Cultural Competence in GKT School of Medical Education

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Background

- 2020 is marking human history with unprecedented turbulences—the ongoing pandemic, the unfortunate killing of George Floyd, and the subsequent BLM movement, Brexit, just to name a few. These events bring diversity and health equality back to the fore in social discourse as well as in healthcare and medical education. The GKT School of Medical Education is one of the few UK medical schools that have initiated comprehensive cultural competence training aiming to produce future doctors that can treat all with dignity, respect and fairness.

National Drive: Cultural competence (CC) is required of all future doctors

1. **Professionalism attitude: 2j**: Recognise the potential impact of their [newly qualified doctors] **attitudes, values, beliefs, perceptions and personal biases** (which may be unconscious) on individuals and groups and identify personal strategies to address this.

2. **14** Newly qualified doctors must be able to work collaboratively with patients, their relatives, carers or other advocates to **make clinical judgements and decisions** based on a holistic assessment of the patient and their needs, priorities and concerns, and **appreciating the importance of the links** between pathophysiological, psychological, **spiritual, religious, social and cultural factors** for each individual.

3. **Consultation/communication: 11b:** encourage patients' questions, discuss their understanding of their condition and treatment options, and take into account their ideas, concerns, expectations, values and preferences.

4. 10a: making adjustments to their communication approach if needed, for example for people who communicate differently due to a disability or who speak a different first language

5. **10b:** when English is not the patient's first language - by using an interpreter, translation service or other online methods of translation

6. **Health promotion: 25c:** evaluate the environmental, social, behavioural and cultural factors which influence health and disease in different populations

7. **25d:** assess, by taking a history, the environmental, social, psychological, behavioural and *cultural* factors influencing a patient's presentation, and identify options to address these, including advocacy for those who are disempowered

8. **24d**. recognise sociological factors that contribute to illness, the course of the disease and the success of treatment and apply these to the care of patients – including issues relating to health inequalities and the social determinants of health, the links between occupation and health, and the effects of poverty and affluence

King's Overarching MBBS Learning outcomes for CC

- **Stage one (year 1)**
- Demonstrate curiosity, openness, and the ability to suspend disbeliefs about other cultures and beliefs about one's own as a way to avoid biased judgement and discrimination of others;
- Identify opportunities for continuous learning and enhancing cultural competence in any educational and clinical settings;
- **Stage two (years 2-3)**
- Engage with education and research to advance the understanding and implementation of culturally and linguistically appropriate health services;
- Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Critique intercultural health and health care events, drawing on both general and specific cultural knowledges;
- **Stage Three (years 4-5)**
- Advocate against and effectively handle any form of discrimination against self, colleagues and patients, based on disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex, sexual orientation;
- Demonstrate and sustain leadership that promotes culturally and linguistically appropriate services and health equity through policy, practices, and allocated resources in the service area;

A spiral curriculum integrated in the 5-year programme

What is currently taught about CC in medicine?

Stage 1 (year 1)

- *Introduction to Cultural Competence lecture*: This lecture introduces students to the rationale of developing clinical culture competence, the basic concepts (e.g. culture, diversity, equality, racism etc.), Popular culture competence models, and the manifestation of diversity.
- *Cultural competence & diversity workshop*: This workshop help students reflect on their own culture and its impact on the way they participate in social interactions.
- *Integrated patient scenario*: In this communication and clinical skills simulation workshop students will practise their clinical skills of assessing BMI of an obese patient, and discuss the possibilities of lifestyle change. This session requires students to recognise the culture of patients which is different from the culture of the doctor, and how the individual culture determines what is valuable and acceptable behaviour for the patient.

Stage 2 (years 2-3)

- *Living with disability workshop (yr2)*: This workshop helps students to understand the life of people living with rheumatoid arthritis and develop their consultation and communication skills.

Stage 3 (years 4-5)

- *Cultural competence webinar (yr4)*: This consists of a series of talks covering the topics of caring for homeless people, caring for LGBTQ patients, working with an interpreter, intersectionality of patients who are homeless, substance users and sex workers.
- *Social determinants/structural competence*: run as webinar in Global Health block in year 4.

What is being developed?

- Clinical simulations on medical consultations, through the mediation of interpreters.
- Clinical simulations/reflections on conducting consultations with LGBTQ patients.
- Reflective sessions on racism, discrimination, institutional racism
- More representations of black clinical and non-clinical lecturers in junior years.

MA Module in Intercultural Clinical Education---a train the trainers programme

1. develop an understanding of **key concepts** of culture and **how they affect** clinical decision making, motivation and behaviour;
2. **explore individual beliefs and values** as a starting point of intercultural learning;
3. critically **examine** current cultural competence models used in clinical education and practice;
4. explore current **models** of intercultural clinical education and **new methods** in clinical education to prepare students, clinicians and trainers for a diverse globalised clinical work environment.

This module is to prepare clinical teachers to deliver CC in their own disciplines.

Myreadinglist

READING LIST FROM THE MA MODULE

- 7TTY0021 - Intercultural Clinical Education

Some key concepts and materials about cultural competence in medicine and healthcare

What is Culture?

- Culture influences every aspect of our lives, yet rarely intrudes into conscious thought.
- Culture is both individual and shared. In other words, while individuals may share characteristics, values, and beliefs with others, the degree to which the characteristics are shared can vary greatly.
- Individuals may belong to many cultures.
- We all approach a situation from our own individual and cultural bias
- Cultural differences are not about right or wrong—just differences.
- Self-awareness is the first and most critical step for developing cultural competence.

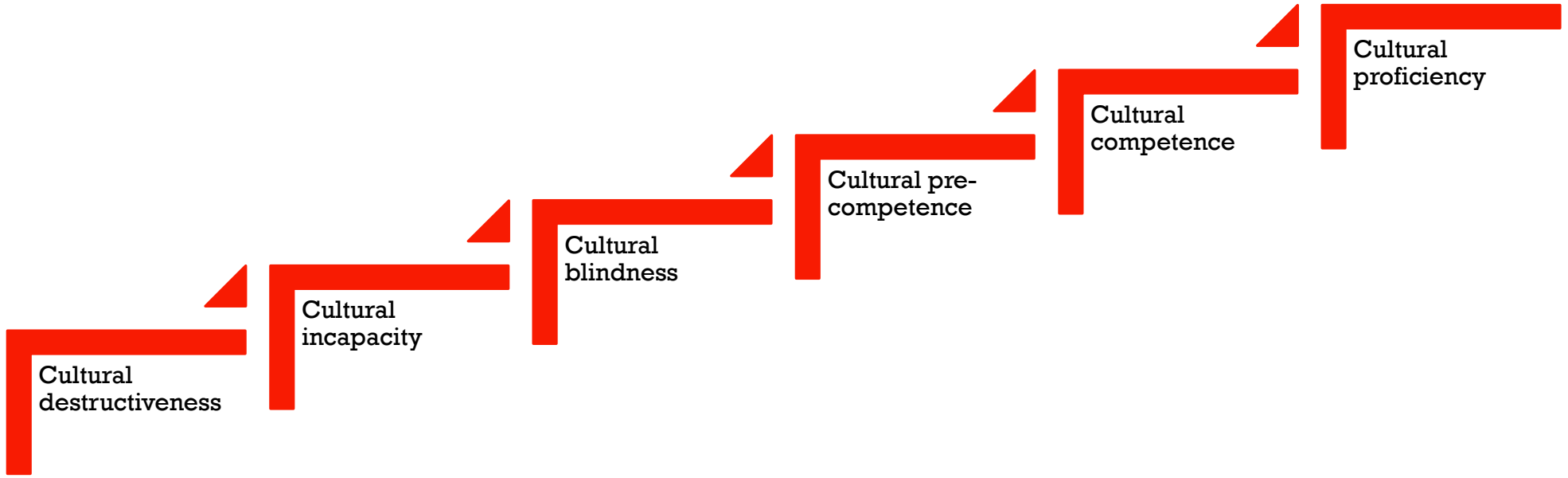
- (Leininger, 1990, Srivastava, 2007)

What is cultural competence?

- A set of values, behaviours, attitudes, and practices within a system, organization, program or among individuals and which enable them to work effectively cross culturally.
- The ability to honour and respect the beliefs, language, interpersonal styles and behaviours of individuals and families receiving services, as well as staff who are providing such services.

(Denboba, MCHB, 1993)

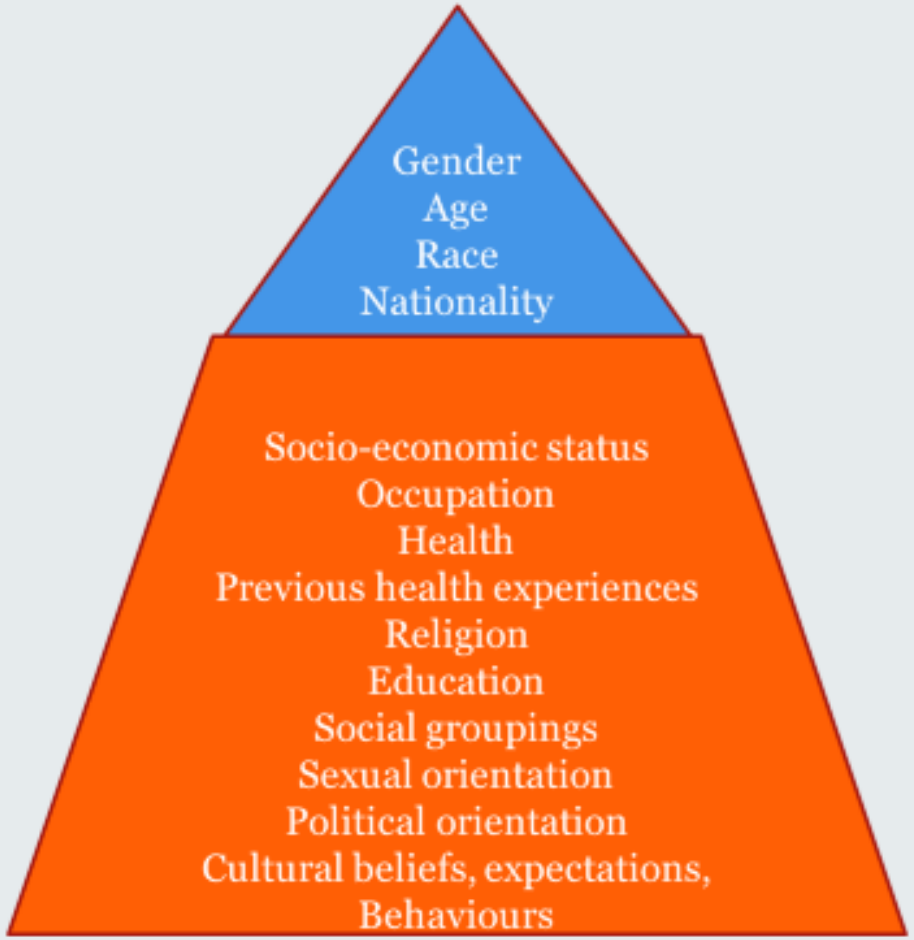
Cultural competence continuum (Cross, 2001)

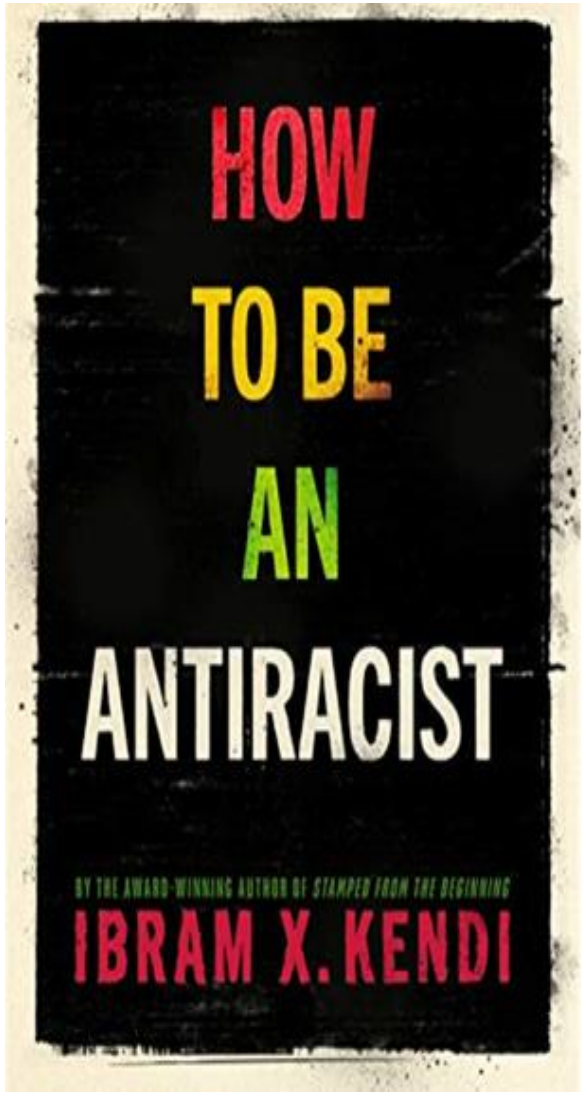


1. Focusing on the superiority of one culture or race, causing destruction to care
2. Aware of the needs to do things differently but not recognise the significance of cultural competence or feel powerless against the system
3. Deny cultural differences and treat all the same; it prevents to examine longstanding systemic biases
4. There is willingness and commitment to engage and involve but runs the danger of tokenism and false sense of achievement. HC professionals may feel demoralised if encountered with challenges.
5. Recognise and respect for differences; conduct ongoing self-assessment and working with diversity. It requires understanding of policy and practice and continuous review of both.
6. Innovative and creative, striving for better care for all.

Elements that shape one's culture

Iceberg model
(Kai 2006, 109)





Is it just relevant to the victims?

- Racism: a social product of power asymmetry predetermined by certain race who historically considered themselves as superior to others.
- Racist: one who is supporting a racist policy through their actions or inaction or expressing a racist idea.
- Antiracist: one who is supporting an antiracist policy through their actions or expressing an antiracist idea.

A person can be racist is not just because that person is not a good person. It is the society we live in that has given them the power to do so. This power only comes from the one's appearance, nothing else. Racism is in the legislations, in the regulations and in the institutions. It has been there for so long that we do not even notice it, needless to say to challenge it.

Prof Ibram kendi (2019) argues that if a person is not racist, they must be anti-racist; because the inaction means to allow the established racist policies and behaviours to continue to harm.

Structural competence

INTRODUCTION

- Knowledge and power emerge together. One produces and sustains the other. This means that the powerful are able to determine what knowledge is valid and valuable. This process emboldens the power of existing systems that potentially marginalise and oppress certain group of people, making it difficult to disrupt systemic inequality. Medical knowledge, like all knowledge, is socially and politically constructed. It is not *objective or value free.* Instead, it is informed by historically established values by those in power, underpinning the coloniality of medical knowledge.

Structural competence

KEY CONCEPTS

- **Structural competency** is a term used to describe the ability of health care providers and trainees to appreciate how symptoms, clinical problems, diseases and attitudes toward patients, populations and health systems are influenced by 'upstream' social determinants of health (Metzl and Hansen, 2014).
- A 5-point model.
- Recognition of "structures that shape clinical interactions"
- Development of "an extraclinical language of structure"
- Rearticulation of "'cultural' presentations in structural terms"
- Observation and imagination of "structural intervention"
- Development of "structural humility"

Structural competency

KEY CONCEPTS

- **Epistemic injustice** is unfairness related to knowledge (Kidd et al., 2017). There are two kinds of epistemic injustice (Fricker, 2011):

- *Testimonial injustice* is unfairness related to trusting someone's word. An injustice of this kind occurs when someone is ignored or not believed because of their gender, their race or broadly, because of their identity.
- *Hermeneutical injustice* occurs when someone's experiences are not well understood — by themselves or by others — because these experiences do not fit any concepts known to them (or known to others), due to the historic exclusion of some groups of people from activities, such as scholarship and journalism, that shape which concepts become well known.

Becoming an active bystander

Bystander Effect: https://www.psychologytoday.com/gb/basics/bystander-effect

References for healthcare for the LGBT+ community

- BACHMANN, C. L. & GOOCH, B. 2018. LGBT In Britain: Health Report. Stonewall, YouGov.
- BOLDERSTON, A. & RALPH, S. 2016. Improving the health care experiences of lesbian, gay, bisexual and transgender patients. *Radiography,* 22, e207-e211.
- BOOKER, C. L., RIEGER, G. & UNGER, J. B. 2017. Sexual orientation health inequality: Evidence from Understanding Society, the UK Longitudinal Household Study. *Preventive Medicine,* 101, 126-132.
- BRISTOWE, K., HODSON, M., WEE, B., ALMACK, K., JOHNSON, K., DAVESON, B. A., KOFFMAN, J., MCENHILL, L. & HARDING, R. 2018. Recommendations to reduce inequalities for LGBT people facing advanced illness: ACCESSCare national qualitative interview study. *Palliative Medicine,* 32, 23-35.

Other events

Events

These two regular events invite participants to join a safe and confidential space to talk about complicated concepts such as racism, inappropriate touch, and discuss how to deal with challenging situations on campus and in workplace.

- Student evening event on Challenging Discrimination, Harassment and Bullying
- Staff lunch time event on Challenging Discrimination Harassment and Bullying

King's Together Project on Attainment Gap in KCL Health Faculties (June 2020-June 2021)

Funded by King's Together Strategic Award, this project aims

- to establish a sustainable network with a collaborative approach across health faculties to understand and address the attainment gaps through research and educational innovation
- to contribute to creating a more equal health workforce and healthcare system through education

The team is composed of over 32 staff and students from three health faculties.