, regarding ‘the prejudices of good people which are so dangerous’. This ‘blind-spot’, be it institutional or interpersonal, is not yet seen as a foundation stone of medical education. This is Wear’s (2003:549) approach, when she urges medical educators to:

provide students with more opportunities to look at their biases, challenge their assumptions, know people beyond labels, confront the effects of power and privilege, and develop a far greater capacity for compassion and respect.

She continues:

students would also learn to identify and analyze unequal distributions of power that allow some groups, but not others, to acquire and keep resources, which would also include the rituals, policies, attitudes, and protocols of the very institution educating them. Such a curriculum incorporates a fuller range of factors that contribute to inequities by looking not only on the doctor–patient relationship but also on the social causes of suffering (Wear 2003:551).

Another curriculum element would include the history of medicine, including how the professional cultural of medicine has shaped, and been shaped, by society. This would include reference to twentieth century theorists such as Foucault and the medicalisation of illness, Engel and the debates about medical models of doctor–patient relationships, and Flexner and the history of the nature of medical schools and training, as well as local histories, such as the development and role of the student’s own medical school. As a vertically integrated curriculum, learning opportunities would be developed in conjunction with clinical skills, and students would be required to integrate and display elements of that knowledge appropriately with clinical skills and patient management that demonstrate a theoretical and historically rich approach to patient interaction. Concurrently, students would also be required to learn, and apply previous learning, about the social processes that shape the patient’s presentation, not just a static notion of the patient’s culture. This would include clinically applicable learning opportunities in sociology, history and, in a New Zealand context, discussions around colonisation, racism, power and inequitable access to resources. As Flexner described in 1910,
One must rely for the requisite insight and sympathy on a varied and enlarging cultural experience. Such enlargement of the physician’s horizon is otherwise important, for scientific progress has greatly modified his ethical responsibility (Flexner 1910:26).

Indeed, in the century since Flexner, scientific progress has continued to modify the physician’s ethical responsibility. The emergence of evidence, based on scientific method, to show unequivocal unequal treatment demands more from medical education, supported by Dolan (2010:394), who says:

It has been claimed that the raison d’être of the medical humanities is to remind us that modern medicine can and should look beyond its technological fixation and reductionism to reconnect with the conditions of disease and cultural contexts of illness, as well as the myriad ways people cope with it. It is an antidote to the alleged dehumanisation of modern medical education which is overly basic-science centred and fails to foster empathic patient care.

**Assessment approaches**

As described in Chapter Five, assessment-driven learning is fully realised if it is programmatic. Assessment that takes a critical approach to cultural competence also requires a programmatic approach to support integration, linked with the myriad learning opportunities. The existing PASAF form at Christchurch School of Medicine is a tool that could be modified, with a greater emphasis on a critical approach to cultural competence. Kumagai and Lypson (2009:786) advocates assessment approaches that:

focus on expressions of internalized, patient-centered orientations, including openness and critical reflection in the area of working with patients in diverse societies. Furthermore, we recognize the potential risks that linking assessments in multicultural education to the traditional components of competency possesses: the danger that knowledge, skills, and attitudes may be quickly reified into rather inflexible categories that test competencies empty of internalized values.

This orientation of assessment away from reified inflexible categories is consistent with the approach outlined by Wilkinson et al., who outline a blueprint for professionalism, and argue:
Professionalism can be assessed using a combination of observed clinical encounters, multisource feedback, patients' opinions, paper-based tests or simulations, measures of research and/or teaching activities, and scrutiny of self-assessments compared with assessments by others (Wilkinson et al. 2009: 531).

They go on to outline areas for further development in regards to professionalism; salient to this study is ‘reflectiveness, advocacy, [and] lifelong learning’ (Wilkinson et al. 2009: 531). The specifics of assessment at any one site will depend on and be responsive to the aims and visions of the site and the specific learning objectives to be assessed, all underpinned by a shared understanding and vision of cultural competence.

**Institution and policy reform**

The primary focus of this discussion of a critical approach to cultural competence has focused on its potential to further inform the doctor–patient relationship on the evidentiary basis that this relationship contributes to health outcomes disparity (see Chapter Two). However, Evans & Greaves raise the question:

> Does an individual therapeutic effect stemming directly from the clinical encounter stand wholly distinct from a more general therapeutic effect stemming from interventions in policy or in the education of practitioners? Alternatively, could both be seen on a continuum? (Evans & Greaves 2002:57).

Most students enter medical school, ready and expectant to be trained as clinicians. It is mostly well after medical school is complete that clinicians move into policy or education. This raises the question about the fundamental role of medical school, and its broader relationship with community health and wellbeing, rather than just biomedicine.

Students need to leave medical school with the basic skills so that they are prepared for lifelong learning, undifferentiated to move into an area of their choosing. With cultural competence, efforts to integrate curricula into specialist and vocational training requires a firm base on which to build, not a truncated and flawed theoretical base. The aim of the curricula approach described is summed up by Riggs (2010:1671), who said:
Healing without science is superstition; healing without humanism is technology; healing with both is medicine.

**Relationship between demographic of student cohort and cultural competence curricula**

*The student cohort*

One of the more influential governing values and variables at the study site was the personal and professional values of participants. Personal and professional values influence and shape the professional culture of medicine, which in turn affects the curriculum and its outcomes. Personal and professional values constitute and are informed by perspectives, personal norms and life experiences that students bring to medical school. These values are further moulded by the enculturation process and experience of medical school.

This section discusses the relationship between the demographic make-up of the student body and the curriculum. This was raised by several participants, from different perspectives, and draws on those previously raised discussion points. It outlines and critically analyses the five arguments present in the literature for minority student recruitment, which are the benefits of racial and ethnic congruence between doctor and patient, the impact on educational outcomes for a diverse student body, an expanded research agenda, role models for community and equity-based arguments. These arguments are then discussed within the context of the case study findings, to propose that with a re-orientation of the curricula consistent with a critical approach to cultural competence, this could be reinforced and aligned with an admissions process consistent with a graduate profile that seeks to reduce health care disparity. The question posed in Chapter Five about the impact of a significant majority Māori medical student body, and its impact on the curricula, is also further discussed.

*Medical students and curricula*

Medical students are central to shaping the future values that will inform the professional culture of medicine. Admissions processes are in place to ensure that those selected to enter the profession have the requisite foundational skills to successfully complete a degree with a strong science-based orientation. Personal and professional values were an important governing variable within the case study site. If
students were selected for admission based on values that prioritised reducing disparity in health care outcomes, rather than just an ability to complete a science-based degree (and they are not necessarily mutually exclusive), how might this change the governing variables themselves? As Smith, M. (2001:np) notes, ‘Any action is likely to impact upon a number of such variables – thus any situation can trigger a trade-off among governing variables’. There is a symbiotic relationship between the demographic of the student body and the curricula that are delivered. One example of this is to revisit the assumption that most curricula perceived to be cultural competence curricula at Christchurch School of Medicine is based on the implicit assumption of teaching about Māori (patients) to non-Māori (doctors). As raised in Chapter Five, what if all of the students were Māori, and what impact would this have on the curriculum? The discussion here focuses on the way that a different demographic make-up of the student body would align with efforts of a medical school to address disparity in health care outcomes.

Because of existing disparity in health outcomes, would hauora Māori still be a thread that interweaved through the course, and would the Māori student body need to learn about ‘White’ culture? If we consider our approach to this mind puzzle, is hauora Māori about teaching non-Māori to teach Māori, and, if so, is this located in a bicultural context of Pakeha/Māori? Then, how do we consider our obligations to all students, non-Māori but also non-Pakeha New Zealanders? What about the significant number of Asian students for example, both international and domestic in origin?

**Racial and ethnic congruence**

A widely suggested argument for increasing minority student representation within medical schools is that of improving racial or ethnic congruence between the doctor and the patient. This takes a separatist approach, such that in a New Zealand context only Māori can treat Māori well, and Pakeha treat Pakeha well – further, that ethnic congruence between doctor and patient will always lead to better health outcomes. This approach, while having merit (but possibly exacerbated only because of the failure of the education process itself), also has the potential to lead down the path of ‘giving up’ on the benefits of fruitful cross-cultural interaction, and consigns minority clinicians to always work with minority populations. It also supports the argument that intrinsic ‘sameness’ between doctor and patient is enough to reduce health
disparity. The arguments for increasing the numbers of underrepresented minority students in medicine have often been at odds with culture competence curricula approaches. Despite often having been proposed, hand in hand, to achieve reductions in health care disparity, a primary tenet of cultural competence curricula is simply that cultural differences between the doctor and the patient can be bridged through the spectrum of educational initiatives previously described. In contrast, one argument for minority student representation has taken the view that there is some essentialist affinity between people of similar ethnic cultures. Nivet et al. (2008: 491, my emphasis) go as far as to say:

The underrepresentation of underrepresented minorities in the healthcare professions has a profoundly negative effect on public health, including serious racial and ethnic health disparities. These can be reduced only by increased recruitment and development of both underrepresented minority medical students and underrepresented minority medical school administrators and faculty.

At odds here are fundamental beliefs about an ability to bridge cultural differences through education, and the essentialist, static notions of culture. The end point of the argument presented by Nivet et al. is that only like can treat like. But at what point does the logic of this argument diminish? Can only women effectively treat women, Hispanics treat Hispanics, and gays treat gays – and thus, could only a gay Hispanic woman receive optimal health care from another gay Hispanic woman? This section of the dissertation proposes an argument for selecting a student body that is most likely to help address disparity in health care outcomes, but not just for reasons of ethnic or other cultural congruence between doctor and patient.

**Impact on educational outcomes**

The impact on educational outcomes argument is that the diversity of the student body itself has an educational impact, and is, of itself, a good thing. It follows that being surrounded by, immersed with and socialised within an environment of diversity helps students understand and engage with that diversity. Terrell and Beaudreau (2003:1048) suggests that:

Diversity in the classroom also promotes learning skills, such as active thinking, intellectual engagement, and motivation, as well as certain social and civic skills,
such as perspective taking, citizenship engagement, and racial and cultural understanding. These are skills that make graduates more ‘culturally competent.’

I question Terrell and Beaudreau’s faith in the causal and linear link between diversity of the student body and cultural competence. Diversity of the student body can also lead to marginalisation, bullying and feeling unwelcome, often for the minority student (Garvey et al. 2009). A diverse student body is potentially a rich and wonderful resource for medical educators to draw upon, but the skills described by Terrell and Beaudreau are ones that should be taught and nurtured as part of the development of a critical consciousness as described above. In concert with a supportive and aligned curriculum, a diverse student body provides many learning opportunities for students and faculty alike. Saha, Guiton et al. (2008) report on a study of 20,000 American medical students, researching the relationship between the diversity of the student body and educational outcomes. Their findings indicate that there is a positive relationship between a racially and ethnically diverse student body and outcomes that contribute to meeting the needs of a diverse population for white students.

[W]hite students attending more racially diverse medical schools rated themselves as better prepared than students at less diverse schools to care for racial and ethnic minority patients and had stronger attitudes about inadequate access to health care. These associations became apparent as the proportion of minority students increased above the 60th percentile (10% for URM [under-represented minority student] proportion, 36% for all nonwhite students), suggesting the presence of a threshold effect (Saha, Guiton et al. 2008:1141).

Saha, Guiton et al. (2008:1142) discuss the interactivity between a diverse student population, the stated vision of the school, the curricula that support the vision, and the supported extra-curricular activities that take place, such as ‘diversity-related initiatives on campuses’.

The following table from Poole et al. (2009) shows that the threshold effect for New Zealand, should it be transferable from Saha, Guiton et al.’s (2008) research carried out in the United States, indicates that New Zealand medical schools are close to the threshold effect for non-White students, but Otago is behind for Māori students.
Table 4: Self-identified ethnicity Bachelor of Medicine, Bachelor of Surgery, (MBChB) domestic students, compared with New Zealand population at 2006 census

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Auckland 2008 All MBChB, n= 703</th>
<th>Otago 2009 All MBChB, n=1391</th>
<th>New Zealand population overall</th>
<th>NZ ages 15–39 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Māori</td>
<td>9.8%</td>
<td>5.0%</td>
<td>15%</td>
<td>17%</td>
</tr>
<tr>
<td>Pacific Islands</td>
<td>7.1%</td>
<td>2.7%</td>
<td>7%</td>
<td>13%</td>
</tr>
<tr>
<td>Asian (including Indian)</td>
<td>34.6%</td>
<td>33.3%</td>
<td>10%</td>
<td>8%</td>
</tr>
<tr>
<td>European and other</td>
<td>48.5%</td>
<td>59%</td>
<td>77%</td>
<td>71%</td>
</tr>
</tbody>
</table>

Source: Poole et al. 2009:91 (Table 1)

An important caveat here is differences between categorisation of racial groups between different countries. As can be seen, Poole et al. use quite different language to categorise different racial and ethnic groups than Saha, Guiton et al. (2008). Nevertheless, for broad comparison, it could be argued that Māori, as an underrepresented minority in New Zealand, do not reach the threshold identified by Saha, Guiton et al. (2008). This threshold is required to support an environment aligned with outcomes to reduce health care disparity, although the percentages of non-White students (Asian + Pacific Islands + Māori) do reach the threshold of 36% of non-White students.

One participant commented that there was a lot of diversity within the medical student cohort, and that that diversity has potential to contribute to the learning outcomes of the school.

I think one of the things that has got the potential to improve the cultural competency of our students is our multicultural student mix, but I think we under tap that as a resource. I think it’s hard to get the balance right between appreciating that the students who come to the group with different cultural backgrounds are a resource and we should learn from them and their colleagues should learn from them and we should all learn from each other without unduly labelling them as being a particular culture and therefore that’s what they can contribute (FP6).

Specifically, in another comment, this was described as being a culturally incompetent way of teaching this diverse student group, with some student
characteristics of being ‘quiet’ not culturally in line with the expectations of the culture at Christchurch School of Medicine.

Wilson et al. (2010:22) describes the importance of training for faculty so that ‘Workshops can enhance faculty members’ cultural competency skills that, in turn, can lead to better understanding and interaction among diverse students’.

A similar sentiment was commented on in the study:

I don’t think we’re teaching the teachers about how to teach our own students, in their way, so we’re not using skills…to engage them in their teaching and learning stuff (FP10).

Expanded research agenda

Much research is driven by the personal experiences and interests of researchers. It is argued that future academics and clinicians from underrepresented minorities are likely to increase the research in areas relevant to their communities. Although this may hold true, it continues the gaze on the Other. Researchers who have an interest in the communities within which they live, and their relationships with other communities, may embrace the ‘critical’ approach to cultural competence described here. Research with a focus on disparity in health care outcomes may be strengthened by medical researchers educated with a ‘critical consciousness’, rather than just an appreciation of the different elements of someone else’s culture.

Role models for community

A third argument for increasing minority student numbers and diversifying the medical student cohort is that medical students from underrepresented groups who are admitted provide role models for other potential students from within their community. This has a longer history, as evidenced by the feminisation of the workforce. This is not to suggest that a simple and linear relationship between underrepresented people in medicine simply leads to an increase in numbers, but could, in fact, be seen as an indicator that the culture of medical education itself is changing – that the hidden curriculum, as well as the informal and formal, is changing to ensure that previously underrepresented peoples are supported, and are able to be a part of the profession.
Equity

The fourth reason is less practical, and more ‘rights based’, and argues ‘that a just society must ensure that equal opportunity exists for those interested in a career in the health professions’ (Terrell and Beaudreau 2003:1049). In New Zealand, this could best be linked with Article Three of The Treaty of Waitangi, which addresses issues of equity of opportunity.

In an Australian context, Anderson, I., Ewen and Knoche (2009:580) capture the breadth of benefit that may flow from increasing Indigenous Australian participation in the health workforce, including equity-based arguments:

Increasing the participation of Indigenous people in the health workforce is an important workforce development strategy, as well as an important goal to pursue for equity reasons. Indigenous Australians can contribute to improved quality of care by aligning their technical and sociocultural capabilities to maximise patient or population health outcomes. The presence of Indigenous practitioners in the health workforce adds a collegiate dimension to relationships between non-Indigenous practitioners and Indigenous Australians, and this has the potential to facilitate reform in health care practice. To that end, the leadership provided by Indigenous practitioners in health research and education is also important. However, the responsibility for quality health care for Indigenous people is one that must be shared. Non-Indigenous colleagues play a critical role, which is why all graduates need to be equipped to work across the entire range of Australian sociocultural contexts, including in Indigenous health.

The proposal to recruit Indigenous (or minority) students into medicine in Australia has been the focus of sustained work by the Australian Indigenous Doctors’ Association, evidenced in the publication of the Healthy Futures report (Minniecon and Kong 2005). This same publication also canvasses the experience and initiatives of Māori recruitment in New Zealand, and Indigenous and minority recruitment in North America. However, the emphasis of my argument for increased Indigenous student recruitment is the potential it has to influence the professional culture of medicine (in the same way that the feminisation of the medical workforce has had a significant influence of the professional culture of medicine). Chapter Two describes Māori representation in the health workforce, with recent gains through graduations being minimal. Recruitment of Indigenous peoples into a curriculum environment,
which encourages all students to ‘become aware of their social conditioning and how it has affected them and therefore their practice’ (Ramsden 2002:2), would help reduce potential issues of marginalisation within the professional culture.

A diverse student body could contribute to the efforts to reduce the cultural dissonance between the professional culture of medicine and the diversity of patients in need of excellent clinical care. However, there is still a requirement to develop, apply and evaluate a critical cultural competence curriculum, which supports students and the future medical profession to consider the social processes that influence the doctor–patient relationship. Interpersonal racism is not the sole domain or product of any one cultural group. A culturally diverse workforce does not automatically lead to a workforce devoid of racism (or sexism, or ageism). However, critically conscious medical graduates, aware of social processes that have led to unequal distribution and representation of some minority groups within their professional ranks, will acknowledge and act on the medical profession’s own role in perpetuating this unequal access, and will put in place processes to address this unequal distribution of resource.

**Cultural Competence Community of Practice**

The previous two sections of this chapter have discussed an approach to cultural competence that considers elements of the governing values and variables, and how they themselves could be addressed. This section describes a model for use within a school for reflection on action, which is described with specific reference to cultural competence.

*A model for organisational learning and cultural competence curriculum reform*

There is no supported ‘home’, or discipline, or block, that provides a structure within which a community of practice can be located to support the development of ideas, curricula, collegiality or research for cultural competence. The responsibility for cultural competence curricula at Christchurch School of Medicine currently sits on the margins, being no one’s explicit curricular responsibility. Nevertheless, it was often described by participants as everybody’s business. The development of a cultural competence community of practice provides an approach to ensure alignment of the
actions, and consideration of the governing values and variables, to guide future efforts.

A community of practice has defined boundaries and relationships with other related content and professional areas and interests. What emerges from this case study is that these boundaries include the governing values and variables (including the legislative requirements and professional and personal values). These boundaries also include the domains of hauora Māori, professionalism, communication and ethics. As argued by Anderson, W. (2011) and highlighted by a case study participant, the role of outsiders is also important for medical education reform. Figure 8 was drawn with perforated lines, or boundaries, with which to portray the transmission and interaction between the different sectors and sections of the conceptual approach – such that the patient has a permeable boundary with his/her culture, and cultures have permeable boundaries with the broader society within which they are iteratively defined, and define.

The concept of a community of practice sits comfortably with Argyris and Schön’s framework for institutional learning. Wenger’s approach to communities of practice is not being used to introduce another theoretical and conceptual framework for analysis. Rather, it is introduced as an approach for organisational coordination, consistent with Argyris and Schön’s organisational learning framework. Communities of practice provides an approach and structure to support double loop learning within the organisation, as its boundaries its membership, and its ways of communication include the governing values and variables.
If a cultural competence community of practice was to be developed as an organisational learning strategy, within a framework of encouraging double loop learning, Wenger (2000:230) proposes looking at the following six elements:

- events
- leadership
- connectivity
- membership
- projects
- artefacts.

**Events**

Events for this community may be developed around a series of school-wide workshops, public lectures and presentations, which could have the effect of
advertising for wider interest, and so that faculty is aware of the development of a community of practice such as this.

**Leadership**

Many participants described leadership as something that was needed to pursue the cultural competence agenda within the school.

I think it would be very good to have a [cultural competence] course director, who could have oversight of the whole program, that links to this departmental structure. If you had a course director it might start to cut across the programs a bit (FP13).

Internal leadership of the community of practice could take many forms, as Wenger (2000:231) described: ‘thought leaders, networkers, people who document the practice, pioneers’. Within this community, students who articulate their interest in cultural competence and related issues would also be provided the opportunity for membership and leadership.

**Connectivity**

Connectivity has multiple levels, from the pragmatics of when and how to meet (breakfast meetings, face to face, online chat, blogs) to connecting people whose interaction would add to the richness of discussion within the community. The ways that people are encouraged to connect need to be aligned with the aims of the community. For example, if strong community input was sought, connecting at times that favour availability of medical faculty members (say, at eight o’clock in the morning) may inadvertently exclude some voices from the community, and the leadership and community in general need to be aware of this.

**Membership**

Membership of a cultural competence community of practice would ideally be diverse, sustainable, fluid, interactive and welcoming. If the membership was overwhelmingly of senior consultants, elevated in the medical professional hierarchy, this may discourage more junior members of the broader community being involved. Similarly, in the Christchurch context, if membership was seen to be exclusively Māori, this too may limit the kind of learning that might take place in such a
community of practice. Outsiders would also need to be encouraged and invited to be a part of the community.

The naïve imagination from without deserves a prominent and invited seat at the table. As with all human endeavours, medical education needs the widest possible set of discussants if indeed change is the goal, for self referentiality, no matter its capacity to fill journal pages and conference lecterns, may very well constitute involution rather than change (Anderson, W. 2011:34).

A well subscribed and active community of practice would aim to develop a shared understanding of cultural competence. To have greatest impact, it would need to be contributed to by faculty, but herein lies a problem. Research indicates that doctors do not generally see that they are responsible for disparity in health care outcomes (see Clark-Hitt et al. 2010). Clinicians who already perceive that their approach has significant influence on student learning, and who are critically aware of the literature and research that indicates unequal treatment, are likely to also be already more along a path of ‘cultural competence’ than those who may not be aware of this. The likely contributors to a community of practice are likely to be ‘the converted’. This is not to suggest that it should not be a strategy taken up and pursued, but, rather, that as a strategy, it will have its limitations. This can be addressed, in part, through faculty training, described previously, and embracing the notion of compulsory participation.

Projects

Potential learning projects in this community of practice have inadvertently already been described by participants of this study, and include coming to a shared understanding of cultural competence for the school, as well as rethinking how cultural competence is articulated through the curriculum database, such that just one hit is returned under a search for cultural competence.

The recommendations made earlier in this chapter regarding curricula approaches and student admissions processes could be considered by this community of practice. Projects include curriculum development projects related to reconsidering the role and place of humanities in a clinical school, and projects related to the relationship between admissions criteria, the graduate profile and the mission of the school. With regards to single loop learning, congruence between the formal, informal and hidden
curricula could be considered a project. This would be primarily single loop learning within the institution. The more robust challenge would be engagement with an organisation learning framework of double loop learning, so that the community is able to identify for itself the range of governing values and variables it sees as defining the range of acceptable actions within the school. This may require expanded membership, including the invitation of external people and perspectives to the group, as advocated by Anderson, W. (2011).

Artefacts

Artefacts of a community such as this are likely to emerge from the learning projects that the community undertakes, and would be expressed through development of further curricula materials, and themes in the Database. Policies and policy development could also be considered an artefact of this community of practice.

Wenger’s community of practice framework can sit within and support double loop learning, but it would need to be aware of the potential of single loop learning. It could be an approach that takes an iterative approach, and helps bridge the understanding and interaction between the governing variables and the actions. For example, engagement with clinicians who themselves are agents in the reproduction of the professional culture of medicine provides one avenue of perturbation of the governing variables. Another avenue is the potential for a school to influence over time the accreditation processes and requirements. If, for example, a school of medicine presented the AMC with a new and well-structured approach to meeting requirements in relation to cultural competence, then this has the potential to infiltrate the thinking of accreditors, who themselves are part of broader and wider communities of practice within the medical profession.

Boundaries

Figure 8 represents some boundaries, which emerged from the interviews with participants. The boundaries are areas where interests and expertise intersect with other areas: ‘Boundaries connect communities and are learning opportunities in their own right’ (Wenger 2000:233). The boundaries demarcate areas of difference, as well as areas of similarity, and, as such, help bring into sharper focus the perceptions and practices of cultural competence within the school. Given the developed shared
language within the community, the difference, for example, between cultural competence and hauora Māori is more explicitly explained and identified by the presence and articulation of the boundaries.

**Existing domain boundaries**

Given the perceptions of the close relationship between cultural competence and hauora Māori, it could be argued that hauora Māori provides a readymade home for a community of practice. However, the contrary argument is also presented, which is that cultural competence is not the sole responsibility of the hauora Māori team, or further, that it is not the responsibility of the hauora Māori team any more than it is of any other team. So if a cultural competence community of practice was to sit with a pre-existing organisational structure, then it would come with the preconceptions and expectations of the pre-existing boundaries.

**External boundaries**

Limited external opportunities for benchmarking or comparison were raised in the study, and highlight an important element of analysis, which may encourage double loop learning. Looking outside the current immediate environment, or institutional context, provides an opportunity to apply a different perspective, and to be aware that other institutions ‘do things differently’. The research by the Indiana School, which implemented an approach to changing its informal curriculum, is a good external example of a school that has documented its approach to addressing issues of congruence between formal and informal curricula (see Cottingham et al. 2008). Not only did the school make internal changes, it also tracked its performance to other (external) graduates over time using student data.

In relation to cultural competence, there were anecdotal examples given of comparison between graduates, but no examples of structural or systemic reflection or comparison with other medical schools. The one example given was the Leaders in Indigenous Medical Education conference, where there are collegial discussions about the overlap between Indigenous medical education and cultural competency.

The LIME [Leaders in Indigenous Medical Education] conference – when we talk about cultural competency we’re talking about Indigenous health. But it’s been interesting to see how other people utilise and explore – define cultural
competency and safety within our own Indigenous medical curriculums and how they measure it. I think that’s been really interesting (FP9).

Influence of community of practice

A cultural competence community of practice can have influence at multiple levels within an organisation. Its activities can have influence across both the actions and consequences, but it can also influence governing value and variables through a double loop approach to learning. This could be achieved in a variety of ways, but would need to include participants being mindful of the range and potential influence of governing values and variables, capitalising on Schön’s notion of reflection on action, and would need to bring this reflection to influence the activities of the community of practice.

Conclusion

This chapter has discussed approaches to cultural competency as an approach to address disparity in health care outcomes. The chapter proposes a rethinking of the role of medical humanities in the clinical years, a reconsideration of the impact of student admissions processes, and how a differently constituted student cohort may impact both on the delivery of curriculum and also on health outcomes in the longer term.

This chapter also introduced a new model of a cultural competence community of practice. This has been outlined as a structure and processes to advance the shared understanding, and thus the uptake, of cultural competence at a school of medicine. As a new model, an opportunity is presented to trial the model, evaluate it according to the articulated aims, and link the outcomes of the activity to the broader cultural competence agenda.
**Chapter Nine: Conclusion and future directions**

This chapter reviews the scope, focus, findings and argument of the case study, and suggests future directions for consideration.

This study has examined the relationship between the perception and practice of cultural competence at one medical school. The relationship between perception and practice has not previously been reported on in the literature, and the implications for curricula reform have not been considered in this light. To answer the questions (restated as subheadings below), I applied the conceptual framework of Argyris and Schön (1978, 1996) of organisational learning, and augmented it with Hafferty and Franks’ (1994) taxonomies of curricula. This framework provided a structure to pursue answers to the research questions, and was also useful as a framework around which to shape the dissertation itself.

The aim of this study was to explore if the concept of cultural competence, as it is perceived and practised, is the best concept to be working with as a tool for medical educators to address disparity in health care outcomes. By developing and exploring answers to the thesis questions, the study concludes that despite the importance attached to graduating culturally competent clinicians, without a thorough foundation upon which to build and develop, cultural competence curricula is likely to be theoretically unsupported and underdeveloped.

The new findings of this research, outlined in more detail below, show how cultural competence initiatives play out in a School of Medicine, across and between students and faculty. This rich and in-depth analysis contributes new knowledge and understandings of the complex issues related to cultural competence, and provides an opportunity for medical educators at other institutions who may be grappling with how they engage with the concepts, to avoid the reform without change dilemma. The application and utility of the methodological approach and conceptual framework employed for this case study is also generalisable to other contexts.
What are the perceptions of cultural competence among faculty and students?

The perception of cultural competence at Christchurch School of Medicine was that it was considered a very important part of medical education in a New Zealand context, particularly employed as a utility to enhance a patient-centred approach in a doctor–patient relationship. Cultural competence was strongly related to hauora Māori and, to a lesser extent, related to the teaching domains of professionalism. The key skill related to cultural competence, consistent with the perception that cultural competence was a utility to enhance the doctor–patient relationship, was communication. Students did not perceive that cultural competence was related to understanding the role that the doctor’s culture, both personal and professional, had on the doctor–patient relationship.

What are the practices of cultural competence of faculty?

The practices of cultural competence were described through the formal, hidden and informal curricula. Through the formal curricula, practices of cultural competence, although explicitly described only once, were articulated through the hauora Māori domain, and in the communication thread. The informal practices reinforced much of the formal curricula, in that it was Māori patients who were described as having a cultural element that was required to be considered and integrated as part of the doctor–patient relationship. The hidden curricula – the policies, slang, evaluation and resource allocation – were interpreted to send a range of conflicting messages. For example, despite being perceived as an important part of the medical curriculum, and strongly linked to hauora Māori, the staffing profile in relation to Māori was limited, and was an area the AMC highlighted for development and attention.

What is the relationship between the perceptions and practices?

In the main, practices were consistent with the perceptions, with a focus through the formal hauora Māori curricula on cultural competence. The most obvious area of inconsistency between perception and practice was the lack of formal assessment or evaluation of students in cultural competence, despite the perception of cultural competence as a central tenet of modern medical education.
In what ways has the concept of cultural competence informed the school’s praxis?

In relation to the school’s perceptions of cultural competence, the concept has permeated through the influence of key governing values and variables. In particular, the regulatory variables as articulated through the AMC influence from the professional culture of medicine by both doctors themselves, as well as by ‘outsiders’,

The critical contribution to knowledge is found in the discussion and analysis of Chapters Seven and Eight, and includes recommendations guided by a double loop approach to organisational learning and reform. These included a reconsideration of the role of medical humanities in the clinical years, with an aim to reduce disparity in health care outcomes. This was based on the model developed (see Figure 7), and cognisant that the cultures of the patient and the doctor are informed and influenced by social processes, including an acknowledgement of the interaction and situational fluidity of cultures. The second area of analysis is the impact of the student cohort on the curriculum, and eventually on the professional culture of medicine itself. Finally, a model for a cultural competence community of practice is offered, informed by the findings and challenges that emerged from the study itself.

Reform without change?

In his 1998 paper, on which this study has drawn, Hafferty comments:

> Throughout this century there have been many efforts to reform the medical curriculum. These efforts have been largely unsuccessful in producing fundamental changes in the training of medical students (1998:403).

If, as medical educators, we are concerned with ensuring that our medical graduates do not repeat the mistakes of the past, such that there persists unequal treatment for some sections of our communities, we also need to ensure that we do not pursue curriculum reform without change.

The research linking the relationship between medical education and patient outcomes is sparse. The findings that emerge from this research require both application and evaluation of outcomes across a range of contexts. Application of a clinically related medical humanities stream, with an aim of ultimately preparing graduates to reduce
disparities in health care outcomes, is a significant undertaking, and would require a whole-of-school approach to ensure that the hidden, informal and formal curricula were mutually supportive, and that efforts at implementation were matched by innovative and rigorous efforts of evaluation.

A radical approach to student admissions criteria requires political will and strength. The articulation of the vision of the school must necessarily filter down and inform the admissions process itself, as it does at Christchurch School of Medicine, with a research priority, underpinned by an allegiance to the scientific method. If a school should adopt a vision such as described at the University of Pennsylvania, a complementary process of admissions must accompany that vision.

The evidence of the contribution of health care professionals to disparity in health care outcomes is undeniable. The challenge is for schools of medicine to critically identify and review the governing values and variables that shape their schools. Consequently, they can determine the curricula that shape their graduates, the future health workforce, and their preparedness to address unequal treatment. Uncritical reliance on past approaches is not enough. The very nature of medical education requires critical review – from admissions to curriculum to processes that facilitate reflection on action.

**Future praxis and research**

This study suggests a range of approaches for medical educators to take into account when considering responses to increasing evidence of the role health professionals play in contributing to disparities in health care outcomes for some groups of people. Formal cultural competence curricula, consistent with and on a foundation of hidden and informal curricula, may prove to be more effective than ad hoc approaches to cultural competence within a medical school.

However, a medical school needs a binding set of values as a reference point which informs its direction, mission, responsibilities and the development of its curricula. In the current age, in the absence of any stated value, science has filled the void in many medical schools. To look beyond the values offered by science alone, and to reconsider the role of the humanities in developing medical students and graduates as healers, rather than just as medical scientists, is our challenge. This challenge is
multifactorial, and extends to all facets of the medical school, from considering its role and responsibilities to its community (local or global), admissions requirements, staffing policies, as well as curriculum, to name but a few.

This challenge also charts a future course of research in the area. How are our values articulated in medicine and medical education? How do our values inform curricula? Whose values should inform the education process? and What impact might a values based approach in medical education have on future clinicians and their practice?

Unequal treatment is not just the sole outcome of the training of medical and health professionals – clinical practice occurs in a context, replete with power imbalances and social advantage and disadvantage. However, medical professionals have, for many years, been seen as leaders in our communities. Now, more than ever, the challenges before us require strong, courageous leadership which charts a new way forward, so that the medical profession is ready and equipped to respond to the unprecedented challenges before it.
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competence into the field. *Health Psychology, 23*(2), 147–155.


Appendix A: Faculty participants

Full list of titles

Dean of School
Associate Dean (Medical Education)
Head, Department of Respiratory Medicine
Senior Lecturer, Māori/Indigenous Health Institute 5th Year Run Block Convenor, and Department of Psychiatric Medicine
Director, National Addiction Centre,
Director, Simulation Centre
Course Convenor, Public Health
Medical Education Advisor
Director, Māori/Indigenous Health Institute
Associate Dean (Undergraduate Student Affairs)
Department of General Practice, 5th Year Block Coordinator
Director, Faculty Education Unit
Course Convenor, Healthcare in the Community
Thread Convenor, Professional Development and Ethics (in Early Learning in Medicine)
Research Manager, Māori
Appendix B: Interview schedule for faculty

Cultural Competence in medical education: A case study

Interview conducted by Shaun Ewen

Interview schedule (semi-structured) for faculty

Introduction of who I am, where I am from:
Brief outline of the research.
Check that PLS has been read, and understood, and that consent form is signed.

Background and Context

The questions about cultural competency may well emerge from discussions about medical education more broadly- which is why the interview is semi-structured.

- Can you describe for me a bit about yourself? Where you are from, how long you have been at Otago?
- What is your role at Otago Medical school?
- What are your key interests/expertise in medical education?
- Can you highlight for me what parts of your educational role you most enjoy?
- What are your research interests related to medical education?

Cultural competency

- Can you describe what you think cultural competence is?
- What do you think the primary aims of teaching CC is?
- In what ways do you think this is an important part of the teaching program for medical students?
- In what ways do you think cultural competency is related to your key areas of interest/expertise in medical education?
- Can you describe to me where you teach CC in the curriculum?
- Can you describe where you think anyone else teaches it, or where it should be taught?
- Thinking about the graduate profile – where do you think cc is best located (personal, interactive, disciplinary)?
- Thinking about the program domains – where/who should lead, influence the CC curriculum across the teaching program?
- In what ways can you related CC to Knowledge, Skills attitudes?
- Can you describe to me where CC is assessed?
- How do you know if the aims of teaching CC are achieved?
- Can you identify any barriers to the inclusion of CC curricula or assessment?
- Can you describe how the concept of CC has ‘infiltrated’, been taken up, at UOC?
- Is there any opportunity of CC training for faculty?
- Transferability -
Closing remarks/questions.

- Can you describe any particular attribute which marks a Christchurch graduate?
- Do you think Christchurch graduates are culturally competent?
- Are there other medical schools in New Zealand or Australia that you look to for leadership in the area?
- Is there anything else you would like to add, anything you think I have missed, or answers you would like to expand on?

Thank participant for their time.
Appendix C: Interview schedule for students

Cultural Competence in medical education: A case study

Interview conducted by Shaun Ewen

Interview schedule (semi-structured) for student

Introduction of who I am, where I am from:

Brief outline of the research.

Identify that interview will take up to one hour, confirm that audio recording will be ok, and that the interviews will be transcribed.

Check that PLS has been read, and understood, and that consent form is signed.

Can you tell me a bit about yourself? Where you are from, and your motivations for going into medicine?

Background and Context

The questions about cultural competency may well emerge from discussions about medical education more broadly - which is why the interview is semi-structured.

- What are your key interests/expertise as a final year/recent graduate?
- Can you highlight for me what parts of your education you most enjoyed?
- At this stage of your career, what thoughts/aspirations do you have about what kind of medicine you want to practice.

Cultural competency

- Can you describe what you think cultural competence is?
- Can you describe the importance you attach to CC?
- Can you identify in the curriculum where and how you learnt about CC? (probe for both formal, and ‘hidden’ examples)
- Can you tell me where you think it should (or should not) be learnt?
- What skills do you think make up cultural competence?
- Do you think these skills are transferable?
- What do you think the primary aims of learning CC should be??
- What forms of assessment include CC?
- Where do you think you are in terms of cultural competence. Unconsciously incompetent
- Consciously incompetent
- Consciously competent.
  (what teaching and learning opportunities helped you get to where you are at?)

Other areas to probe –

Teaching about health care disparity

Closing remarks/questions.

- Do you think Christchurch Trainee interns are culturally competent?
- Do you feel that you are culturally competent or are there aspects you feel that require greater development?
- Is there anything you would like to add, anything you think I have missed, or answers you would like to expand on?

*Thank participant for their time.*
Appendix D: The Medical Council of New Zealand’s Statement on Cultural Competence

Retrieved 9 November 2010
Statement on cultural competence

Purpose of this statement

01 This statement outlines the attitudes, knowledge and skills expected of doctors in their dealings with all patients.

02 The Council has developed a complementary Statement on best practices when providing care to Māori patients and their whānau which deals with the standard expected of doctors when dealing with Māori patients. A resource booklet entitled Best health outcomes for Māori: Practice implications has also been developed which addresses the disparity between mainstream and Māori health outcomes, discusses cultural concepts and provides advice for doctors. These resources should be read in conjunction with this statement. The Council also aims to develop additional resources to help doctors when treating patients from other cultural groups.

Introduction

03 Medical doctors in New Zealand work with a population that is culturally diverse. This is reflected by the many ethnic groups within our population, and also in other groupings that patients may identify with, such as disability culture, gay culture or a particular religious group. The medical workforce itself includes many international medical graduates and a variety of ethnic groups. Cross cultural doctor-patient interactions are therefore common, and doctors need to be competent in dealing with patients whose cultures differ from their own.

04 Patients’ cultures affect the ways they understand health and illness, how they access health care services, and how they respond to health care interventions. The purpose of cultural competence is to improve the quality of health care services and outcomes for patients.

05 Benefits of appreciating and understanding cultural issues in the doctor-patient relationship include:

- Developing a trusting relationship.
- Gaining increased information from patients.
- Improving communication with patients.
- Helping negotiate differences.
- Increasing compliance with treatment and ensuring better patient outcomes.
- Increased patient satisfaction.

06 Cultural appreciation or understanding also has the potential to improve the efficiency and cost-effectiveness of health care delivery.

Statutory responsibilities

07 In addition to setting standards of clinical competence, the Medical Council has a responsibility under section 118(i) of the Health Practitioners Competence Assurance Act 2003 to ensure the cultural competence of doctors.

08 The Code of Health and Disability Services Consumers’ Rights (the Code) also imposes a statutory duty upon doctors. The Code states:

Right 1 – Right to be treated with respect

(1) Every consumer has the right to be treated with respect.

(2) Every consumer has the right to have his or her privacy respected.

(3) Every consumer has the right to be provided with services that take into account the needs, values and beliefs
of different cultural, religious, social and ethnic groups, including the needs, values and beliefs of Māori.

**Right 2 – Right to freedom from discrimination, coercion, harassment and exploitation**

Every consumer has the right to be free from discrimination, coercion, harassment, and sexual, financial or other exploitation.

**Right 3 – Right to dignity and independence**

Every consumer has the right to have services provided in a manner that respects the dignity and independence of the individual.

**Definition of cultural competence**

09 The Council has adopted the following definition of cultural competence:

“Cultural competence requires an awareness of cultural diversity and the ability to function effectively, and respectfully, when working with and treating people of different cultural backgrounds. Cultural competence means a doctor has the attitudes, skills and knowledge needed to achieve this. A culturally competent doctor will acknowledge:

- That New Zealand has a culturally diverse population.
- That a doctor’s culture and belief systems influence his or her interactions with patients and accepts this may impact on the doctor-patient relationship.
- That a positive patient outcome is achieved when a doctor and patient have mutual respect and understanding.”

10 Cultural mores identified by the Council are not restricted to ethnicity, but also include (and are not limited to) those related to gender, spiritual beliefs, sexual orientation, lifestyle, beliefs, age, social status or perceived economic worth.

11 The Council emphasises that doctors need to be able to recognise and respect differing cultural perspectives of patients, for the purpose of effective clinical functioning in order to improve health outcomes for patients.

**Cultural competence standards**

12 To work successfully with patients of different cultural backgrounds, a doctor needs to demonstrate the appropriate attitudes, awareness, knowledge and skills:

13 **Attitudes**

a A willingness to understand your own cultural values and the influence these have on your interactions with patients.

b A commitment to the ongoing development of your own cultural awareness and practices and those of your colleagues and staff.

c A preparedness not to impose your own values on patients.

d A willingness to appropriately challenge the cultural bias of individual colleagues or systemic bias within health care services where this will have a negative impact on patients.

14 **Awareness and knowledge**

a An awareness of the limitations of your knowledge and an openness to ongoing learning and development in partnership with patients.

b An awareness that general cultural information may not apply to specific patients and that individual patients should not be thought of as stereotypes.

c An awareness that cultural factors influence health and illness, including disease prevalence and response to treatment.

d A respect for your patients and an understanding of their cultural beliefs, values and practices.
e An understanding that patients’ cultural beliefs, values and practices influence their perceptions of health, illness and disease; their health care practices; their interactions with medical professionals and the health care system; and treatment preferences.

f An understanding that the concept of culture extends beyond ethnicity, and that patients may identify with several cultural groupings.

g An awareness of the general beliefs, values, behaviours and health practices of particular cultural groups most often encountered by the practitioner, and knowledge of how this can be applied in the clinical situation.

15 Skills

a The ability to establish a rapport with patients of other cultures.

b The ability to elicit a patient’s cultural issues which might impact on the doctor-patient relationship.

c The ability to recognise when your actions might not be acceptable or might be offensive to patients.

d The ability to use cultural information when making a diagnosis.

e The ability to work with the patient’s cultural beliefs, values and practices in developing a relevant management plan.

f The ability to include the patient’s family in their health care when appropriate.

g The ability to work cooperatively with others in a patient’s culture (both professionals and other community resource people) where this is desired by the patient and does not conflict with other clinical or ethical requirements.

h The ability to communicate effectively cross culturally and:

- Recognise that the verbal and non-verbal communication styles of patients may differ from your own and adapt as required.
- Work effectively with interpreters when required.
- Seek assistance when necessary to better understand the patient’s cultural needs.

Related Council statements and resources

- Statement on best practices when providing care to Māori patients and their whānau
- Best health outcomes for Māori: Practice implications

10 August 2006

This statement is scheduled for review by 10 August 2011. Legislative changes may make this statement obsolete before this review date.
Appendix E: Search of Undergraduate Curriculum Outcomes Database to identify the formal cultural competence curricula
Appendix E: Search of Undergraduate Curriculum Outcomes Database to identify the formal cultural competence curricula

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<th>Learning Opportunity</th>
<th>Assessment</th>
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<td>Hauora Māori</td>
<td>Guided Learning</td>
<td>Observed Skills (OSCE)</td>
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<td>Tutorials</td>
<td>Written Presentation</td>
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<td>Unsupervised Clinical Work</td>
<td>Written/computer based exam</td>
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<td>HM022: Ways of working with Māori to achieve positive health outcomes with Māori as individuals, whanau, communities and populations</td>
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<td>Population health of Māori</td>
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<td>HM029: Describe inequalities in health outcomes between Māori and non-Māori</td>
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<td>Lectures</td>
<td>Observed skills mastery (inc OSCE)</td>
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<td>Hauora Māori Thread</td>
<td>Lectures</td>
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</table>
Generic clinical approaches – history, exam, decision making, practical procedures
PM044: Negotiate a management plan in conjunction with the patient and their carers as appropriate, acknowledging the person’s particular culture and the place of Māori mental health and Health Pacifika services as appropriate.

<table>
<thead>
<tr>
<th>Keyword search: Culture</th>
<th>Hauora Māori Thread</th>
<th>Lectures</th>
<th>Oral Presentation</th>
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<td></td>
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<tr>
<td>Psychological medicine</td>
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Generic professional issues – respect, social context, ethics, evidence base for practice and guidelines etc
RD074: Describe the diversity of women's health needs over the span of their lives, including those related to pregnancy and childbirth, and how these needs reflect differences in race, class, ethnicity, culture, sexual orientation, levels of education and access to health care.

| Obstetrics and Gynaecology | None | None |

Impact of cultural background and beliefs on health and health care.
EPD028: Engage in reflective practice on how you have integrated your awareness of elements of culture

| Professional Development/Ethics/medico-legal thread | None | None |

Māori societies, cultures and medicines
HM016: Apply knowledge of Māori

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<td>Activity</td>
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<td>Hauora Māori Thread</td>
<td>Apply Māori models of health when working with Māori individuals, whanau and communities</td>
</tr>
<tr>
<td>HM017: Apply Māori models of health when working with Māori individuals, whanau and communities</td>
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<td>Self Directed Learning</td>
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<td>Written presentation</td>
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**Keyword search: Māori**

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<td><strong>Analyse one’s own reactions to this history</strong></td>
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<td>Special ethical considerations</td>
<td>Professional</td>
<td></td>
</tr>
<tr>
<td>EPD098:</td>
<td>Discuss the variety of values and ethical concerns and practices of ethnic, cultural and religious groups, including Māori</td>
<td>Development/Ethics/medico-legal thread</td>
<td></td>
</tr>
</tbody>
</table>

**Keyword search: Communication**

<table>
<thead>
<tr>
<th>Module Code</th>
<th>Module Title</th>
<th>Thread</th>
<th>Lectures</th>
<th>Tutorials</th>
<th>Reflection</th>
<th>OSCE</th>
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</thead>
<tbody>
<tr>
<td>CS027:</td>
<td>Demonstrate skills in patient interaction - Adapt communication according to differing patient knowledge and expectations and differing doctor-patient relationships</td>
<td>All blocks</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<tr>
<td>CS067:</td>
<td>Demonstrate skills in patient interaction - Promote effective communication and continuity of care across the primary or secondary care interface, managing and embracing conflicting shared information.</td>
<td>All blocks</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All blocks</td>
<td>Demonstrate skills in patient interaction - All blocks</td>
<td>All blocks</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Course Code</td>
<td>Description</td>
<td>Blocks</td>
<td>Learning Outcomes</td>
<td>Notes</td>
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<tr>
<td>CS010</td>
<td>Elicit and consider the patient's perspective</td>
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</tr>
<tr>
<td>CS002</td>
<td>Interpret and act appropriately on the evidence base for communication</td>
<td>All blocks</td>
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<td>CS005</td>
<td>Commitment to partnership and the principle of patient autonomy.</td>
<td>All blocks</td>
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Appendix F: Professional Attitudes and Skills Assessment Form
### Professional Attitudes & Summary of Achievement Form (PASAF)

**Purposes**
- To provide a standardised summary of student performance at the end of each module
- To record assessments of aspects of professional attitudes considered essential, but not captured by academic tests
- To detect students having difficulties and help implement remedial activities

<table>
<thead>
<tr>
<th>Overall achievement in the attachment</th>
<th>I</th>
<th>Conditional Pass</th>
<th>CP</th>
<th>F</th>
<th>P</th>
<th>P</th>
<th>PD</th>
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<tbody>
<tr>
<td>Student name:</td>
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<td>Attachment:</td>
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<td>Class:</td>
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<td>Module Dates:</td>
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<td>Year:</td>
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</tbody>
</table>

### Summary of all formal summative assessments

Module conveners should maintain a more complete record of student performance separately. This might include some or all of the following:

1. History taking
2. Diagnostic formulation
3. Physical examination
4. Management plan
5. Procedural skills
6. Clinical judgement
7. Interpretation of data
8. Problem solving skills
9. Knowledge base
10. Time management
11. Appropriate professional boundaries
12. Motivation to learn
13. Demonstration of appropriate cultural,
14. Sensitivity
15. Communication skills towards patients
16. Skills in listening
17. Skills in expression
18. Attendance
19. Respect for colleagues
20. Collaboration
21. Problem solving skills
22. Recognition of own limitations
23. Demonstration of

### Collective opinion of relevant tutors on professional attitudes

Not all attributes can be commented on but a concern in any should result in a F or CP:

**Summary of strengths / priorities for improvement / concerns**

Details of “Conditional Pass” and condition(s) imposed (include timeframes where appropriate)

**Convenor signature and date:** ...........................................  **Student signature and date:** ...........................................

**Conditions Achieved**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Achieved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pass ACM</td>
<td></td>
</tr>
<tr>
<td>F</td>
<td>Fail</td>
</tr>
</tbody>
</table>

**Comments on CP result**

(I have seen the above information)
The attributes that may be assessed, and their definitions are as follows:

<table>
<thead>
<tr>
<th></th>
<th>Attribute</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>History taking</td>
<td>able to take a full medical history in an organised manner showing appropriate sensitivity when required; shows increasing ability to prioritise information gathered; can write history up, collating information gathered into a coherent story.</td>
</tr>
<tr>
<td>2</td>
<td>Diagnostic formulation</td>
<td>able to identify the problems, including those from the patient’s perspective, impacting on the patient’s health, identify the most likely differential diagnoses, apply rationally diagnostic tests and critically interpret the results in order to make a diagnosis.</td>
</tr>
<tr>
<td>3</td>
<td>Physical examination</td>
<td>able to perform a competent physical examination, as appropriate to the history and presenting symptoms.</td>
</tr>
<tr>
<td>4</td>
<td>Management plan</td>
<td>able to outline a plan, appropriately prioritised and acknowledged by the patient, of treatment and management based upon a formulated problem list.</td>
</tr>
<tr>
<td>5</td>
<td>Procedural skills</td>
<td>able to carry out a range of practical clinical skills appropriate to the clinical module.</td>
</tr>
<tr>
<td>6</td>
<td>Clinical judgment</td>
<td>able to make appropriate clinical decisions including the need for, and timing of, intervention based upon clinical findings.</td>
</tr>
<tr>
<td>7</td>
<td>Interpretation of data</td>
<td>able to draw together results from diagnostic tests and clinical findings into diagnostic hypotheses.</td>
</tr>
<tr>
<td>8</td>
<td>Problem solving skills</td>
<td>able to suggest approaches to, or solutions for, problems which lie outside the student’s own knowledge base.</td>
</tr>
<tr>
<td>9</td>
<td>Knowledge base</td>
<td>demonstrates in both formal (tutorial, case presentation, etc.) and informal settings (clinical discussion, ward round, etc) an adequate understanding of relevant knowledge.</td>
</tr>
<tr>
<td>10</td>
<td>Tutorial preparation</td>
<td>prepares for tutorials ahead of time by doing requested readings and preparing short talks.</td>
</tr>
<tr>
<td>11</td>
<td>Tutorial participation</td>
<td>actively participates (in keeping with personality/cultural background) in tutorial sessions; participation may be verbal or non-verbal; is not overtly critical of others’ views.</td>
</tr>
<tr>
<td>12</td>
<td>Respect for colleagues and others</td>
<td>demonstrates tolerance and a non-judgmental attitude towards both patients and colleagues, regardless of race, religion or culture.</td>
</tr>
<tr>
<td>13</td>
<td>Collaborative work</td>
<td>shows a willingness to work within a team, assist, communicate and compromise when necessary to further the best interests of the patient.</td>
</tr>
<tr>
<td>14</td>
<td>Demonstrates sensitivity</td>
<td>able to identify the concerns, wishes and needs of patients and modify the clinical approach accordingly.</td>
</tr>
<tr>
<td>15</td>
<td>Communication skills</td>
<td>is articulate, has a good grasp of English.</td>
</tr>
<tr>
<td>16</td>
<td>Skills in listening</td>
<td>able to listen to patients, tolerating their negative affect; hears and acts upon constructive criticism; does not dominate tutorials/ward rounds at the expense of his or her colleagues.</td>
</tr>
<tr>
<td>17</td>
<td>Skills in expression</td>
<td>able to clearly impart information to colleagues, in both formal and informal settings (e.g. ward-rounds, tutorials); able to impart information clearly, sensitively, and appropriately to patients.</td>
</tr>
<tr>
<td>18</td>
<td>Attendance</td>
<td>is present at scheduled clinical and teaching venues; where absence is unavoidable, acts professionally by informing the appropriate people.</td>
</tr>
<tr>
<td>19</td>
<td>Motivation to learn</td>
<td>willingness to research clinical cases. Makes good use of teaching opportunities; demonstrates evidence of independent learning.</td>
</tr>
<tr>
<td>20</td>
<td>Time management</td>
<td>is punctual; able to prioritise duties; gets assignments in on time.</td>
</tr>
<tr>
<td>21</td>
<td>Appropriate professional boundaries</td>
<td>acts professionally in his or her interactions with patients, colleagues and peers; understands the power imbalance that exists between doctor and patient and that sexual relationships with patients are inappropriate.</td>
</tr>
<tr>
<td>22</td>
<td>Recognition of own limitations</td>
<td>knows when out of his or her depth in terms of knowledge, clinical skills or professional situations; seeks appropriate help and does not attempt to cope alone.</td>
</tr>
<tr>
<td>23</td>
<td>Appropriate cultural, religious and ethical sensitivity</td>
<td>demonstrates understanding of, and respect for, patients’ and colleagues’ different cultural, religious and ethical beliefs; does not force own beliefs on others or discriminate against others on the basis of culture, race, or religion; acts professionally in situations where ethical issues are prominent.</td>
</tr>
</tbody>
</table>