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Cultural competence is a topic that concerns social scientists and medical anthropologists who pay attention to demographic changes and health disparities. This study demonstrates practical approaches to developing cultural competence in medical education by using factors from the social environment to develop protocols for action. With current concerns in domestic and global health care, it is evident that health care organizations struggle to deliver culturally appropriate services. Additionally, educational institutions also struggle to evaluate culturally applied medical practices and competencies. Unlike medical competence, cultural competence is seldom evaluated, and as a result, a gap exists in health care delivery. The purpose of this research is to examine the changes in self-assessment of physician assistant (PA) medical students and graduates, as indications of changes in their medical practice and attitudes. Key objectives explore how PA medical students self-assess their own cultural competence; what factors impact their evaluation, and if change indicates cultural competence.

The methodology consisted of a qualitative approach designed to conduct focus group discussions, in-depth interviews, and field work, while results of existing

quantitative data was used to inform the study. Triangulation methods substantiated the findings along with environmental and data analysis to provide rigor to this investigation. Participants were students and graduates from a Physician Assistant Studies Program in Oregon.

Major findings showed changes in participants' cultural competence self assessment due to a change in self-awareness, exposure and experiences with diverse underserved populations, in domestic and international encounters with the real world. In conclusion, change in self assessment had actually occurred, but the change in the quantitative results really portrayed a level of development on a cultural competency continuum, but not cultural competence itself.

It followed from these findings that using components which influenced change along with external and internal environmental factors, provided a basis for a model to establish procedures for action. This strategic model, the *praxis of cultural competence*, takes critical elements or protocols to move medical students from theory to practice. From the results of this study we can see evidence of closing the gap between the theory of cultural competence and culturally competent practices.

The Praxis of Cultural Competence in Medical Education: Using Environmental Factors to Develop Protocols for Action

by
Sheryl Magee Stohs

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I understand that my dissertation will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my dissertation to any reader upon request.

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Sheryl Magee Stohs, Author

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DEDICATION

This dissertation is dedicated to my husband, Luther, and our children, Walter Lawrence Doyle, Raymond Alexander Doyle and Megumi Joy Stohs, for their undying love and support as we have lived and walked this cultural journey together.

The Praxis of Cultural Competence in Medical Education: Using Environmental Factors to Develop Protocols for Action

By

Sheryl Magee Stohs

CHAPTER I
INTRODUCTION

Medical educators have a responsibility to teach students to communicate effectively, yet ways to accomplish this are not well defined (Kalet et al., 2004). Much is said about diversity and identifying cultures, but there is limited information that validates and/or standardizes assessments of medical students in a health care environment. More recently, standards have been recommended for addressing cultural competence in health care organizations, but criteria to evaluate the development of cultural competence in medical education are still a mystery.

Cultural competence is a term that is not widely understood. At the Society for Applied Anthropology Conference (SFAA) Conference in 2003, I observed a presentation on cultural competence in which the presenters questioned the validity of the concept. They suggested a substitute term or terms that would reduce the impact of cultural competence. Their argument was that the ability to achieve cultural competence as in "medical competence" was not attainable. This suggestion caused an uproar among the audience participants, who seemed stunned that the presentation appeared to have a hidden agenda.

We seem to understand medical competence, but when the qualifier of 'cultural' is added the sense of understanding may bring a different meaning. Some might even wonder if the possibility of becoming culturally competent the same way a health care professional is medically competent is attainable. Others may even feel that developing appropriate procedures or protocols for developing cross-cultural knowledge and even evaluating it, is too complicated. Yet, consider medical disciplines that include diagnosing and treating a medical condition affecting ones health and well being. Would a person be concerned if this skill included developing an attitude of inquiry and ability to assess information, calibrating the language and vocabulary to accommodate communication, while eliciting an understanding of the patient's perspective of the condition and all contributing factors as seen by the

patient? Would it be too much to expect a level of knowledge regarding the identification of certain conditions and contributing symptoms and health factors in order to treat, and determine and recommend a course of action? Would it further stretch the expectation that these abilities, attitudes, knowledge and understanding help formulate appropriate skills which constitute a level of medical competency? If the answer is to accept the importance and validity of this competence in medicine, then the acceptance of cultural competence can follow. Therefore, it is important to begin with a definition of cultural competence.

There are several accepted definitions that can be analyzed theoretically from each of the following two perspectives: (1) cultural competence as a "means to an end," a *process,* and (2) cultural competence as an "end unto itself," a *goal* to be reached. To approach the definition of cultural competence one must first consider the context of culture and its definition. Culture refers to "shared values, traditions, norms, customs, arts, history, folklore or institutions of a group of people" (Orlandi, 1992). From this perspective culture is viewed from the standpoint of issues relating to ethnicity, languages, beliefs, and how people function.

When a medical professional or medical student encounters a person in a clinical setting, that person is not just encountering *medicine*, but he/she has encountered another patient and the sum total of their culture. This is also true for the patient, when he/she encounters a medical professional. When the encounter takes place and the inquiry begins, the responses from the patient are delivered with the backdrop of his/her own health care beliefs, values, traditions, norms, customs, history, etc. When the medical student responds in the encounter he/she also reciprocates with his/her own values, health care beliefs, norms, traditions, etc. that have been massaged by the customs, practices, protocols, education, norms, values, etc. of his/her medical education. Hence, cross-cultural communication of a very complex nature is taking place and this communication requires some level of cultural competence in order to be effective in the health care setting. While many definitions of cultural competence have evolved from the notion of culture, I have chosen the

following definition to work from in my research because it addresses both individual and organizational aspects of the term:

> Cultural competence is the ability to serve and support individuals and families in our communities from all cultural backgrounds. To be culturally competent an organization needs to have both the ability and the interest to develop and continuously enhance its understanding and appreciation of cultural differences and similarities between and among groups (Kula, 2002)

Although this definition defines cultural competence in terms of critical characteristics, measuring how clinicians practice or learn medicine, with respect to cross-cultural knowledge, has not become a benchmark. There are generally accepted practices within social settings for dealing with diverse cultures, but the broadness of the topic of cultural competence has required the medical community to expand its awareness of the issues that impact health disparities in the twenty-first century.

In the last decade medical anthropologists and sociologists have provided academic applications to the medical community for encountering diverse cultures. Yet there seems to be a conflict between the social scientists and the applied health care professionals as to whether cultural knowledge can be raised to a level of real competence in order to be assessed. There is a lack of knowledge regarding assessments, limited understanding of diverse communities and insufficient clarity of the nuances in the social environment that can support the needs in health care education.

Other factors that contribute to this problem (the dilemma of whether cultural knowledge can be raised to a level of real competence) relate to traditional practices of Western medicine. A medical practitioner is skilled in the practice of medicine and healing, with an understanding of ethics. Therefore, while he or she must consider that all human beings have anatomical similarities, diagnosing and treating a condition without regard to race, color, creed, religion, gender or financial means, can lead to complications and barriers to the healing process. Cultural competence calls for an expansion of the practitioner's skill to diagnose and treat with regard to these same socio-factors.

Now, we must ask more specifically, how can cultural competence be adequately and accurately defined in the medical and educational environment when there are many definitions that have been accepted by government entities, policy makers, health care organizations and professionals? This question is among many that require resolution internal to the educational process of health care professionals. We shall see that while internal questions present challenges to educating the health professional, external factors play an additional and pivotal role in this process of developing cultural competence.

With the change in demographics in our communities, the role that diverse backgrounds and cultural beliefs will play in health care will be significant to cultural competence. Demographic changes have always occurred in our domestic health care arenas, but these changes, as well as health disparities within the last two decades, have become more rapid, compelling the need for culturally competent health care professionals. Disparities in healthcare are defined to be "racial or ethnic differences in the quality of healthcare that are not due to access related factors or clinical needs, preferences, and appropriateness of intervention" (Smedley, Stith, & Nelson, 2003) . It is believed that one of the strongest contributors to health disparities is the lack of cultural competence consistent with cross-cultural communication in the health care community – clinicians encountering diverse patients with backgrounds, beliefs, etc. different from those of the clinician. If medical education can form a bridge for health care in diverse communities, then it is worth exploring the assessment of cultural competence in the educational environment to develop cultural competence protocols.

The problem of assessing cultural competence can be explored though the medical education of the Physician Assistant (PA) student. This study began by investigating how and why Physician Assistant students self-assessed their own cultural competence. Physician assistants are "non-physician health care providers" (Smedley et al., 2003).

> They are licensed to practice medicine with physician supervision. As part of their comprehensive responsibilities, PAs conduct physical exams, diagnose and treat illnesses, order and interpret tests, counsel on preventive health care, assist in surgery, and in virtually all states can write prescriptions (AAPA American Academy of Physician Assistants, 1998-2005).

Physician Assistant graduates and PA students of Pacific University School of Physician Assistant Studies Program were invited to participate. The knowledge gained from focus group discussions and interviews informed the researcher not only regarding concepts, practices and applications for clarifying cultural competence, but also in understanding the factors necessary to develop effective protocols for training culturally competent health care professionals.

The primary objective of this research was to discover why physician assistant (PA) medical students, in the class of 2004, self assessed their cultural competence lower at graduation than when they entered the PA program. Secondary objectives were to (1) discover what influenced cultural competence self-assessment of the PA students; (2) evaluate the impact of the medical environment on their cultural competence self-assessment; and (3) determine if change in their self-assessment indicated cultural competence.

The benefit of answering these questions helped bridge the gap between medical training and professional practice in delivering culturally competent health care services to diverse and underserved communities. This research fits in with the larger goal as recommended by the Institute of Medicine. "...Research should assess how educational programs can best improve ...attitudes, behaviors, and communication with racial and ethnic minority patients" (Smedley et al., 2003).

The primary information presented relies on qualitative methods used to collect the data and the analysis of findings. Secondary information from the results of cultural competence self assessments is presented in order to show the change in pre and post measurements for the classes of 2002, 2003, and 2004 of the PA program. These resulting measurements provided the starting point for this investigation. Reflections and discussions are presented to give context to my thinking in developing the conclusions and recommendations for this research study. The next chapter presents the literature review, which examines existing research that is significant to my study.

CHAPTER II

LITERATURE REVIEW

This chapter is a review of the literature covering the practical application of theory. It comprises four key areas that form an interdisciplinary strategy in my research: social environment, medical anthropology, cultural competence and medical education. Given that there is strong evidence for socio-cultural barriers to health care at multiple levels of the health care system, culturally competent care is a key cornerstone in efforts to eliminate racial/ethnic health disparities. This statement warrants reviewing the evidence through the research databases that make reference to the medical/social/environmental issues in my study (see Table 2.1 below).

Table 2.1

Reference Search Categories	PUBMED	EBSCO
cultural competence	342	346
cultural competence, medical education	31	22
medical anthropology	585	833
medical anthropology, cultural competence	2	3
medical education	74547	33104
social environment	24028	24006
cross-cultural	3535	14281
social environment and medical education	100	68
social environment, cultural competence	0	0
medical education, medical anthropology	3	11
cultural competence, medical education, and social environment	0	0
cultural competence and clinical competence	97	211
social environment of care	0	4
critical medical anthropology	21	29

Results of Data Base Search

Under the topics which were key to my research the following counts for peer review journal articles were revealing. Both Pub Med and EBSCO had listed and cited over 24,000 journal articles under the key words "social environment". Under the key words of "medical education" Pub Med listed over 74,500 while EBSCO referenced a little over 33,100 journal articles. This would indicate that numerous articles and studies had been done in these two disciplines. Yet when the term "cultural competence" is researched through these same databases, only 342 and 346 journal articles respectively are cited for Pub Med and EBSCO.

When I considered that many scholars reference the term cross-cultural communication in the medical and health care environments, I searched these same databases for that term. My findings showed that there were a greater number of journals cited under this term; PubMed identified over 3,500 and EBSCO cited over 14,000 articles. Using these same databases to explore the journal wealth regarding "medical anthropology," the findings were not overwhelming. PubMed cited over 500 journals, while EBSCO cited a little over 800. When associating *cultural competence* with any of the other disciplines medical education, social environment or medical anthropology, the number of cited journal articles within these two databases declines considerably or is non-existent. Thus, Lazarus' remark "...the social environment of care has been little studied" has some validity (Lazarus, 1990).

Other scholars such as Joseph Betancourt, a leading physician and scholar in the fore-front of developing perspectives on cultural competence recognizes that there is a need to develop strategies to evaluate the impact of curricular interventions (Betancourt, Green, Carrillo, & Owusu Ananeh-Firempong, 2003). But in spite of this need for more research, as indicated by Betancourt and other scholars in this area, there has been limited evaluation published to date on the impact of cross-cultural medical education (p.563).

Research and literature being reviewed are in the areas of medical education, social environment, cross-cultural, and cultural competence. All of these subjects lie within the interest of *medical anthropology*, which provides the theoretical perspective for my investigation.

Considering the literature available, I selected resources for review from key researchers and scholars in the combined fields of medical anthropology and medical education. I further combined these searches to review resources which included cultural competence and other scholars who have recognized the importance of the social environment in health care.

Resources include writings and research by Peter J. Brown, Merrill Singer, Hans Baer, Joseph Betancourt, Robert Like, Tawara Goode, James Mason, Campinha-Bacote, Locke, Cross, Trevalon, Green, the US Dept of Health and Human Services, Institutes of Medicine, and the National Center for Cultural Competence. Cultural competence conferences were also a good source of reference where leading researchers presented scholarly work as well as standards and resources for cultural competence.

Many writings and scholars have taken the recommendations from the previously mentioned individuals and organizations, but for the purposes of this research I selected those studies and writings that are most appropriate and provide background and understanding for questions answered in my research regarding the assessment of indicators of cultural competence in medical students.

Medical Anthropology

Before addressing the literature concerning cultural competence, I explored the theoretical perspective of what makes cultural competence a viable subject to study, and why the wealth of knowledge and research in this area may still be lacking. Peter J. Brown's work provides the framework for applied medical anthropology that gives rise to some of the questions being researched in this interdisciplinary study. In Brown's text, *Understanding Medical Anthropology*, the topic of medical anthropology is presented from two viewpoints, *bio-cultural* and cultural approaches. According to Brown,

> The term *bio-cultural* (or biosocial) refers to an anthropological view of the ways in which people adapt to their environment and change that environment

> that make health conditions better or worse...cultural approaches...emphasize the role of ideas, beliefs, and values in creating systems of illness classification and medical programs for curing illness (Brown, 1998)

Brown presents an exhaustive and simplifying view of the appropriate articles, and case studies that cover the topic, medical anthropology, from five perspectives. He recognizes and admits to the relative newness of this sub-field of anthropology, and also makes a case for sub-fields of medical anthropology. He further stresses the argument for the actual need for this specialized field of anthropology. Definitions of common terms (sickness, illness, healing, and disease) that we may take for granted are discussed. Brown engages his readers by approaching this new field from different directions yet, his main focus is on health care, in the broadest sense, and it's affect on diverse communities. His five approaches consider (1) biological, (2) ecological (3) ethno-medical, (4) critical and (5) applied medical anthropology (Brown, 1998). It is the fourth approach, *critical medical anthropology,* with which my research has a greater connection because this approach focuses on the issues of provider-patient communication, as well as understanding the impact of political and economic forces, human relationships, behaviors and experiences which generate cultural meanings relating to health issues (Singer & Baer, 1995).

Many scholars have been critical of their colleagues who persisted in thinking that health disparities were the result of local socio-cultural differences (Brown, 1998). It has been common thinking that: either a person was among the underserved populations in health care because they did not have the money for health care, no insurance, they lived in sub-standard housing, their education was insufficient to understand risks to their health, ill social behavior, limited or no access to health care in rural America; or that people came from areas where they had no previous health care, e.g. immigrants, refugees, etc.

While these considerations do contribute to my study of the medical environment, focusing on the area of medical education, medical anthropologists are known for studying *shamans and healers*, using ethnographic descriptions of their cross-cultural encounters. So it makes sense that studying the education of *healers*

today, in the case of this study, "would-be" health professionals, Physician Assistant (PA) medical students, from an anthropological perspective, is beneficial to understanding the application of critical theories that surround the health care delivery system and health disparities. This approach refers to an inquiry that Brown calls critical medical anthropology (CMA).

> Critical medical anthropology can be defined as a theoretical and practical effort to understand and respond to issues and problems of health, illness and treatment in terms of the interaction between the macro level of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the micro level of illness experience, behavior and meaning, human physiology, and environmental factors (Baer et al.1986; Scheder 1988; Singer 1986, 1990a in (Brown, 1998)).

From the perspective of these discussions, arguments, and even advocacies, to study health and the implications of health disparities, Merrill Singer and Hans Baer have developed a social science series on *Critical Medical Anthropology*. They pursue their argument, challenging previous models for their adequacy, and pointing out the contradictions in the medical anthropology camp (in which other medical anthropologists really are seeking to adhere to their own principles of research to improve the health of human society, eliminating the barriers to that end). The following example summarizes this approach:

> By its very nature as a social science concerned with socio-cultural phenomena, medical anthropology is a critical project that challenges, to some degree the adequacy of the disease model of biomedicine (Singer & Baer, 1995).

Their book gives further examples of case studies demonstrating why and how critical approaches to health care need to be taken, looking at the political and economic effects of health care and our society. Evidence is given for issues of hegemony, social environment, relationships, knowledge and the dynamics of change. Basically, Singer and Baer address the issues of *power and inequality* as prime reasons to explain the issues behind health disparities.

Singer, in his article *Critical View of Medical Anthropology*, stresses that the challenge to anthropologists is not just to study their subjects (human kind and human systems), but to push for positive change in the health care systems that will not render human kind as a victim of cultural system praxis (Singer & Baer, 1995). The implications for health care delivery under the CMA praxis do not just stop with the medical environment, but also extend to economic environments as well. Actually, Singer reaches for the second most powerful word in his argument for CMA—funding. His perspective seems to be that change cannot occur without the capitalist entrée of money. I hope that this is not the fundamental catalyst for the work of the medical anthropologist. While funding, money, is certainly a pragmatic resource for continuing research in understanding and eliminating health disparities, I believe developing and using cultural competence in a position of influence in health care systems, higher education and government organizations is a powerful way to counteract health disparities.

Cultural Competence and Health Disparities

Greater attention is now being placed by government and the private health care industry on cultural competence in light of the overwhelming literature on racial/ethnic disparities in health and health care (Betancourt, 2003; Betancourt et al., 2003). Yet, a review of the literature indicates that very little has been published in the area of self- assessments of cultural competence or in the disciplines of medical education and its impact on cultural competence. Many people have the perspective of culture as only being the race or language, traditions and tangible items that we can bring back, for example, when we go on a vacation. But culture is more than that, and because of this broadness and characteristic of being intangible, it is important to understand the social and cultural influences that impact health and wellness from a wider perspective, as Betancourt states,

> ...in health care,...understanding the importance of social and cultural influences on patients' health beliefs and behaviors, considering how these factors interact at multiple levels,...and...devising interventions that take these issues into account... (Betancourt et al, 2003).

Cultural competence is demonstrated not only by the broad knowledge of cultural groups represented, but also through a wealth of practical, experience-based knowledge about the community being served (HRSA Health Resources and Services Administration, 2001).

In light of the importance of this topic this section will concern itself with a review of the literature on cultural competence in three areas:

1. Defining cultural competence and the significance of its use in health care.
2. Assessing cultural competence in health care settings, including medical educational environments.
3. Developing competencies in medical and health care professional education.

Cultural Competence and its Significance in Health Care

The literature on cultural competence approaches the issue of competence in two ways: theoretical and methodological (OMH Office of Minority Health, 2003). Accepted definitions of cultural competence can be analyzed theoretically from each of these perspectives: (1) cultural competence as a "means to an end," a *process,* and (2) cultural competence as an "end unto itself," a *goal* to be reached. To approach the definition of cultural competence one must first consider the context of *culture* and its definition. Culture refers to "shared values, traditions, norms, customs, arts, history, folklore or institutions of a group of people" ((Orlandi, 1992)) From this perspective culture is viewed from the standpoint of issues relating to ethnicity, languages, beliefs, and how people function. Functionalism is one of the many theoretical schools of thought for anthropology. This framework holds to the thinking that cultural institutions function to meet the basic physical and psychological needs of people in a society (McGee, 2000, p.158). Functions within health care organizations require cultural competent processes in order for to meet the appropriate needs of diverse patients.

Campinha-Bacote discusses the "process" factor of cultural competence by presenting a model of cultural competence that health care providers and organizations can use as a framework for implementing culturally responsive services (Campinha-

Bacote, 1999). Five constructs are given as a way of addressing cultural competence: (1) cultural awareness, (2) cultural knowledge, (3) cultural skill, (4) cultural encounters and (5) cultural desire. The author defines these terms within the model, the Inventory to Assess the Process of Cultural Competence (IAPCC). This is a tool developed by this researcher to measure cultural competence and was field-tested, with nurses, but has limitations regarding reliability. Since this model for measuring cultural competence approaches the concept from a theoretical framework, it was important to look for a definition that can be measured from an operational perspective.

While many definitions of cultural competence have evolved from the notion of culture, I have chosen the following, which brings in the ability to wisely apply action, using culture as a basis for directing service and support:

> Cultural competence is the ability to *serve and support* individuals and families in our communities from all cultural backgrounds. To be culturally competent an organization needs to have both the ability and the interest to develop and continuously enhance its understanding and appreciation of cultural differences and similarities between and among groups (Kula, 2002)

To develop a better understanding and practical use for this definition we will explore both theoretical and methodological aspects of the definition. The theoretical considerations would answer the question of whether this definition is consistent with the goals of other accepted definitions of cultural competence. The methodological considerations would answer whether this definition will work.

Theoretical vs. Methodological

Let's explore this definition of cultural competence from a theoretical perspective. Is this definition a means to an end? Is it theoretically rooted in an approach that is consistent with other definitions? Is it a process to reach other goals? We notice first, in this definition, that cultural competence is described as *ability*. This quality extends beyond a cognitive approach, and implies a behavioral quality that permits or facilitates achievement (hyper dictionary); a "can-do" characteristic. One might ask, "...can do what?" A key factor that organizations and individuals must

possess is an ability to act or respond to the specific and unique needs of their patients, clients, or individuals in a community.

Salmon and Hall state, "The discourse of the patient as an active agent in managing illness and health care has become very important in medicine. It is seen in the significance attached to patient empowerment and participation, and in the burgeoning research into patients' coping with illness" (Salmon & Hall, 2003) Without the ability to act, there is no empowerment for the provider, patient, or ultimately the organization or the community. Theoretically, this part of the definition matches with other cultural competence definitions. Compare, for example, the South Carolina Department of Mental Health's definition: "Cultural competence is the ability to work effectively within the cultural orientation values of others..." (Latiff-Bolet, 2003).

This ability spoken of in the definition I have chosen (Kula, 2002) is an ability to *serve and support.* This phrase indicates that action is required to render service, to help and to "support, stand up under, and even to adopt a belief" (hyper dictionary). In researching the guidelines for assessing cultural competence, the necessary qualities of culturally competent organizations or individuals include, among others, helping communities and adopting new beliefs in delivering services to diverse communities. The "daily experiences of community members, shared in teaching settings, locate culture in the context and quality of life and health in that moment, for that community, in that uniquely complex interface of culture, health, and society" (Trevalon, 2003).

Cultural competence "means more than client satisfaction with services that only minimally meet the cultural or linguistic needs of the target community" (HRSA, 2001). While serving implies that one is aware of and sensitive to cultural needs, a culturally competent system is also "built on awareness of the integration and interaction of health beliefs and behaviors, disease prevalence and incidence and treatment" (Lavizzo-Mourey, R., MacKenzie E. in (Betancourt et al., 2003). Without this awareness and sensitivity some form of empowerment could be present, but it would be without the awareness, or knowledge and sensitivity to act appropriately.

Kula's definition goes farther by focusing on whom to serve and support. The object in this case is *individuals and families*. There is recognition that an organization, program, or community is not only made up of individuals and families, but that these individuals and families must be served and supported. Here is where most researchers begin to classify and categorize by ethnicity. But what can we learn from the families and individuals that need access to health care? Leninger describes a Sunrise Model that includes seven dimensions of identification of individuals, using: (1) cultural values and life-ways, (2) religious, philosophical, and spiritual beliefs; (3) economic factors, (4) educational factors, (5) technological factors, (6) kinship and social ties, and (7) political and legal factors (OMB Office of Minority Health, 2002). Although this culturally relevant package provides a broader arsenal of information to support and treat individuals, using cultural competence, the right questions still must be asked.

One might ask "Is it true that no man is an island?" If the premise is true (that no man is an island) then it follows that we must have structures and people in place to provide services that meet the needs of *both* individuals *and* families. Many people disagree with the theory of this statement (that cultural needs must be met), from the perspective of "real people" (human bodies and minds, regardless of culture). Basically, health care providers are "real people" with differences in culture, who diagnose and treat other "real people." This argument collapses when one considers the intangibles that are actually present within health care settings, and in clinical encounters that are influenced by the culture of "real people."

Clinical *barriers* can many times be *intangibles*; however, they are significant and must be removed in order to support families. Clinical barriers have to do with the interaction between the health care provider and the patient or family. They occur when socio-cultural differences between patient and provider are not fully accepted, appreciated, explored, or understood (Betancourt et al., 2003) One key element of support is to eliminate barriers.

The definition of cultural competence described at the beginning of this paper begins to make evaluating the practice of cultural competence possible, by providing

the guidelines for the presence of cultural competence. Both the *ability* and the *interest* must be present. These two key components in the definition require more than the present theoretical framework to explain. Moreover, they also provide an *applied* basis for cultural competence on which to stand. Both conditions (ability and interest) must be present, so we can say that an organization or program or individual must possess a certain *power*, as well as have an interest. Now here is where the definition brings in a new theoretical concept.

How does one qualify or define *interest*? Theoretically, most definitions have not leaped to this end. In order to determine if someone is interested in other cultures, just saying it is not enough. True *interest* must be evidenced by *actions,* and may have methodological implications. This is in contrast to Betancourt, et al (2003), who has defined cultural competence as identifying components for intervention. For them, "Cultural competence in health care entails understanding the importance of social and cultural influencers on patients' health, beliefs, and behavior, considering how these factors interact at multiple levels of the health care delivery system...[which includes] clinical decision-making" (Betancourt et al, p.297).

As Kula and others have coined a definition of cultural competence that is workable for this research, it is worth reviewing other accepted definitions. T. Cross's et al definition is probably the most widely used in health and social services,

> Cultural Competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross, Bazron, Dennis, & Isaacs, 1989).

Particularly in the area of alcohol and substance abuse agencies this definition along with T. Cross et al. cultural competence continuum is applicable in tracking or guiding one's progress in developing cultural competence. A definition put out by the American Medical Association states,

> The knowledge and interpersonal skills that allow providers to understand, appreciate, and work with individuals from cultures other than their own. It involves an awareness and acceptance of cultural differences; self-awareness;

> knowledge of patient's culture; and adaptation of skills (American Medical Association, 1994).

A later version supported by the AMA in the Cultural Competence Compendium...

> Culturally competent physicians are able to provide patient-centered care by adjusting their attitudes and behaviors to account for the impact of emotional, cultural, social and psychological issues on the main biomedical ailment (AMA, 1999).

This last definition is applicable for grant applications with the Health Resources and Services Administration (HRSA): "the level of knowledge based skills required to provide effective clinical care to patients from a particular ethnic or racial group" (HRSA, 2005). There are many more definitions that have been developed and applied by agencies and organizations. As cultural competence involves many cultures, the term multiculturalism comes to mind in determining how this term might be applicable.

Cultural competence vs. Multiculturalism

From one perspective, the term multiculturalism stimulates criticism of achieving this as a goal with diverse communities. It can be said that,

> "Multiculturalism is racism in a politically-correct guise. It holds that an individual's identity and personal worth are determined by ethnic/racial membership and that all cultures are of equal worth. Multiculturalism would turn this country into a collection of separatist groups competing with each other for power, regardless of their moral views or how they treat people. Multiculturalism holds that ethnic identity should be a central factor in educational and social policy decisions (Ayn Rand Institute, 1998).

This statement reflects only one point of view. However, others see multiculturalism differently. The terms "multiculturalism" and "diversity" have been used interchangeably to include aspects of identity stemming from gender, sexual orientation, disability, socioeconomic status, or age. Multiculturalism, in an absolute sense, recognizes the broad scope of dimensions of race, ethnicity, language, sexual orientation, gender, age, disability, class status, education, religious/spiritual orientation, and other cultural dimensions (American Psychological Association,

2002) p.121. Multiculturalism "can [also] be used as a guide to understand culturally diverse individuals and groups" (Locke, 1992).

In Locke's model of multicultural understanding he suggests that one must begin with self-awareness. The other components of his model include global influences, dominant culture, cultural differences, research, theory and curriculum. Even though Locke's model specifies and defines various aspects of multicultural understanding, he does not address skills, which is a necessary aspect of providing culturally competent care (p.12). Developing skills for multicultural understanding would require an application of cultural knowledge as well the components that Locke suggests.

In an applied sense, multiculturalism has its place in clinical encounters. Culturally competent medical practice "describes a skill set that enables a physician, in a culturally discordant encounter, to respectfully elicit from the patient and family the information needed to make an accurate diagnosis and negotiate mutually satisfactory goals for treatment" (Kagawa-Singer & Kassim-Lakha, 2003). This perspective broadens ones view of diversity, cultural competence and multiculturalism in health care delivery. Health Care Organizations accept definitions....

The Institute for Linguistic and Cultural Skills, a division of Harvard Pilgrim Health Care Foundation, was created to help reduce health disparities by providing services to health care and community based organizations and linguistically and culturally diverse communities. Their definition of cultural competence states...

> ...the ability to deliver effective medical care to people from different culture. By understanding, valuing and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health providers deliver more effective and cost efficient care (Harvard, 2004).

In the development of their definition they have taken apart the term cultural competence in order to define the core of the issue, *culture*.

> The learned and shared knowledge, beliefs, and rules that people use to interpret experience and to generate social behavior. The guiding forces behind what people think, say, expect, and do (Harvard, 2004).

This definition and even the dichotomizing of the definition present a rationale that is similar in other definitions of cultural competence. This recognition that cultural competence has to go deeper in understanding the definition is important to looking further at the importance of defining cultural competence in other social, political and cultural contexts.

Social, Political, and Cultural Contexts

As we struggle with defining concepts, understanding theories and methodologies, there are social, political, economic and environmental concerns that challenge our society to take action to address a lack of cultural competence. From the social, political and cultural halls, controversy seems to follow the terms that identify concepts that are supposed to help bring people together. When the issues of race and culture present themselves, tension seems to follow. There is considerable controversy and overlap in terms used to connote race, culture, and ethnicity (Helms & Talleyrand, 1997; in Phinney, 1996). While multiculturalism tends to cover race and ethnicity from a narrow perspective the cultural competence definition seeks to define the competence from a much broader perspective. Since health care is generally dispensed to individuals, and there are other characteristics in addition to race, language, and ethnicity that contribute to a person's sense of self in relation to others, cultural competence seems more appropriate.

Politically, it becomes prudent to evaluate one's own level of cultural competence, as these issues have translated into economic challenges. Social implications of not considering cultural competence, as well as health disparities, have also challenged our health and social service systems, specifically, in human resources, fiscally, and in education and training. The result of these circumstances is a call for "educating health care professionals in the attitudes, knowledge and skills necessary for providing quality care to a diverse population—a nexus of practice patterns and attributes that has come to be known as cultural competence" (Gilbert & Puebla-Fortier, 2003).

The issue of families without proper health care or limited access to health care intertwines with other social systems, including employment (e.g., when people can't

go to work because of illness, or are unable to get a job because of dental problems). As Kagawa-Singer and Kassim-Lakha state, "While understanding the patient as an individual in the context of culture does not prevent conflicts over differing values, beliefs, or practices, information gained from such an assessment serves to identify areas for negotiation of conflicts should they occur" (Kagawa-Singer & Kassim-Lakha, 2003), and, I might add, can also serve as a starting point for reducing barriers to health care. It is important to recognize that many health disparities result from a lack of understanding of the patient's beliefs and practices and how to incorporate the patient's values in appropriate treatment regimens.

Economically, there is more to be concerned with as we reap the benefits of diverse cultures making up our communities but cannot see to provide services that will sustain the profit from the labors of others. Hispanic Farm-workers contribute to a billion dollar agricultural industry within this country but what portion of those economic benefits comes back to them in resources or income? Not surprisingly given the differences in language and education, native-born Latinos earn more than the first generation. According to Current Population Survey data for the second quarter of 2003, first-generation Latinos had mean weekly earnings of $457, the second generation was earning $535 per week, and the third $550 (Suro, 2003). The question to ask is: will our development of cultural competence have an impact on these figures?

The social environmental area is also impacted by our level of cultural competence. Although happiness and well being have long been a concern of social scientists, medical researchers have traditionally focused on pestilence, disease and death. However, recognizing that health is more than the absence of disease, CDC developed a set of health related *quality of life* questions for use in the Behavioral Risk Factor Survey (OHD Oregon Health Division, 2001). (According to this summary, a lack of health insurance was not related to poor physical health. Since this study was done using telephone inquiries it is reasonable to consider whether or not these same conclusions would have been reached if a more culturally competent method was used.)

Our physical environment also is being challenged. This can be seen, for example, by the hazards of the effects of pesticides in rural areas on the air pollution, and by the effects of the production of greenhouse gases in urban areas, and globally as well. "Through multiple means, an original set of 90 Oregon Benchmarks has been narrowed into a smaller set of sustainability indicators in order to gain an integrated view of statewide sustainability as well as the capacity to look at social, environmental, and economic sustainability in isolation" (Schlossberg & Zimmerman, 2003). It will be interesting to see how to address cultural competence in light of these Benchmarks. A different set of questions will be needed in clinical encounters to ascertain the impact of the physical environment on the health of patients.

Given the literature highlighting the importance of socio-cultural factors in the clinical encounters and their impact on medical decision-making and outcomes, targeting providers and their attitudes and practices will be a crucial aspect of an overall framework for cultural competence (Betancourt et al., 2003). In summary, the challenges that face us will cover these issues in the political, economic, social, physical, and environmental arenas as we define and refine the definition of cultural competence in light of the effective delivery of services in diverse communities.

Assessment of Cultural Competence

Health Care Settings

Literature on the evaluation and assessment of cultural competence in medical education is limited. The notion of cultural competence lies embedded within the umbrella of cross-cultural issues. Many peer review journal articles present strategies for developing cultural competence, but also make a claim that there are challenges that leave areas that must still be investigated. Leading author and senior scientist, Joseph Betancourt addresses similar issues.

> Despite the progress in the field of cross-cultural medical education, several challenges exist. Foremost among these is the need to develop strategies to evaluate the impact of these curricular interventions (Betancourt, 2003).

Betancourt's inquiry addresses the meaning of culture and focuses on the traditional means of presenting cultural competence issues as part of a multicultural/categorical approach to cross-cultural education. His premise is that cross-cultural education covers three basic areas: attitudes, knowledge, and skills. This approach is generally considered to be a knowledge based approach, which can be effective in two areas: from the external environment and from the delivery of health care (p.563). Many papers have been published and presented that include the theoretical tenets of cultural competence but the actual testing from quantitative and or qualitative inquiry has only just begun.

Over the last few years as health disparities have become an issue and have been brought to the attention of health care policy makers, practicing clinicians, and health care providers, have been trying to wrap around the issue of assessment. Even more challenging is that many providers do not want the issue of competencies of their cultural knowledge to be considered in their evaluation. This tactic may be due to the fears of many providers, relative to cultural health issues that go beyond their training or practice in medicine. However, these fears seem to be directed more toward external issues and concerns that affect them economically, (i.e. malpractice). Ethical considerations also play a role in assessing cultural competence. Since the focus of this investigation is on medical students, it warrants exploring the literature on how medical students are assessed for their competencies in general.

Medical Education Environments

PAs are educated in a medical model designed to complement physician training and they are taught, as are medical students, to diagnose and treat medical problems The medical educational setting for the Physician Assistant (PA) student is in three basic arenas:

> Education consists of classroom and laboratory instruction in the basic medical and behavioral sciences (such as anatomy, pharmacology, path physiology, clinical medicine, and physical diagnosis), followed by clinical rotations in internal medicine, family medicine, surgery, pediatrics, obstetrics and gynecology, emergency medicine, and geriatric medicine (AAPA American Academy of Physician Assistants, 1998-2005).

In the masters program, research comprises the third environment in social or clinical settings. Very few articles have been written on the evaluation of the PA in these environments. Categories are mostly limited to the how to evaluate the patient evaluation skills, diagnostic skills, treatment from a physical medicine perspective.

> The evaluation of clinical performance is a critically important issue in PA education, yet the validity of clinical evaluation tools utilized by PA programs has not been systematically analyzed in the literature. Studies of medical students and residents have raised questions about the validity of several evaluative mechanisms (Gregg & Dehn, 1999).

Even though this research demonstrates the use of a tool for evaluating students' clinical abilities, it questions with the diversity of patients how to actually evaluate appropriately the clinical experience. The Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) has indicated general requirements for diversity education, but does not specify target areas within diversity in which students should be educated (Marquez, 2003). This would seem to indicate that the limitations of this instrument leave a gap in understanding how to practically apply cultural learning and diversity training in clinical settings.

A PA's ability to take patient histories and retrieve full information does not always get at the underlying cultural issues. The ARC-PA describes the role of the physician assistant as "one that requires good interpersonal skills, respect for self and others, and commitment to the patient's welfare." But, Marquez suggest that these values and skills can only be accomplished with an understanding and respect for diverse populations (p.116). Still, this does not operationalize the concept of cultural competence in health care delivery. Betancourt agrees that the cross-cultural approach teaches skills that meld those of medical interviewing with the ethnographic tools of medical anthropology. "Despite the lack of extensive literature on cross-cultural curriculum evaluation, it is clearly possible to develop a framework of assessment that is modeled after those utilized for other educational processes" (Betancourt, 2003). Several scholars and organizations have begun establishing guidelines and standards for cultural competence.

Evaluation and Standards

It is important to note that in recent years the focus of governments and organizations has been to establish guidelines and standards for cultural competence in health care. Jean Gilbert and a team of scholars received a grant to develop *the* Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals (Gilbert & Puebla-Fortier, 2003). The Health Resources and Services Administration (HRSA), U. S. Department of Health and Human Services contracted The Lewin Group, Inc. to conduct the research necessary to prepare the document, Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile (Lewin Group, Linkins, MacIntosh, Bell, & Chong, 2002).

National standards were issued by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) to respond to the need to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) were formed and finalized to ultimately contribute to the elimination of racial and ethnic health disparities (US, 2000).

Books and articles have been written presenting arguments for and against health disparities and their cause(s). In addition, greater attention is now being placed by government and the private health care industry on cultural competence in light of the overwhelming literature on racial/ethnic disparities in health and health care - (Betancourt et al., 2003). But the volumes written do not begin to approach what is needed in research to actually eliminate health disparities in our country and worldwide, whether theoretical or applied approaches are used. The time has come to confront health disparities and to bridge the gap between theory and practice.

The Institutes of Medicine (IOM) of the National Academies commissioned a five-year study that presented the most resounding voice so far in a report entitled Unequal Treatment Confronting Racial and Ethnic Disparities in Healthcare. This report presents exhaustive findings from reviewing literature, studies, demographics,

data collection and analysis of health disparities. In all of the research finding presented in this report, quantitative and qualitative, giving evidence of health disparities, relating demographics, insurance status, access to services, attitudes, employment, linguistic barriers, housing, criminal justice, environmental settings, the report still concludes that a gap exists in the research:

> The most significant gap in this research is the failure to identify mechanisms by which these disparities occur.... Such research must consider the range of influences on patients' and providers' attitudes and expectations in the clinical encounter, clinical decision-making processes employed by health care providers, ...the environments and settings in which care is delivered.... ...No research has yet illuminated the relative contribution of these factors to the healthcare disparities observed in the literature (Smedley et al., 2003).

The IOM report of findings can be summarized to declare that health disparities exist; with evidence relating to historical and contemporary social and economic inequality, and having many sources that contribute to health disparities—among these sources, healthcare providers (p.19). Biases, stereotyping, prejudice and clinical uncertainty on the part of healthcare providers may contribute to this matter, while a small number of studies suggest that racial and ethnic minority patients are more likely than whites to refuse treatment (p.178).

Recommendations cited by the IOM report cover areas of awareness, especially for providers, legal, regulatory policy and health system interventions, patient and provider education, data collection, and monitoring and more research. My research is timely because it occurs in a setting seeking to follow the IOM recommendation of cross-cultural education in the health professions...integrating cross cultural education into the training of all current and future health professionals (Smedley et al., 2003). In addition, the study that I am doing with the physician assistant studies program at a private college of health professions is consistent with the recommendation for more research. More specifically, the IOM report encourages the type of research that I have conducted.

> To date, far greater research attention has been directed to documenting racial and ethnic disparities in care than in understanding how these disparities

> emerge in the structure and process of care...latter sections discuss areas where research has been minimal or notably absent. This includes intervention research...and research on the role of non-physician healthcare professionals, such as ...physician assistants...and others in eliminating racial and ethnic disparities in care (Smedley et al., 2003).

While this report provides documented evidence addressing health disparities, it recognizes that there has to be a comprehensive strategy in order to eliminate the disproportionate lack in quality health care. Recommendations, guidelines and encouragement are given, along with placing the responsibility for change on cross-cultural education in health care delivery, as part of the role of health providers.

> Cross-cultural curricula should be integrated early into the training of future healthcare providers, and practical, case-based, rigorously evaluated training should persist through practitioner continuing education programs (Smedley et al., 2003).

The findings of the IOM report provide a strong, documented resource, as well as give teeth to policies and practices for enforcing systematic strategies and interventions that will eliminate health disparities. Prior to the IOM Report on Unequal Treatment, the goals and objectives of Healthy People 2010 embraced the concept of cultural competence as a way of eliminating health disparities.

> Healthy People 2010 provide a framework for prevention for the Nation. It is a statement of national health objectives designed to identify the most significant preventable threats to health and to establish national goals to reduce these threats (US, 2000).

Healthy People 2010 also outlined the top 10 "leading health indicators," where cultural competence was seen as a way of evaluating the achievement of the goals and objectives of Healthy People 2010 (US, 2000). The Healthy People 2010 documentation brought people together who were interested in eliminating health disparities in specific health areas. For example, this document gave statistics of mortality rates, but not the evidence of why mortality rates were higher in non-white communities. It speculated that and encouraged physicians to join in with this battle of making a healthier nation. But it did not give definitive solutions or strategies that recognized cultural competence as a means to an end.

> While cultural competence is a factor that may eliminate health disparities, it is also important to consider the behavioral and environmental factors that influence health. Social environment includes interactions with family, friends, coworkers, and others in the community. It also encompasses social institutions, such as law enforcement, the workplace, places of worship, and schools (US, 2000).

It is equally important to keep in mind, that educational institutions, such as universities and medical schools that train physician assistants be included in this sphere.

Healthy People 2010 was not the only initiative to propose strategies and initiatives to address health disparities. The National Center for Cultural Competence (NCCC) identified six reasons why cultural competence is needed: (1) to respond to current demographic changes, (2) to eliminate long-standing disparities in the health status of people of diverse racial, ethnic, and cultural backgrounds, (3) to improve the quality of services and health outcomes, (4) To meet legislative, regulatory and accreditation mandates of Title VI of the Civil Rights Act of 1964, the Hill-Burton Act, the Emergency Medical Treatment and Active Labor Act, Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards, and the Culturally and Linguistically Appropriate Services (CLAS) standards set by the Office of Minority Health, U.S. Department of Human Services. Check with your attorney to determine which apply to your practice; (5) To gain a competitive edge in the market place, and (6) To decrease the likelihood of liability/malpractice claim (Cohen & Goode, 1999).

Using cultural competence is an application of theoretical premises used in sociology, anthropology and other social sciences. This application most appropriately fits sub-disciplines that can be seen in medical anthropology. T. Goode in a special article, *The Role of Self-Assessment in Achieving Cultural Competence*, supports the concept that cultural competence is a developmental process and evolves over an extended period (Goode, 2001). This article indicates that self-assessment is helpful if based on individuals and organizations capacity to

1) Gauge the degree to which they are effectively addressing the needs of culturally and linguistically diverse groups;

2) Determine their strengths and areas for growth and

3) Strategically plan for the systematic incorporation of culturally and linguistically competent policy, structure and practices.

The findings of this article also support the idea that a quantitative self-assessment tool can be important in evaluating cultural competence. This project conducted by NCCC utilized the Cultural Competence Self-Assessment Questionnaire developed by James Mason, PhD. This same tool was adapted by Mason for the Physician Assistant Studies Program to use in the monitoring and evaluation of PA medical students. The advantages of this tool is that it promotes growing without labeling, allows the design of relevant training and it's a "win-win situation according to Mason (Goode, 2001).

While the National Center for Cultural Competence registers the need for cultural competence training, other scholars take a pragmatic approach for the need for cultural competence in medical education.

> Cultural competence curricula will, perhaps, achieve their greatest success if and when they put themselves out of business-if and when, that is, medical competence itself is transformed to such a degree that it is no longer possible to imagine it as not also being "cultural" (Taylor, 2003).

A cultural competence curriculum must be integrated as part of the medical curricula that medical students are taught and adhere to.

Medical Education and Social Environment

Several scholars and researchers in medical education are beginning to address the issues of the social environment, attitudes of medical students, and cultural issues between providers and patients in medical training. Only a few researchers address all three of these issues or make a connection with more than two. "The social environment or "informal" curriculum of a medical school profoundly influences students' values and professional identities" (Suchman et al., 2004). These scholars recognized that the social environment had a tremendous effect on medical students. The informal curriculum of medical education was a major contributor to their

learning in dealing with patients. It was also noted that influences that impact retention and continued learning about people in communities affect what and how medical students respond to patients in clinical settings. This medical school stressed innovation for the twenty-first century in training medical students. They found that as students participated in more activities that emphasized partnerships and collaborations, drawing upon their relationships they already possessed, including the social, they were more inclined to have a better attitude about the medical school.

This innovative perspective exemplifies the kind of thinking that many universities are recognizing as they struggle with the challenges of training their students. This article has implications for my research in that it points out other factors in the social environment that affect attitudes, and how medical students see themselves or self assess. Attitudes actually influence behavior. Therefore, when medical students develop and maintain proper attitudes, it is possible that the quality of health care they delivered to their patients will reflect these attitudes.

Woloschuk et al. conducted a research study that administered a quantitative measurement tool (questionnaire) to medical students to determine proper attitudes. Their questionnaire was administered at entry; end of pre-clinical training and at the end of the program, just prior to graduation. The researchers identified that there was a decline in the attitude scores as the medical students progressed through their medical program. They also identified possible reasons for the change in attitudes as loss of idealism, and the impact of the unintended curriculum (Woloschuk, Harasym, & Temple, 2004). They concluded that "further study of the impact of medical education on student attitudes is warranted" (Woloschuk et al., 2004).

This admission suggests the opportunity for a qualitative approach, the lack of which is one of the limitations of Woloschak's study.

"Despite progress in the field of cross-cultural medical education, several challenges exist. Foremost among these is the need to develop strategies to evaluate the impact of ... curricular interventions" (Betancourt, 2003). Betancourt's article only looks at a conceptual approach to assessing attitudes, knowledge and skills as they relate to socio-cultural issues in the curricula of medical education. But it does

not address changes in attitudes and behavior and how those changes occur in the medical student. My research looks at how and why attitudes and behaviors change in the PA medical student. In addition, my work actually explores these implications through field research at a Physician Assistant Studies program in a College of Health Professions.

Green, et. al. discusses in cited journal articles the relationship between the cultural and social aspects for developing standards or protocols for curricula in medical education.

> As standards are developed, it is crucial to realize that medical educators cannot teach about culture in a vacuum. Caring for patients of diverse cultural backgrounds is inextricably linked to caring for patients of diverse social backgrounds (Green, Betancourt, & Carrillo, 2002).

Green and colleagues propose that there is a link between cultural background and social background, and therefore suggest that medical students could be taught to address the cultural aspects by expanding the role of patient's social history. The implications of this approach would suggest that health care beliefs of a patient can be accessed from the social history. This may or may not be true with certain cultures. It is important to consider that certain religious beliefs, that impact health care practices and beliefs, may not be expressed in the social status or history alone. My research looks at the exposure of medial students to diverse social settings and activities in order to understand how these experiences impact their self-assessment of cultural competence. While these journal articles are valuable to understanding theoretically how cultural competence is supposed to be developed in medical training, empirical data that demonstrates this application is limited in this field (Betancourt, 2003).

There are two recent studies that have been done that try to approach the issue of cultural competence and how it is developed in a setting with health care providers. One of these studies was explored by Molly McNees in her study of *Cultural, Communication and Health Care: The Development of Cultural Competence in Primary Health Care*. McNees takes a qualitative approach in exploring the use of cultural competence by providers and staff at a community health center serving an immigrant population in New York. She explores whether the goal of cultural

competence to eliminate language and cultural barriers to health care is actually achieved in the physician-patient communication and relationship.

McNees also addresses the issue of cultural competence in medical education, being critical, that the failure of physicians to respond appropriately in clinical encounters has to do with their training. "Much of this failure is thought to originate within the process of medical training, something which medical educators recognize and for which reforms have been proposed at various times"(McNees, 2001).

This researcher observed the issues of power and miscommunication in the clinical encounter, and reports on how those issues become barriers in the health care delivery while frustrating young providers. Findings also showed that, "...obstacles to communication and establishing rapport with patients that most concerned residents were time restraints and language differences, but rarely did they feel that patients' beliefs were an issue"(McNees, 2001). This researcher took a very aggressive approach in applied research to develop participant observations, interviews and field work that documents an understanding of what helps to make cultural competence work in clinical settings with immigrant communities. The next chapter presents the methods used for this applied research study.

Chapter III

Methodology

Overall *Approach*

The methodology for my research took a qualitative field work approach in determining how PA medical students self assess their own cultural competence. As Denzin and Lincoln state,

> Qualitative researchers stress the socially constructed nature of reality, the intimate relationship between the researcher and what is studied, and the situational constraints that shape inquiry. They seek answers to questions that stress *how* social experience is created and given meaning (Denzin & Lincoln, 1998)

Process

This process included sending out a mass mailing to all graduates of the PA graduating classes of 2002, 2003, and 2004, seeking participants willing to be subjects in research with current PA students regarding cultural competence. Basic qualitative data collection methods were used in conducting focus group discussions and in-depth interviews with members of the graduating classes of the School of Physician Assistant Studies Program (including those already practicing medicine). Guiding questions for focus groups and interviews were developed from the results of data acquired from curriculum evaluations, in order to perform the primary qualitative inquiry. The setting for this exploration was in the medical educational environment on campus at a four year university.

Analysis of the data was done with the help of qualitative and quantitative analysis software tools (NVivo and SPSS). Observations from my field work, along with an analysis of the social aspects of the environment, and an analysis of the qualitative data provided the bases for my conclusions. Rossman and Rallis suggest using triangulation as a possible a strategy to help enhance the credibility and rigor with which to conduct the qualitative study (1998, p.69). Hence, this approach was appropriate to use considering I had access to multiple sources of data, namely, focus groups, interviews, quantitative self-assessments, and observations from *being there.*

Rationale

The rationale for using a qualitative approach is based on several factors. First, the issue of cultural competence has been linked overwhelmingly with eliminating health disparities by empirical data from quantitative research, but not as much by information gained from a qualitative perspective. While the quantitative approach has been helpful in quantifying and collecting data relating to health disparities, it does not help to explain and understand the nuances of the attitudes and behaviors of medical students who are learning cultural competence, aspects that would tend to escape researchers using other [quantitative] methods. Field research is especially appropriate to the study of those attitudes and behaviors best understood within their natural setting, as opposed to the somewhat artificial settings of experiments and surveys (Babbie, 2004). It is the best way of helping us understand identity or provide meaning for reaching the development of cultural competence. Thus current research has *speculated* on the "hows" and "whys," but very few have actually tested these concepts.

Second, the advantage of qualitative research is that it allows the participants to supply meaning to suggested concepts and behaviors, as well as allowing for an understanding of related and important issues, concepts, and behaviors to surface in discussions with open-ended questions. For example, the qualitative approach allowed room for my participants to have a voice in a crucial and important matter that had not been strictly prescribed by me as the researcher. The methods used also allowed a means of validating the meanings that were provided by the focus group discussions and interviews, and allowed for me to learn from them; hence my participants became the experts.

Third, the qualitative approach allowed for the fruitfulness of collaborative discussion, even though the participants had the limited risks of speaking out in front of their peers. The in-depth interviews allowed an opportunity for informants to speak out further and give more clarity with more anonymity on issues that they felt needed to be said.

Fourth, this method of doing field research is well suited to the study of social processes over time. Rossman and Rallis also consider *being there* or "prolonged

engagement" another strategy for enhancing the credibility of the qualitative study: "Being present for a long period of time in the setting or spending a substantial amount of time with participants also helps ensure that you have more than a snapshot view of the phenomenon" (Rossman, 1998). As a researcher in the field I was able to examine some of the undercurrents expressed by students, especially regarding having diversity training and learning cultural competence. As the Diversity Coordinator over the last 5 years, I coordinated diversity activities for the PA Program, curriculum community activities, developing and maintaining partnerships and advisory committees, teaching and facilitating workshops on the university campus. My observations of student behavior in classroom exercises, together with comments I noted, combined with the qualitative inquiry, would allow for a more comprehensive examination over time in the medical education environment than would be possible in a snapshot approach to the issue of developing cultural competence.

Time Line

The time line for the collection of data, analysis and drawing conclusions followed this sequence of events from spring 2004 to spring 2005. During the spring of 2004, the research design was outlined and approved; second, results from current quantitative data (CCSAQ) were reviewed to determine what questions to ask during the qualitative inquiry.

During the summer of 2004, Institutional Review Board (IRB) approval was obtained for the collection of data using human subjects. Afterwards, members of the classes of 2002, 2003 and 2004 were invited to participate in the study. Focus group discussions (FGD) and in-depth interviews were conducted with those participants who volunteered for the study.

During fall of 2004, preliminary analysis began with reviewing and interpreting themes and categories from transcripts of the interviews and FGDs. Solicitation continued through the fall of 2004. In the winter of 2004-2005, data collection completed and the environmental analysis was conducted, of the external and internal aspects of the health care industry and the medical education institution.

A comparison and interpretation of the qualitative data was reviewed with the data from the results of the quantitative CCSAQ for all three classes.

During the spring of 2005, final analysis of the environment and of all transcripts was completed; findings, conclusions and recommended protocols were developed.

Setting

This research was conducted at the PA program campus of a four year institution. The PA program is housed in a temporary trailer-type classroom facility, that the students lovingly call, the "double-wide." When more space is required, the PA medical students attend lectures on the main campus in the auditoriums of the Optometry School, where technological/audiovisual equipment is state of the art. While the double-wide is fitted with a state-of-the-art data projector/computer and audio visual technology, it opens outside to wooden steps, an uncovered patio and opportunities to get in touch with nature (rain, sun, ice, snow, cold, etc.).

The campus is located in the rural community of Forest Grove, in Washington County, Oregon. This county is known as the fastest growing county in the state (Colby, 2005). It also holds claim to having the fastest growing Hispanic population in the state. The county is known for its agricultural growing seasons, migrant workers, stronger economic and educational bases than most counties, as well as being home to some of the most sophisticated technological centers and headquarters--Nike and several Intel campuses. Many people who live in Washington County are transplants from other countries, states and urban cities.

This university is a private institution, providing comprehensive liberal arts and professional education, offering 52 undergraduate majors in the College of Arts and Sciences, doctorates in optometry, and physical therapy and masters degrees in occupational therapy, physician assistant studies, and education. Its programs provide a wide variety of options for internships, study abroad, research, community involvement, and co-curricular activities. This university has a satellite College of Education campus in Eugene, Oregon, and facilities in Portland that support the academic and clinical programs of the College of Optometry and the School of

Professional Psychology. At the time of this research the School of Physician Assistant Studies, School of Professional Psychology, the Schools of Physical and Occupational Therapy had recently come together to form the College of Health Professions.

The three focus groups for this investigation were held in two separate lecture auditoriums and a conference room within the School of Optometry. The auditoriums had central air conditioning, but the participants in the conference room had open windows to keep them cool. Fortunately, it was not the hottest day in mid August, and the outside noise coming from the construction site of the new library was minimal. The description of the locations of the focus group discussions is provided to show the difference in a actual setting. Even though two groups (those with the auditorium) had an identical setting, the third group was conduct ed in a smaller conference room, it did not appear that the setting made any difference with the outcome of the information that was gathered by the facilitators.

These locations were used for convenience—in that they were available, and the students would be meeting in the same lecture halls later for their own research presentations. While I was anticipating the completion of three focus groups, the students were anticipating their graduation within three days. Some were getting married, some were going to have babies, many were returning home, others experienced changes in housing arrangements, and all were anticipating passing their board exams to make them fully certified physician assistants.

Seven interviews were done by telephone, one through e-mail and one face to face with PA graduates of the class of 2002, 2003 and 2004. Seven individuals participated in the in-depth interviews. Telephone interviews also were conducted in order to accommodate participants' work schedules. and/or those who had relocated to other states. PAs and graduates participating in interviews were located in New York, Washington, Massachusetts, Idaho, Oregon, California, and Montana.

The email interview allowed for flexibility for a PA graduate who had just given birth to twins. I was amazed and delighted that this participant was still willing to inform my research in spite of the long awaited family events that had occurred.

The face to face interview was conducted in a participant's office. I was able to connect with this participant after over six months. The significance of this notation has to do with the notion that the farther away from the time of graduation, the less likely it is to get people to participate, especially if they are not local. Many PA graduates are active in with family activities, community and organizations. As I neared the end of collecting and interpreting data, I did not expect any others to call and volunteer to participate. Since this participant was now a working PA with a full patient load, active in organizations and continuing education, our only opportunity for an in-depth interview was after work hours, as we sat at a table in the kitchen eating chicken Caesar salad and pizza.

PA Program Description

The Physician Assistant Studies Program is a twenty-seven to twenty-eight month graduate level medical program that is divided into three phases over seven consecutive semesters. The class of 2002 was a twenty-seven month program which began in summer of 2000. Subsequent classes were moved to an earlier start date to allow new students more time for access to the university's administrative staff, i.e. financial aid and other registration logistical personnel before the summer term. As a result this change increased the time of the program to twenty-eight months.

This is a medical program where the instructors are primarily PAs and physicians. The first twelve months is the didactic phase, where students attend classes (e.g. health care delivery, patient evaluation, pharmacology, etc.). The second year is phase two which includes clinical rotations at sites throughout Oregon, across the US and at international sites. Phase three of the program is at a clinical site that is selected by the student for the purposes of conducting a clinical graduate research project.

Class sizes range from 28 to 31 students, the average age of the class of 2002 was 27.8 years of age, for the class of 2003, 31.5 years of age and for the graduating class of 2004 the average age of the class was 28 years. Of those who self declared their ethnicity in the class of 2002, there were 16% from diverse ethnic backgrounds,

and 9% and 20% for the Classes of 2003 and 2004 respectively. A profile of the graduating classes represented in this research is provided in Appendix C.

Qualitative Inquiry

Using the convenience approach with the support of adjunct faculty, I was able to recruit eighteen men and women from the class of 2004 to participate in my research study. This was enough to form three focus groups. Prior discussions with PA faculty and students, and previous course evaluations revealed that the issue of cultural competence and diversity were sensitive yet negative topics for the students. Therefore, I chose to have experienced outside facilitators conduct the focus group discussions. This would hopefully allow the medical students to feel more comfortable in their discussions.

As the researcher, I was also on staff at the PA program and had developed and taught the diversity curriculum with previous classes. I also wanted the greatest possible chance for objectivity and freedom from the medical students participating in the research. Neither I nor any PA Program faculty was in the rooms while the Focus Group Discussions (FGDs) were being conducted. The facilitators were also experienced in working toward developing a culturally competent workforce for their organizations, a local health plan in Multnomah County. The facilitators were briefed in advance of the focus group discussions and debriefed after the sessions concluded.

Questions used to guide the focus group discussions were developed from topics within the Cultural Competence Self-Assessment Questionnaire (CCSAQ). A sample example of cultural competence was read to the students by the facilitators after ground focus group ground rules were presented and discussed. The following topics were selected to formulate questions: 1) definition of cultural competence; 2) assessing students' own cultural abilities, 3) clinical experiences, activities, and involvement, 4) knowledge about certain cultural groups, 5) the role of outreach activities, 6) barriers to understanding and appreciating cultural differences, 7) recommended changes in medical education, 8) level of knowledge prior to graduation vs. level at program orientation, and 9) level of their ability prior to graduation vs. level at orientation.

Triangulation

Triangulation is the process of using multiple sources of data, multiple points in time, or a variety of methods to build a picture (Rossman, 1998). One of the sources of data was taken from the results of CCSAQ quantitative (secondary data) instrument that had been administered to PA medical students, as part of the diversity curriculum. PA medical students were surveyed three times during their medical education: once as they entered the PA program, second, just prior to clinical rotations, and a third time, just prior to graduation. The graduating class of 2002 was the first class to be administered the CCSAQ three (3) times during the course of their master's education (Legler & Stohs, 2003). The results of the CCSAQ were the source of this secondary data that had been collected during the course of the program from students in the class of 2002, 2003, and 2004.

Wolcott is another proponent of triangulating the data, but stresses that "triangulation is one of those ideas that sounds great in a research seminar but can pose real problems in the field" (Wolcott, 2001). His concern is that participants and informants may be concerned if they knew that their information was being corroborated with other sources. I believe that this issue, while valid, was softened by the fact that participants knew in advance that the research was based on looking at preliminary results of their CCSAQ from PA graduating classes at the PA Program. Guiding questions used in the focus groups and interviews referred to previous aggregate responses of PA students on the topic of cultural competence. Students were also invited to participate in follow-up interviews, which a few of the students elected to do.

This information provided monitoring and evaluation of diversity curriculum as required by a Health Resources Services Administration (HRSA) funded PA Training grant.

In-depth Interviews

The in-depth interviews were guided by some of the same questions as those used in the focus groups, in addition to clarifying questions and issues that were raised in the FGD sessions. Several graduates and students offered to provide additional

information as needed for the sake of the research in an effort to support and help make changes to medical training that would benefit future PA medical students in the area of cultural competence. Those individuals became key informants, many of whom I was able to contact later for follow up and clarification of new topics and new ideas.

Transcripts of the FGD were produced from audio recordings of the discussions and interviews. Participants were only identified by gender due to the small number of participants. Given the small number participating, and given the demographics of the class of 2002, 2003, and 2004, racial identifications were not provided with the transcripts—in order to protect the identity of those participating.

Analysis

Preliminary analysis of the quantitative data (secondary data) CCSAQ had been conducted earlier in the year. Cursory inspection of the data collected from the classes of 2002 and 2003 indicated that the medical students' level of cultural competence declined from the time of orientation, when they entered the program and the period prior to graduation. Quantitative analysis came from SPSS reports of means and frequency distributions of the self-assessment evaluation of class scores. It was this discovery that led me to question why had the decline taken place after students had received training and had been placed on rotations at clinical sites with diverse patient populations. It was clear that there was an opportunity to explore this further.

Qualitative analysis was done by using NVivo software to identify themes, categories and new meaning given to ideas as the project unfolded. NVivo is a qualitative software program where documents such as transcripts, observations, and notes can be imported and coded to show relevant themes and relationships (Richards, 2002). Linkages between concepts, such as "knowledge of diverse cultures and involvement with diverse cultures," can be identified along with relating the didactic, clinical and social activities experienced by the students during their twenty-seven month medical program.

Environmental Analysis

In order to understand the influences of the social environment and the environment of the medical education it was necessary to conduct an environmental analysis. Exploring the environment, external and internal to the PA program, and investigating those internal issues that influenced student behavior was valuable in understanding the students' self-assessment of their own cultural competence. Ginter and colleagues stress the importance of environmental influences in the following manner...

> Fifty years ago the delivery of health care was usually an uncomplicated relationship of facilities, physicians, and patients working together. Government and business stood weakly on the fringes, having little significant influence. Today, a multitude of interests are directly or indirectly involved in the delivery of health...To be successful, health care organizations must have an understanding of the external environment in which they operate... (Ginter, Swayne, & Duncan`, 2002)

The American Medical Association also cites the necessity for environmental analysis in health care which includes medical education in its 2004 Health Trends report. This report examines the future of medical practice by identifying the major forces for change.

> The purpose of the *Environmental Analysis* report is to assist the American Medical Association (AMA) and the Federation of Medicine in planning for the future. While no one can predict for certain the future of health care, this report provides a description of the critical factors that will likely influence medicine and the delivery of health care in the 21st century...We believe this is very important because the future of health care in this nation depends on the ability of physicians and their associations to anticipate and shape changes in the medical care environment (S. P. AMA, 2004).

While it is important to consider the external environment in understanding the influences that affect a medical education program, that's only half the puzzle. Next, the emphasis should shift to the internal environment to look "inside the organization" (Ginter et al., 2002). In order to analyze the environmental context of the responses given by the medical students I used a model recommended by Ginter (et al) in order to get an introspective view of the external and internal factors that may affect medical

student responses. In spite of the detail that is given to the data collection and analysis, it is worth mentioning a few of the limitations in conducting this research.

Limitations

"Limitations set some conditions that acknowledge the partial and tentative nature of any research" (Rossman, 1998). There are three areas that provided context for the limitations of this study: (1) questions used to gain information, (2) biases of the participants and (3) confidentiality within focus group discussions. The questions that guided the discussions were based on the results of the quantitative self assessment data. These same questions and topic areas were used with the focus groups and the in-depth interviews to provide consistency in the inquiry. But there may have been other relevant issues which were not based on the CCSAQ that were not addressed.

Another limitation was the biases of the participants, could have prevented other salient issues from surfacing in the FGDs. Furthermore, participants' attitudes and behaviors could have biased the discussions by suppressing relevant issues. Finally, the confidentiality within the FGDs was limited. Those who were in a particular group knew what was said by participants in their group, even though ground rules were stated. Transcripts indicated that participants were concerned about who would hear the tapes. Some individuals expressed that they were not comfortable with the FGD and did not participate. However, this study was successful in its recruitment, data collection and analysis such that conclusions could be formed.

Forming Conclusions

Conclusions were formed using the analysis of primary data from FGD transcripts, interviews, debriefing and observations of my field research. Debriefing with the facilitators was valuable in helping me to target certain topics for clarification and gain a better understanding of the negative attitudes and feelings of some students. Observations and the environment analysis also helped to produce conclusions and reflections that clarified, validated and added rigor to my study. The next chapter contains the findings from my research.

Chapter IV

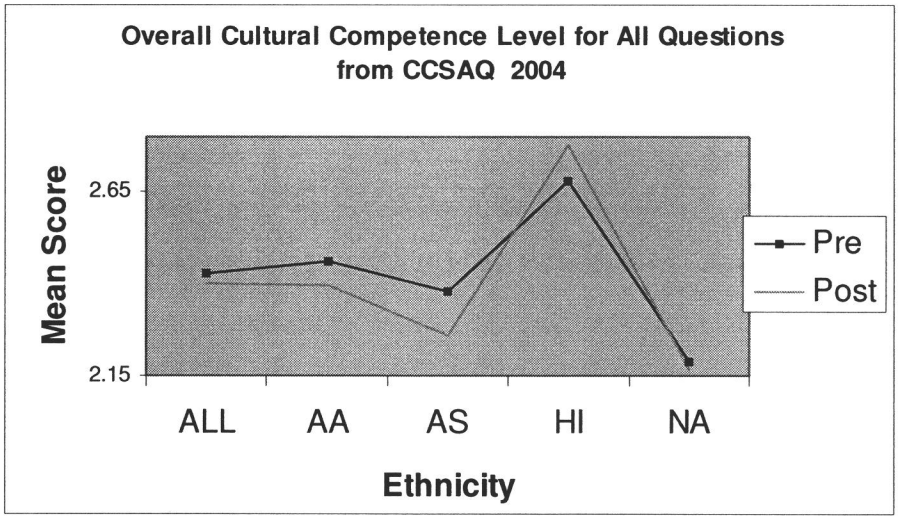
Results of Findings I and II

Explanation of Self-Assessment

This research examined changes in self-assessment as indications of attitude changes. Key objectives explored (1) why PA medical graduates' and students' self-assessment changed over time, (2) how their evaluation was impacted by the medical and social environment, and (3) if these changes indicate cultural competence. The main objective was to discover why Physician Assistant students self assessed on the Cultural Competence Self Assessment Questionnaire (CCSAQ) at a lower level prior to graduation than they had self assessed twenty-seven months earlier, during orientation, when they entered the PA Program.

Results of secondary data from the CCSAQ indicated that changes had occurred from the time PA medical students entered the program until just prior to graduation. A review of the results from the class of 2004 showed that the medical students self assessed their own level of cultural competence lower upon graduation (see Figure 4.1). While the 2004 graduating class had similar program and curriculum activities, the results of the CCSAQ were different for the class of 2003 and 2002. These CCSAQ scales showed an increase in their self assessment (see Figure 4.2 and 4.3). It was the results of the class of 2004, which led to questions which guided the qualitative exploration of the self assessment of PA medical students and graduates. It was not the intent of my research to prove or disprove the validity of the quantitative data. My interests rested in explaining how this change could occur and understand what it means as it relates to the education and development of culturally competent health care professionals.

Figure 4.1



Cultural Competence Self-Assessment of PA of Class 2004

Notes: The following applies to Figures 4.1, 4.2 and 4.3:

ALL - the mean score for all questions relating to ethnicity.

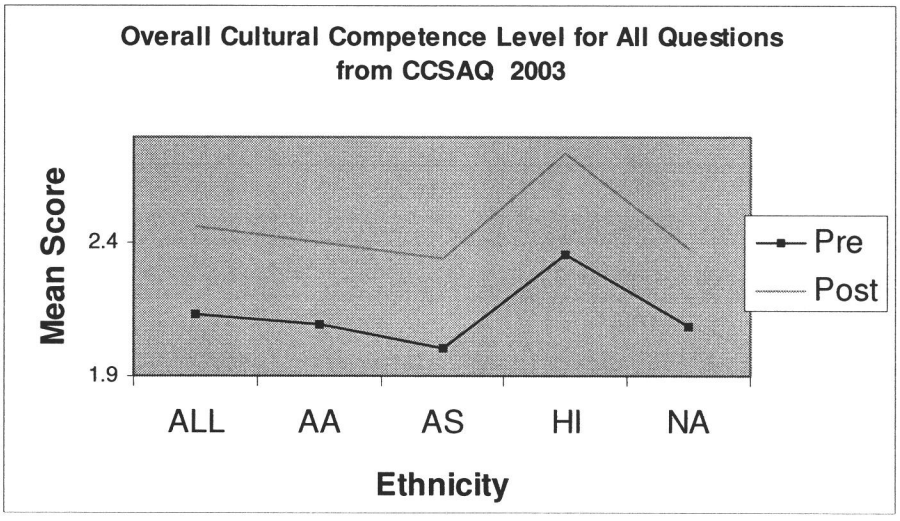
AA – the mean score for responses relating to African Americans.

AS – the mean score for responses relating to Asian Americans.

HI – the mean score for responses relating to Hispanic Americans

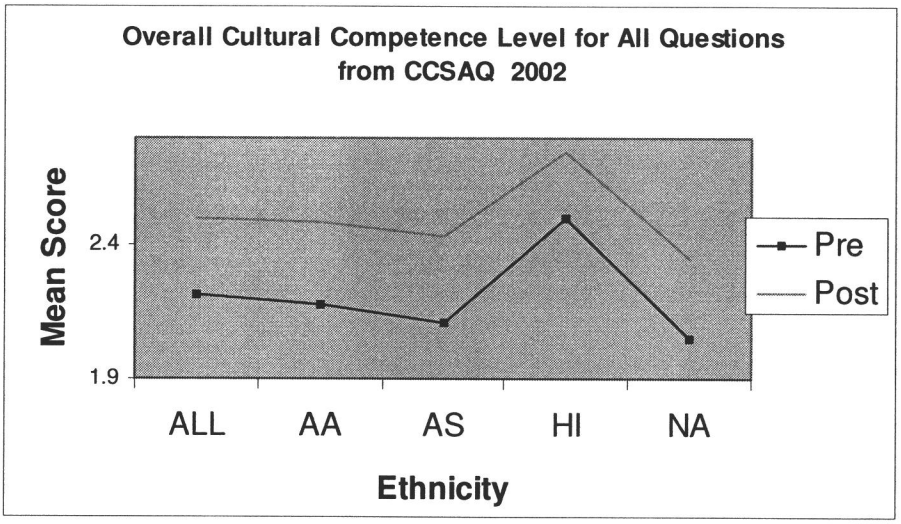
NA - the mean score for responses relating to Native Americans

Figure 4.2



Cultural Competence Self-Assessment of PA of Class 2003

Figure 4.3



Cultural Competence Self-Assessment of PA of Class 2002

Results of Findings I

This chapter discusses the theme of their self-assessment and explores the reasons why students think they had a change in their own evaluation of cultural competence and possibly a change in attitude. It also looks at whether the environment of medical education is a factor in their self-assessment. The next chapter examines the participants' definition of cultural competence and the factors that led them to choose that definition. Findings presented in Chapter VI describe the participants' cultural abilities along with the experiences that contribute to those abilities.

There were four themes that emerged as a result of the explanatory inquiry between the focus groups and interview participants in this research. These themes centered around (1) "I thought I knew," (2) experiences, (3) exposure and (4) "the real world"

Theme 1: "I thought I knew"

When the PA medical students were asked what factors could have contributed to their change in self assessment from the time they entered the PA program until the time just prior to graduation there were some interesting and seemingly honest

explanations. Some based their assessment on who they knew and what they perceived about them. Some used previous work associations with other people they knew. Some based their assessment on what they knew, while others responded that they had friends while in school and played sports with people who were from different cultural backgrounds.

When focus group discussions were conducted, participants (Class 2004) told why they thought students' self-assessment of their cultural competence was lower at the end of the program as opposed to when they entered the program. Marla responded in this manner...

> For me, when I started PA school, I thought, "Oh, (because we had not filled out the questionnaire)...I think I know quite a bit about different ethnic communities and cultures. And I had a friend who was from Vietnam and an African American friend and I had a Hispanic friend and you start thinking ..., "Well, how much do I really know about their backgrounds?" You know, we didn't talk about their values when we were hanging out, shopping or going to movies or different things like that or what was valuable as far as their family structure, the challenges or things that they face.... "I don't know these people as well as I thought".

Rosalie, from the class of 2003 said,

> ...the assessments are probably based on ... like growing up in a certain community or you know a guy in a certain community, it's very subjective in terms of how you would assess yourself .... When I took the questionnaire, [I] was like thinking "how much do I know about certain people, certain cultures." I don't remember the exact question. But it was things like "how do you relate to a certain culture... how much do you think you know about the culture," things like that. "And what do you know about the medical needs of the culture."

While Berlina, from the class of 2002, indicated...

> I think it's that, maybe having a perception that you know, I think that I felt like I knew quite a lot about a lot different cultures just working in mental health kind of situations. However, then you start, the more you learn, the more you learn you don't know anything...

While some self-assessments stemmed from thinking "they knew," other comments focused on what they realized they didn't know and "really needed to know". Roscoe, from the class of 2003, had this to add to the argument...

> ... we really need to know... we should have been given some training on how to deal with nurses. Some nurses don't respect you [as a PA] ... Some don't respect you... Being that I am not confrontational, I heard some pretty bad things [on clinical rotations]. Some people enjoyed confronting you and eventually you loose respect in the real life.

Theme 2: Experiences

While there was strong indication that self-assessment was based on the students thought they knew about other diverse persons they had come in contact with, these experiences were not the only factors that played a role in students overall self assessment. In self assessing their level of cultural competence students compared their experiences with their medical perspective, as explained by these participants in the class of 2004. Roxanne:

> ...like what I was thinking. They probably just had seen...maybe what they had learned before about different cultures from their various experiences was not as in-depth as the medical perspective...

In an in-depth interview, Barbara remarked with a similar assessment...

> ...just personal experiences not having to do with medicine as well, I think medical and anatomical experience probably.

During the in-depth interview, Berlina remembered that her experience on one of the international clinical rotations made a difference in how she self-assessed at the end of the twenty-seven month program...

> ... The first time I went down [to Honduras] I was completely by myself and I had to sink or swim. I had to assimilate into that culture and understand everything and understand how things worked and their system, and how they related to one another.

Theme 3: Exposure

While some participants attributed the change in the self assessment to finding out that they didn't really know, because of their experiences in medicine and cultural immersion on international rotations, others recognized that the exposure to different

cultures opened their eyes about what they didn't know. Roscoe compared his exposure to patients of certain religious groups and from rural settings to patients in urban settings.

> ...in Portland and at St Vincent we had mostly middle class patients. In Utah I had Caucasian, Latter Day Saints. A lot of them were of Semitic descent and with low social background. I was also in St Helens [Oregon] and Belleview, Washington where there was a lot of upper and middle class folks. [While] in Washington [the areas I had rotations] it was mostly rural. People there are very rural... It's kind of a different culture in rural areas. Usually, many people there were on drugs. Particularly in this culture, methamphetamines run rampant.

Similarly, Mitch made this comment in one of the FGD...

> ...if you have been exposed to a population [different from you] exposed to, like the Native American or African American [people] and if you have become involved other cultures, like Asians.

Theme 4: Real World

While self-assessments seem to have changed because of students own self awareness after experiences and exposure to underserved, rural and diverse populations, reality set in for some as they recognized that it was the "real world" experiences in their rotations that really made a difference in their self assessment. Berlina commented on the reality of her clinical rotations...

> I think that is very real world... even in the rotations that I had ... I was not always dealing with wealthy population[s], I was dealing a lot with lower income, uninsured [maybe], population[s]...and so it was an eye opening experience to have a lot of education about diversity issues in our first year and then get out and see how really the real world in medicine kind of works; and it really [was different] between preceptors and different peoples' experiences that would come back.

Roscoe recounted...

> ... I can tell you that [the PA Program] taught fundamentals but really didn't teach real world circumstances. The faculty did not hit that enough... about issues like drug seeking, reimbursement issues for Medicare and Medicaid and people on assistance...

In the interview, Marla made some admissions about her acceptance of the real world; as she recalls...

> ...even, when they had all those rotations with a large Hispanic base of patients, when they graduated, I was like pretty strong on the Hispanic [populations].... In the real world ... I'm pretty weak on that, and that was like my strongest point...

These themes provide clues into the possible explanation of changes in the self-assessment scores resulting from PA students responding to the CCSAQ quantitative instrument as part of the PA curriculum. These themes also directed my attention to clues in the medical education environment that can be analyzed for understanding their impact on the self assessment.

Self awareness, to recognize what they didn't know, points to clues about issues in their personal lives as well as the climate surrounding the acceptance of PAs in the medical arena while on clinical rotations. Experiences point more specifically to issues regarding clinical rotations, community service, access to care, insurance and underserved populations. Exposure or lack of exposure to diverse populations, either prior to entering the PA program or after, suggests analyzing issues around urban vs. rural, drug behaviors, and the uninsured populations. Factors relating to the "real world," point to a variety of issues impacting the PA student. Among them are demographics, language differences, cultural beliefs, health disparities, uninsured populations, treatment plans, and isolation from cultures as well as lack of respect for PAs.

Results of Findings II

Definition of Cultural Competence

Just as the PA participants' explanations fell into specific categories of what they thought influenced their self-assessment of cultural competence, their responses also fell into distinct categories when asked what their definition was for cultural competence. Definitions provided by those who were still graduate students focused on awareness and understanding, treating people like they wanted to be treated, a goal

or continuous learning, and making a connection while pushing their medical knowledge. We began the group discussions and interviews by providing Kula's example of a definition of cultural competence. My interest was to give the participants a *jumping off point* in the guided discussion. They knew in advance the subject of the discussion and had some introductions to the matter during their 27 month program. So I was not surprised when most of them seemed to expect that they should know what the definition really meant, even though they stumbled over words trying to craft their own definition.

Awareness and Understanding of diverse cultures (CI)

The most "votes" went to cultural competence being an *awareness* and *understanding* of different cultures, people, religions, and beliefs. Most students saw understanding different cultures as the ultimate goal in cultural competence. Some tried to expand upon the definition and recognized that cultural competence could even refer to geographical or regional differences within the same race of people, i.e. "Southern whites vs. Northern whites." Mohammed discussed this in FGD 2...

> I think it's basically the understanding the nuances of the individual cultures, of different ethnic groups and that could even be within I just think anyone which could even be a white culture from the South versus a white culture from the North. Its just that we all come from a different cultural background and it is, as far as competency, in that it is understanding that it is not simply race, but that it is about religious belief and geographic location.

Bridget thinks that cultural competence is awareness...outside of your own cultural group and willingness to learn more." Campinha-Bacote defines cultural awareness as the "deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, life ways, practices, and problem solving strategies of clients' cultures" (Campinha-Bacote, 1999).

Participants continued to discuss their own definition trying to say something different that had not already been said. Some of them, like Jacob and Priscilla, in FGD 3, recognized that they were overwhelmed by the concept of cultural

competence, thinking that it required them to understand a "gazillion cultures out there."

> In terms of my own level of cultural competence I definitely feel like cultural competence is an ongoing process and I don't know that I would ever consider myself cultural competent, in any aspect even with... And again like you know there's [a] gazillion cultures out there, and chances are I'd never, I may feel more comfortable with one culture over another culture just because I may encounter that culture more often than I encounter another culture.

Jacob's definition was more of an assessment of his level of cultural competence and he related it to his encounters with other cultures. He also expressed that his comfort level was impacted by the thought of engaging with so many cultures to a point that he would never be able to really get to becoming culturally competent. This seemed to overwhelm and frustrate him. Priscilla was also overwhelmed and expressed her frustrations as well...

> ...You know the difficult thing for me, ...at times it is overwhelming to try to incorporate all this, you know, from the Hispanics to the African-Americans to the Asians and try to get a good understanding of all of them. And then at times I am like "Gosh, you know, it's no way that I am going to be able to understand, you know, all the cultural aspects of what one likes and what one does not like; and what should be best."

Ability to understand or acknowledge and relate to practice (CC)

Participants who had been working as PAs for a year or two defined this concept as an ability to do something. They paired the definition with the *ability to understand*, or the *ability to acknowledge*. Berlina gave a different *twist* to the definition by relating it to language. She defines cultural competence in this manner...

> The ability to understand other cultures, relate and apply that understanding to everyday practice and be able to treat people from different groups almost, using culture as a different language, if you will. I think that everybody comes from a different frame of reference, and whether that be an ethnic minority or a different socioeconomic group, I think everybody's frame of reference is different in ... all [diverse] cultures, and I think you have to understand where someone is coming from in order to better treat them.

Rosalie, who has only been out for a little over a year, terms the concept this way…

> … the way I deal with it most often is … trying to incorporate another person … my patient's cultural beliefs, and … background into what I view. So it's, I guess my definition would be the ability to acknowledge and work with a culture different from my own.

"Treat folks how you would like to be treated" (CB)

Priscilla continued expressing her difficulty with actually defining cultural competence, but finally approached the definition from how she would treat her patients.

> …It's, just because I found it to be so overwhelming to try to determine, you know, what's appropriate for one, and I know it is important, but it is hard for me so I just kind of taken the approach that these people are coming in to see me I am going to treat them just like I did the last guy or like I did my, like you would your brother or mother or whoever….

Like Priscilla, many medical students, in an attempt to try to provide culturally competent care, not knowing what to do, resort to providing the *same* care for everyone. They don't realize that treating everyone the same can contribute to health disparities.

As in Timothy's definition, he thinks that cultural competence is similar to people making assumptions because of their own understanding (stereotyping). To circumvent the fallacy, he says that one should treat everybody as an individual.

> …I think with you kind of skip treating that person as an individual and treat them as … stereotyping their entire culture, then I think that does more harm than good. So I think it is important to try to understand that you know the generalizations of the different cultures, but I think when it comes down to treating the individual in the clinic, I would still be more apt to go back to "this is a person and not a culture that is in front me," I am going to treat them as such."

"A trick word" (CI)

Medical students in the FGD continued to have difficulty defining cultural competence, as they made comparisons to what their feelings were and what they may or may not know about themselves. Jacob struggled with not knowing...

> ...So just from familiarity I may ... start to learn things about a certain culture over another. ... I think that I don't, even with the culture that I may be immersed [in], ... I don't know that I would ever feel that I am competent, I don't even feel like I am competent about my own culture. There are people that you know study my own culture and I grew up in it. ... so cultural competence is one of the, I don't know, a trick word for me.

Goal – of continuous learning of different cultures

Some of the medical students defined cultural competence as on going learning, like Jacob, who thinks that it is continuous learning, didn't think that he would ever learn all that he needed to learn. This attitude that he would never learn it all seemed to carry with it some despair, so, "Why do it?" Yet other students, who also defined cultural competence as continuous learning, spoke about their definition with some hope and attached their learning to how they work with other people. Eldridge from FGD No.1 defined cultural competence as...

> Cultural competence is the kind of thing that creates a goal it is I think it is a work in progress to know more about different people, and if you think you know about a culture and it may be that you know about an individual. So it is kind of like a work in progress, and cultural competence is working toward understanding who you work with better.

Their definition carried more learning in the part of the health care provider. Many of the PAs who had graduated defined cultural competence in the form of action that they performed or tried to learn in the process of treating patients. At the same time, they admitted to not knowing everything, but they saw this learning process as part of their business and what they wanted to do. Roscoe gave his definition...

> My definition of cultural competence is being able to go and see a patient regarding their race or religion before being able to treat them... even if you don't speak [their language and they don't speak] the English language.

"Not having a bias"

Some participants thought that being culturally competent meant not having a bias. In Roscoe's perception of cultural competence he went beyond race and religion to qualify the definition as, "Not having a bias... providing their care especially to those that are aged or older patients." When Isaiah was interviewed, he had been practicing for over two years as a PA graduate of this program; he had a similar impression about treating patients that included, "having no biases when treating the patient... in respect to their diversity, their racial diversity or living or sexual preference.'

"Treating Patients according to their beliefs"

As Isaiah continued, his views of the definition not only incorporated a characteristic of *no bias*, but *understanding*. This sense of *understanding* was paired with an *ability* to incorporate the patients' beliefs.

...understanding or being able to interact with various, different communities, whether it's a racial competence or understanding, the competency or sexual preference, and having a respect between the provider and the patient and understanding...hopefully respecting that treating the patient in [a] way that they would want to be treated according to their beliefs.

"Respect, asking questions of diverse patients"

The findings from interviews with PA participants, currently practicing with diverse patients, presented definitions that described how they practiced. Asking questions helped them to provide better services for their patients. Hortense gave her impression of cultural competence in an interview.

> I cannot say by any means I don't have opinions that may be considered racist or that I am completely culturally competent but I feel I have tried to make an effort and continually to try growing in this area and asking questions. I try and treat everyone how I would like to be treated. I realize that I may make mistakes but I continually learn from this process.

In FGD No.2, Barbara described cultural competence as asking questions...

> ...I think it's also just asking, just not assuming; when you see a patient of diversity, to simply ask. It helps make you competent, because you then know, giving you a chance to have a broad view, not just putting them in a box.

Many participants recognized that there was so much that they did not know, and were not taught, that they learned in the real world.

"Making a connection but pushing medical knowledge"

Medical students want to be in tune with their patients so that they are able to provide better medical treatment. But they recognize that language and the culture may present a challenge for them. So they see cultural competence as a means to an end. That end may be pushing their medical knowledge onto the patient. This might be termed as having a *compliant patient.* Marla, who graduated with the class of 2004, participated in one of the FGD. She had been practicing for a few months by the time of her interview. Her definition when asked in the interview was as follows...

> ... In my words I would say that for me cultural competence is to be able to readily provide service, but to really make a connection with each patient regardless of their background. So that means that they would be, you know, interested in the treatment plan and really kind of, for me to be in tune with what they want, as well as for me to kind of push my medical knowledge on them as well. It's, for it to be an evolving process, where I am always learning, you know, new things and just, how to approach different subjects better and, yeah, that's the best I can do.

In looking at how participants defined cultural competence, most felt that *understanding and awareness* were part of the concept. In defining it from a cognitive perspective, medical students pair their definitions with their feelings or comfort level about the subject of other cultures. Graduates of the PA program moved toward defining this term by using their *abilities*, even if it meant making a connection in order to influence the patient with the provider's own medical knowledge. Treatment of the patient was another way of defining cultural competence, either according to the belief system of the patient or the belief system of the PA participant. Respect seemed to be a component of the definition for many, along with considering that cultural competence was a *life learning goal. Asking questions* and having *no bias* were

important aspects for others, and some medical students thought the concept was a *trick word.* An analysis of the participants' self assessments, definitions, and indicated cultural abilities point to possible gaps in developing cultural competence in medical education.

Analysis of Findings

The Change in Self Assessment

When participants were asked about the change in their self-assessments from the time of orientation until the period before graduation they identified four key areas which attributed to this change. Experiences, exposure, immersion in the real world provided three key factors in the change. But most participants, including those that had graduated in the class of 2002 and 2003 admitted that they only thought that they knew more than they really did. The expectation of the PA program was that their medical students would increase in cultural awareness if certain objectives were met. Therefore, it was important to uncover possible explanations for a self-assessed decline in cultural competence in order to understand and validate the monitoring and evaluations of integrating diversity and cultural competence concepts into this PA program.

They didn't know as much as they thought

When students said that they realized prior to graduation that they didn't know as much as they thought, this was a new awakening for many of them. Entering the PA programs is a competitive process, which inspects their qualifications. These qualifications include knowledge of the role of a PA, previous medical experience, previous community service, strong academics in the sciences and good writing skills. A competitive Community Service scholarship is even offered to first year students who demonstrate their commitment to serving underserved communities after graduation.

Students at the point of entry are geared to know. Knowing other cultures, having exposure to other languages, understanding issues in the medical field,

possessing professionalism and good communication skills, all play a role in giving the would be PA a competitive advantage. Cultural knowledge might be termed "the process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures (Campinha-Bacote, 1999). As students, the participants were more interested in seeking and obtaining a sound educational foundation in medicine and made more assumptions about the diverse cultures they exposed to. Participants gave accounts of preceptors that encouraged their medical knowledge and discouraged any desire to seek and gain cultural knowledge. Even though the participant didn't think that this had any effect on their thinking, the comments made showed that the student did not gain as much knowledge as they needed.

Another consideration is that many of them [PA students] were already health care technicians who have worked in diverse and underserved communities. They aspired to work side by side with the best physicians. They are highly motivated and intelligent, with impressive skills and GPAs, and many have traveled in global communities since childhood. It is no wonder that PA medical students think that they know more than they really do. The focus group discussions allowed for participants to come face to face with their peers with an objective outside facilitator to admit that a change had occurred and that it was also due to their exposure.

They were exposed

Exposure to underserved populations and patients who spoke a different language was an intentional aspect of developing diversity and developing qualified PAs in the profession. Exposure to diverse communities through participation in activities in the heart of the African American community in Portland, Oregon, and the Hispanic hub of Hillsboro, Cornelius and Forest Grove in Washington County was a key focus of the program. The Martin Luther King Jr. Health Fair and the Wellness Village provided opportunities for screening for diabetes, hypertension, and cardiovascular conditions. PA students were required to plan these events from start to finish, by coordinating with the Diversity Coordinator at the Program, partners in the community, other health care providers, other medical schools, such as the School

of Optometry, School for Occupational Therapy, and the School of Professional Psychology, and with the Lloyd Center Shopping Mall management.

They developed the partnerships and received media coverage with a little guidance from the Diversity Coordinator. Participating in the Children's Fair "Dias de los Niño's (The Day of the Children), taking the weight and height of young Hispanic children was encouraged. These opportunities allowed them a chance to try out their two or three words or short phrases in Spanish and pick up some more from the crowd of people who pressed for their services and attention. These activities fulfilled objectives for integrating diversity and cultural awareness into the PA program.

In coming to this PA program you find that many PA students have not had exposure to diverse and underserved communities. Many have not seen a large number of African Americans or Native Americans. Some students have not been exposed to cultures other than their own. Others have only been exposed personally through people they know, but didn't take the time to get to know their values or beliefs. Many participants had traveled, while growing up, to global places where people were poor. But they didn't have to live with them. These PA "want-to-be's," dressed in their white T-shirts, or white lab coats, bearing their program name were exposed to the community. Part of their exposure was the use of the Spanish language, not only in the community but in a Spanish survival class in the first year.

Exposure came from class room experiences, with members from the community coming to talk about people with disabilities, African American culture, Migrant life style, and Native American culture here in Oregon. This was just a taste of the culture--a classroom panel discussion held during an hour and a half session. It was not immersion. This exposure, though limited, occurred during the didactic period, their first twelve months in the PA program. These activities, in the community and in the classroom, provided preparation for the experiences that would come in clinical rotations.

Experiences made the difference

This medical education program intentionally provided experiences that would produce outcomes for objectives of their grant funded Diversity Development

program. One objective was for the PA program to increase the number of clinical training sites which served diverse populations. Another objective was to obtain successful placement of their PA students in Spanish-speaking health centers. These objectives focused on preparing their medical students to have diverse experiences to meet the needs of underserved populations. During this time, the program secured preceptors for clinical sites in Honduras and Ecuador for international rotations, and other sites in New Mexico, California, Oregon and Washington. Each year the program branched out and increased their clinical sites serving diverse populations in rural and underserved areas.

To add to the cultural experience of the diverse clinical rotations the students took part in what a former PA graduate calls "forced choice". Second year PA students did not get to select the locations of their choice, nice urban areas. They were forced to accept the rotations and times that were deemed appropriate according to their curriculum and the Clinical Coordinator. Students did not seem to understand that could not just go anywhere. A preceptor agreement had to be signed in advance. Many times students tried to set up their own rotations but the agreement was not signed, or the preceptor wasn't there, or other issues developed. This was always a stressful time for the Clinical Coordinator as well as the students. There were times when students were caught climbing up the wall outside the clinical coordinator's office trying to see his clinical rotation board through a rectangular window that was more than five feet from the ground. These medical students no longer had control of their lives. They were about to have an experience.

These experiences had more to offer than just a home away from home. The students were responsible for making their own travel and lodging arrangements, as well as having the financing, during their stay, which could last from one to three months. Some of the living conditions were not so nice. Some lived in trailers; others were in apartments, some with preceptors, and some with their own parents. Some communities didn't smell nice, some patients didn't smell nice; there were drugs; and there was poverty. The PA students went through changes, while spouses, partners and pets were left behind.

Many times the students couldn't speak the language as well as they thought. They were sometimes isolated and immersed in a different culture. Medical students thought they knew the poor, but they faced and lived with those who were in poverty. This immersion was not like going on a trip abroad with the family. They had to use skills of collaboration, negotiation, translation, and cross-cultural communication. They misunderstood and were misunderstood by others. They became the minority. Some rotations were on Indian Reservations at Grand Ronde and Warm Springs, while others went to remote areas of New Mexico. With these kinds of experiences I can see why the second twelve months in the PA program brought about a change in their self awareness. These experiences brought them to the real world.

Welcome to the real world

In real world experiences PA students faced underserved populations. Migrant workers, the elderly, children, women and men made up the patient clients of their preceptors. They worked in clinics and emergency rooms at Federally Qualified Health Centers. One had rotations in the prisons, where they treated criminals. I suspect that the student had never been in prison before.

Other PA students encountered the realities in global communities of China, Honduras, Ecuador and the Bahamas. Apart from the diversity within those communities, PA medical students, faced poverty, language barriers, longer hours, people who had not been receiving care, people who couldn't pay, or people who may have been fearful, yet willing to receive care. Some participants shared about how they faced multi-racial families and their need for child care. Other participants shared about how they were treated by others and their thoughts about what they had encountered in the real world.

Many patients were uninsured and could not pay for services. These individuals and families were seen at the Essential Health Clinic in Washington County, Oregon. There were people who could not afford to pay for an aspirin or other over the counter (OTC) drugs. This may not have been expected or taught in their didactic sessions.

Religious beliefs played a role in the lives of these diverse patients. These beliefs impacted whether they would or would not take the advice of the PA student. Not taking the advice of the medically educated PA is hard to accept. Facing patients who nodded their head to say yes and not comply with the regimen, probably did not compute.

But one aspect of underserved populations that students mentioned in their discussions and interviews is that they did not see as many African Americans in their clinical rotations. That was not the real world for some. One student was sent back east to a clinical rotation in Maryland. This student came face to face with new cultural beliefs, eating habits, drug habits, financial stresses in their patients. These clinical encounters with the real world can be defined as the process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds (Campinha-Bacote, 1999).

By the time these participants had finished their twenty-seven months of not knowing what they thought they knew, exposure to underserved and rural populations, immersion experiences, international and domestic, facing the real world, their self perception had changed. The change in their cultural competence level on a quantitative scale (either up or down) was based on an initial perception that one "knows already."

Synthesizing the Explanation of Self Assessment

Synthesizing the PA students and graduates explanation of their change in self assessment is indicative of the following premise. First, a change in one's perceived cultural competence is dependent on self perception plus exposure, experiences, and a change in the environment of their real world (e.g. living, surviving, working in a new environment etc.). Participants all concurred that their change in perception was based on the different cultures they had been exposed to, or settings of poverty and underserved populations, and language differences that they had experienced or encountered.

Second, more experience, exposure, and real work encounters does not necessarily increase your knowledge of cultural competence. But this experience

demonstrates how much more knowledge is needed. When students were exposed repeatedly to underserved populations, or diverse cultures, along with those who spoke a different language, they found out how much more they still needed to know. They admitted to recognizing the limitations of their current knowledge which they previously held in high regard. This was particularly noticeable with participants who had prior experience with a particular culture or language. Hence one cannot just say that cultural competence is continuous learning. Some were frustrated to the point of thinking that they could not possibly learn enough. Therefore, the learning must be actively pursued.

Third, a change in self perception equates to a change in the controlled environment, in relationships, in experiences and the ability to navigate the real world. One of the complaints that I have heard repeated by students during the course of this investigation is their "loss of control." They longed for having their lives back. During the course of the twenty-seven month program, the program, where they would be on rotations, when they would have lunch, breaks; dinner, or when they could socialize dictated their schedule. On many rotations, students had to live with parents, in order to conserve expenses. While parents and the students were glad to be able to see family, their lives were not their own.

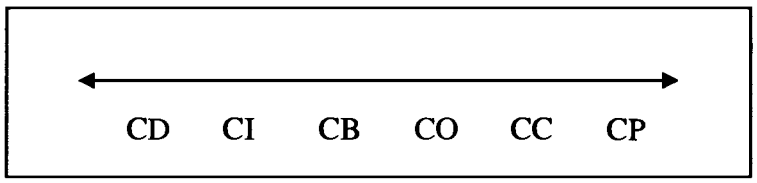
Some PA medical students had to move away from family, partners, and pets. Their support systems were disrupted to a certain extent. They had to find places to stay in areas where there might have been language difficulties. Some had to move out of places that were not "to their liking" after they arrived. These challenges and not being in control had an effect on their self-assessment. Basically, complaints of the students regarding the repetition of the CCSAQ forced them to re-evaluate what they thought they knew about being culturally competent.

Synthesizing their Definition of Cultural Competence

One way to evaluate the students' definition of cultural competence is to compare their responses with the cultural competency continuum developed by T. Cross et al. If there are indeed different levels or stages of development, then it is important to identify at what level the PA students might be, based upon their

definition of cultural competence (Orlandi, 1992) (See Figure 4.4) The continuum scale has six levels: (1) Cultural destructiveness (CD) represents a set of attitudes or practices designed to promote the superiority of the dominant culture; (2) Cultural incapacity (CI) refers to a set of attitudes or practices that promote "separate but equal" treatment; (3) Cultural blindness (CB) refers to attitudes or practices of being unbiased, under this paradigm people are basically all alike; (4) Culturally open (CO) refers to attitudes or practices geared toward learning, receptive to new ideas; training in cultural sensitivity; (5) Culturally competent (CC) refers to attitudes or practices that respects, enhances the quality of services, actively seek advice and consultation from ethnic/racial communities and incorporates such practices into the organization with a sense of commitment; and (6) Cultural proficiency (CP) is characterized by attitudes or practices that hold cultural differences in highest esteem, proactive posture regarding cultural differences; aim to improve the existing quality of services through active research, and to promote cultural relations among diverse groups.

Figure 4.4



T. Cross et al Cultural Competency Continuum

The cultural competency continuum can be illustrated in the responses of the participants in focus group discussions and in-depth interviews. Cross (et al)'s categories are useful in understanding the meaning given by the participants as a way to determine where they are on the continuum. I have detailed and paired themes identified by the participants with levels on the continuum.

"Awareness and understanding of diverse cultures"

Mohammed's comments compare more with cultural incapacity (CI) because there is nothing said about services or abilities; but what is said is about "white culture," the dominant culture according to Cross. This concept promotes a separate but equal attitude. Similarly, Bridgett thinks that cultural competence is awareness of external cultures, without regard to seeking advice or delivering services.

"Ability to understand or acknowledge and relate to practice"

Berlina and Rosalie express that understanding is part of this cultural ability that is related to practice and the treatment of patients, which shows they are more open and trying to learn from their patients. In further conversations with both these graduates, they stated that they consult with interpreters to verify their understanding and the understanding of the patient. This comment demonstrates moving toward cultural competence.

"Treat folks how you would like to be treated"

Priscilla's comments fall between cultural incapacity (CI) and cultural blindness (CB) because explicitly she promotes treating everyone alike, but implicitly she has attitudes that promote superiority of the dominant culture ("overwhelming"). Timothy's comments lends more toward expressing cultural blindness because he really has stereotypes but tries to negate his attitude by treating everyone a like, "like a person." This seems to be a typical comment where a person thinks that the best way not to offend anyone is to treat everyone a like.

The supposition is that the person, in the case of the student, could not be accused of acting differently toward a patient. But in the case of diverse cultures this is far from the truth. This statement also assumes that every culture wants to be treated like white culture or the same as other cultures, which is basically a form of stereotyping. Stereotyping can be defined as the process by which people use social categories (e.g. race, sex) in acquiring, processing, and recalling information about others (Smedley et al., 2003). When communication styles have different meaning for

different cultures, this "treating everyone the same," leads to assumptions on the part of the provider and the patient.

"A trick word"

Jacob expresses cultural incapacity, as he does not know his own culture and refuses his own or others ("don't think I would ever..."), and still distinguishes his own culture from others. This "trick word" would presuppose that no one could possibly learn cultural competence or there isn't a real answer or real definition. Holding to this comment, places the participant in a state of denial—denial that cultural competence actually exists or has importance.

"No bias"

Roscoe is between cultural blindness (CB) and cultural openness (CO) level on the cultural competency continuum because, he explains his definition to include "no bias" which references being cultural blindness (CB), he also uses the patient's race and religion as a reference point or guide first, before trying to help treat the patient, regardless of language. This latter statement moves shows him moving from one stage to another. From the major context of his interview, he is geared toward learning, and receptive. However, he is not to the point of being CC where he would be actively seeking advice. Humans are social animals, and social categories, typically relating to dimensions such as age, gender, and color (Smedley et al., 2003). Even when a person thinks he is not biased, he usually is. Some forms of bias may be more overt than others.

Isaiah's comments showed him moving between cultural blindness and cultural openness as well. He defines cultural competence as having "no bias", but also references that treating the patient the way the patient want to be treated which seems to reflect an attitude geared towards solutions to improve services to a particular target group.

"Goal – of continuous learning of different cultures"

While Eldridge seems to have expressed a positive attitude toward his definition, in reality he expresses a sense of cultural incapacity (CI). Further exploration of his thinking shows that in one instance he describes cultural competence as a goal of knowing or learning about other people. But he separates the people that he has learned about according to whom he can "work with better."

"Respect, asking questions of diverse patients"

Hortense is moving along Cross' cultural competence continuum between cultural blindness and cultural openness. Her expression that treating everyone the way she wants to be treated is a reflection of being cultural blindness (CB), but asking questions and learning from the process is an attitude of cultural openness. Barbara, on the other hand, seems to be more culturally open since she references that cultural competence is asking questions, which does indicates that she is receptive and open.

"Making a connection but pushing medical knowledge"

Marla is hinging on being culturally destructive without knowing it. She is more interested in "pushing her medical knowledge" for a "good" reason, her reason was to have a compliant patient. Even though she wants to "make a connection, regardless of their [patient's] background," ultimately she uses the cultural connection to manipulate the patient. Marla's attitude seems to also express similar attitudes exhibited in some preceptors as described by participants. Here is another instance of how influential the preceptor is in the educational process of developing cultural competence.

Evaluation of this participants' definition with T. Cross et. al cultural competency continuum reveals a low level of cultural competence, yet their learning continues to move them toward the higher level as they practice medicine in diverse communities, i.e. developing cultural skills. Campinha-Bacote would suggest that a cultural skill is the ability to collect relevant cultural data regarding the client's health histories and presenting problems as well as accurately performing a culturally

specific physical assessment (p. 204). This attitude of "pushing medical knowledge' and the accompanying behavior can be contrasted to other participants who have been out working as a PA.

Those who had graduated and had been working over a year and a half (e.g. Berlina and Rosalie) tended to exhibit a higher level on the cultural competence continuum. Their cultural abilities have increased and their definition of cultural competence is a demonstration, not only of their knowledge, but also of their actions, experiences, learning, exposure and encounters in the real world. These participants demonstrated a desire to learn more and indicated that they had learned to ask questions in order to learn from the patient before assuming that they knew how to treat the patients. Their desire to get involved and engage with patients requires motivation and a "want to" of health care providers (Campinha-Bacote, 1999). From the cultural competence self assessment and the definitions, it is important to see that the gap between the theoretical and the practice of cultural competence can be bridged with the elements that made a change. Using the experiences, exposure, encounters to the real world and the self awareness of "don't know" can help to build a model for change.

A Model – The Praxis of Cultural Competence

Rapp proposes that the ability to create a lasting model of cultural competency begins with the selection of medical students (Rapp, 2004). He explains developing cultural competence would benefit from prospective medical students having social, behavioral and cultural prerequisites before entering the program. While prior cultural knowledge has its benefits, the finding from this research shows that prior knowledge predisposed medical students to think that they know more then they really do. Still, the idea is worth moving toward in creating future candidates who are more cultural savvy when they enter medical programs.

Kula's definition of cultural competence involves having certain abilities and interest in continuously developing understanding of cultures. This definition parallels Cross' definition of enhancing services and seeking advice, basically inquiring of the other culture. This in itself indicates that a person does not *know*, but seeks to find

out, in order to delivery appropriate services according to the other cultures needs. This idea of cultural competence is more theoretical until one puts the theory into action. The translation of an idea into practice or action is known as *praxis*.

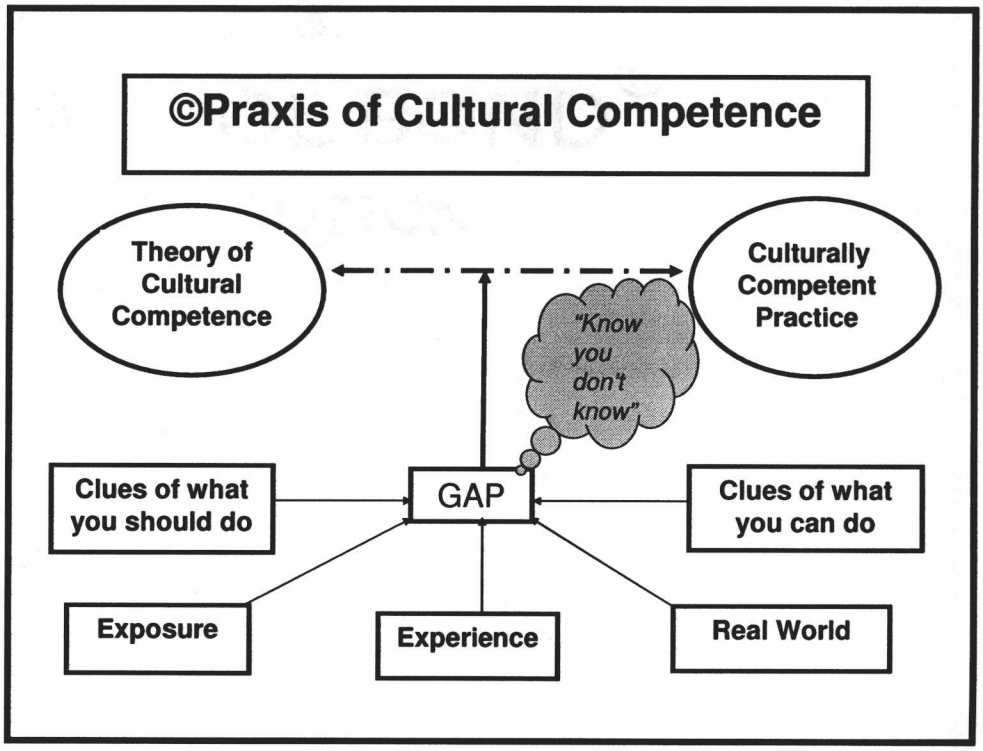
Theoretically we think that cultural competence is a way to eliminate health disparities, but in and of itself, makes good sense to develop in medical students. Cultural competence moves beyond "cultural sensitivity" as it calls for knowledge and skills to diagnose and manage disease in a multicultural patient population as opposed to simply acknowledging and tolerating differences (Ochoa, Evans, & Kaiser, 2003). If and of itself [cultural competence] we are unable to put the theory into action then there exist a gap in the process.

To date, there has been limited evaluations published on the impact of cross-cultural education (Smedley et al., 2003). Despite the lack of an extensive literature on cross-cultural curriculum evaluation, it is clearly possible to develop framework of assessment that is modeled after those utilized for other educational processes (Betancourt, 2003). This research gives more clarity to understanding this cross-cultural gap in the delivery of health care, which has partially been identified by the medical students as the exposure, experiences, and encounters with the real world. The other part of the gap is identified through the environmental analysis. The IOM report suggest that it is difficult to evaluate change in provider attitudes given the potential for social desirability bias on surveying, and the difficulty in observing encounters in real time (Smedley et al., 2003).

But, applying Cross' cultural competency continuum or some other measurement that is similar provides a scale for measuring the progress of developing cultural competence while transforming from theory to practice. This takes into account the complex dimensions of attitudes, knowledge and skills. A significant piece that is often overlooked is the ability to cultivate self-awareness to the extent that medical students recognize and admit that "they don't know." "Self-understanding is a necessary condition before one begins the process of understanding others" (Locke, 2003). Bringing these critical pieces together with identifying the clues that tell us what medical students should do (i.e. external environment) plus taking

inventory of their assets or what medical students can do, (i.e. internal environment) forms a bridge across the gap toward culturally competent action. This model I have called the *praxis of cultural competence* (see Figure 4.5).

Figure 4.5



©Model – The Praxis of Cultural Competence

The model of the Praxis of Cultural Competence takes the critical elements of what moved the medical students forward. The next two chapters present an analysis of the external and internal environments. An examination of the health care issues and identification of the resources, competencies and capabilities of the medical students and the PA program will provide more clarity for bridging the gap that exist between the theory of cultural competence and culturally competent practices.

CHAPTER V

EXTERNAL ENVIRONMENTAL ANALYSIS

An environmental analysis of the Physician Assistant Studies Program comprises one of the strategies that I used to analyze the data. Ginter, Swayne, and Duncan have a provided a model for approaching environmental analysis which is appropriate for organizations in the health care industry (Ginter et al., 2002). Even though the PA Program is part of a higher education institution, it is certainly tied to the health care industry, since it develops and produces mid level health care providers. The instructors of the program are also currently practicing PAs.

The environmental analysis has two major components: the external analysis and the internal analysis. Ginter et al propose that the external component of the analysis provides clues for what health care providers should be doing as a strategic measure critical to success (Ginter et al., 2002). The external analysis is therefore presented first, even though it was not the first part of the analysis that was tackled. Ginter (et al)'s model of environmental analysis is comprised of four major processes: scanning, monitoring, forecasting and assessing (p.68).

Scanning the External Environment

Scanning is the process of identifying signals of environmental change. Since the PA program trains its medical students for the health profession, I identified issues and information in the health care environment and that represented prevalent concerns. First, evidence of racial and ethnic disparities in healthcare is, with few exceptions, remarkably consistent across a range of illnesses and healthcare services (Smedley et al., 2003). Closely related, an "increase in training costs has had profound effects on the availability of doctors" (p.107). Minority medical graduates, including African Americans, Asians Americans, Hispanics, and Americans, represent 9% of the country's physicians. Of these 9%, one-third (33.3%) is African American, 40.1% are Asian American, one-fourth (24.9%) is Hispanic, and 1.8% is American Indian (AAMC, 2000 in Smedley, p.115). These are just a few of the concerns

recognized by the Institutes of Medicine, but further scanning of reports put out by the American Medical Association and the Association of Physician Assistant PA Programs give a broader view of the environmental issues affecting health care providers and medical education.

The scanning process acts as a window to view external information, organize it and identify issues affecting the PA program and its medical students (Ginter et al., 2002). The second part of this process, therefore, was to explore further issues affecting health care as cited by the American Medical Association in its Environmental Analysis Report (AMA American Medical Association, 2004). These issues are covered in the following categories: (1) Demographics of the US Population; (2) Health status of the population; (3) Health care resources; (4) Medical Education; (5) Health care expenditures; (6) Health care access and coverage; (7) Third Party Payers; (8) Medical Practice; (9) Science and technology in medicine; (10) Information and communication technologies; and (11) International Medicine. I have chosen to highlight a few of the issues from these categories in this environmental analysis report.

Demographics and diversity

The American Medical Association (AMA) recognizes that the US population is growing increasingly older and more ethnically diverse (AMA American Medical Association, 2004). This increasing diversity produces a multiple challenge for health care providers in the areas of treatment, medication management, and cross-cultural communication. In addition, increasing diversity requires providers to be more versed on issues affecting Medicare and Medicaid, as some of the PA participants recognized. Roscoe, from the class of 2003, recognized the need for more information about these issues as he states, "they did not teach [enough] about issues ..., reimbursement issues for Medicare and Medicaid, and people on assistance." Health issues affecting diverse populations have become the concern of several health professional associations.

The "Association of Physician Assistant Programs (APAP) and the American Academy of Physician Assistants (AAPA), have both acknowledged the importance of diversity within the PA profession" (p.3).

> The lack of diversity is a key barrier to ensuring a culturally competent health care system at the provider, organizational, and system levels. It diminishes our nation's capacity to eliminate racial and ethnic health disparities and compromises our national capacity to advance the health sciences (Sullivan Commission, 2004).

"Because ethnic diversity in the PA profession is a priority," the APAP considers educational institutions one way of accomplishing targeted recruitment. Historically Black Colleges (HBCs) and universities and those institutions serving Hispanics present avenues for targeting recruitment efforts. The APAP task force for Recruitment recommends looking at the field of study (i.e. education and business) that minority students are pursuing, in order to focus their recruitment strategies (APAP, 2005).

Health Status of the Population

Other issues related to the health status of the population involve the treatment of acute illness as well as addressing personal behaviors which are associated with poor health (AMA American Medical Association, 2004). Health resources for optimal patient care are delivered by the health care team, which includes physicians, nurses, and other health care professionals like the physician assistant (p.11). There is also a growing concern because of the shortage of health care providers and the time that it takes to train them in graduate medical schools. While the number of medical school applicants has been on a decline, all medical school positions are being filled and the academic qualifications of applicants continue to increase (p.17). It is important to note the similarities of this issue with the university PA program where I did my research. For the classes of 2002, 2003 and 2004, one hundred six (106), one hundred seven (107), and one hundred six applicants were interviewed for those respective years. During these periods, only thirty-two (32) seats were available for PA applicants entering in the class of 2002 and 2003. All seats were filled at the start of the program year. For the class of 2004, the number of available seats was increased to 35, and all seats were filled with entering PA candidates.

Health Care Resources

The AMA cites health care resources as another area of concern, due to a shortage of physicians, nurses and non-physician providers (AMA American Medical Association, 2004). But the IOM report cites additional information that details the critical issues behind a decline in underrepresented minorities (URM) (Smedley et al., 2003). A recent report of the Association of Physician Assistant PA Programs (APAP) also has provided information that identifies concerns related to health care resources, for the PA profession. The APAP National Recruitment Strategies Task Force responded to issues that affect the future of their profession in four key areas: (1) Importance of Diversity; (2) Education (3) Other Health Professions, (4) Recruitment and Retention in PA Programs (APAP, 2005).

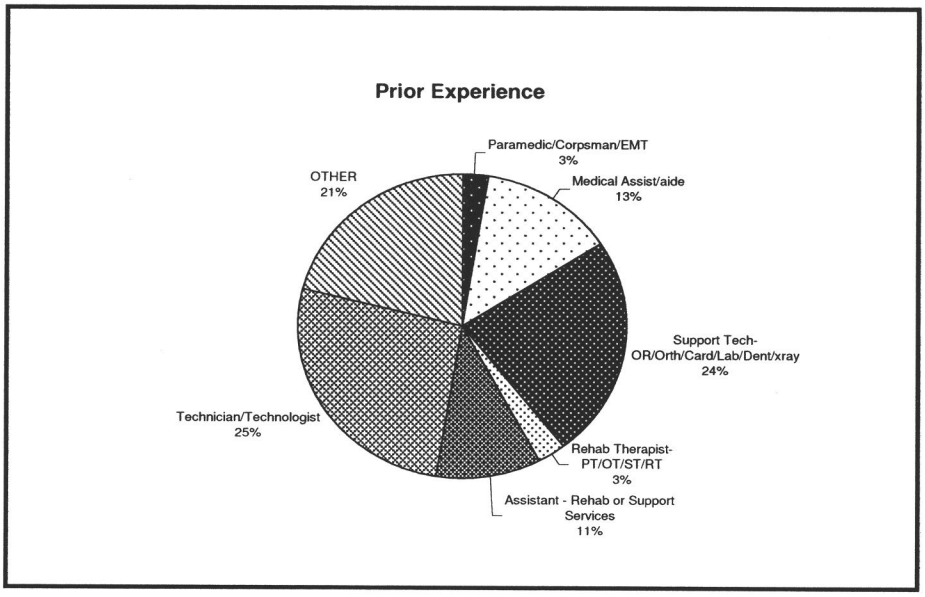
The APAP Recruitment Task force has observed that "some professions have begun to realize that they had become complacent, assuming that the supply of resources and applicants was inexhaustible. The dental profession has responded more proactively than many and has developed some of the best available programs for minority recruitment (p.6)." Therefore the task force has recommended collaborating with the American Dental Association to develop a pipeline concept through community partnerships (p.6).

Addressing the need for culturally competent resources, recruitment and the retention of diverse candidates in PA Programs is of prime importance to the PA profession. The APAP focuses on increasing diversity by expanding their pool of available applicants. Not only did the APAP look at the strategies of other professions but also at the successes of different PA programs. However, in APAP Recruitment report only four of the 135 PA programs around the country were identified as having developed strategies for diversifying their programs. (Among those highlighted in their report is the PA program where I have done my research) (APAP, 2005).

While recruitment and retention of diverse candidates is important to developing culturally competent health care resources, looking at the prior experience of PA students introduces another aspect of the external environment (see Figure 5.1). From this chart we can see that the technology sector provided the prior experience of

almost half of the students in the PA program, which, as we shall see, is consistent with the accelerating role of technology in the medical field itself.

Figure 5.1



Prior Experience of Students Applying to PA Program
Source: PA Program Data

Medical Education

Scanning the issues affecting medical education yields the picture of a significant decline in the number of applicants entering medical education programs. Other challenges involve (1) diversity of applicants, (2) the cost of medical education (3) the inability to attract Native Hispanic citizens, and (4) the financing of teaching hospitals and allied health programs which provide medical education. These issues characterize the complexities of developing culturally competent providers, and, at the same time, require institutions to develop strategies that give a competitive advantage in the health care industry.

Health care expenditures

Health care costs continue to rise faster than the Gross Domestic Product (p.21). The impact of this on patients is that "as baby boomers enter retirement age, pushing up Medicare expenditures, younger cohorts will complain more intensively

about having to pay for the health care of the elderly." The impact on providers is that they will be pressured to reduce cost, even while the cost of liability insurance continues to rise for physicians. This may create "dilemmas for physicians in providing appropriate health care services to patients, limiting liability risks and possibly impacting relationships with patients" (p.23). It is worth noting that the liability for the PA is in many cases is shared by the supervising physician, clinics and hospitals.

Science and technology in medicine

In some cases, new medical technology increases the population that can be served, increasing health care expenditures, while in other cases, new technological advances achieve dramatic cost savings by reducing the incidence of disease (AMA American Medical Association, 2004). The trends in new technology not only foster the reduction in the incidence of disease but new achievements in the areas of organ transplantation. The success of organ and tissue transplantation continues, as evidenced by the improvement in long-term survival rates and the increased number of organs being transplanted (p.42).

> "Hartford Hospital in Hartford, Connecticut, has been steadily adding PAs to its staffs since the Accreditation Council for Graduate Medical Education (ACGME) adopted new rules in July 2002. The hospital has added PAs on the transplant service for the evening shift and to the supplement resident coverage" (AAPA American Academy of Physician Assistants, 2003).

Technology has also paved a way for genetics to become a part of disease prevention, diagnosis and treatment.

> With the completion of the human genome project in 2003 ...genetic breakthroughs will yield new prevention and treatment options.... To date, genetic clinical tests have been developed for nearly 500 human genetic disorders and this number is likely to grow rapidly (AMA American Medical Association, 2004).

International Medicine

Among the top ten global health concerns are HIV/AIDS, heart disease, diabetes, smoking, alcohol and depression (Health, 2003). These diseases are also critical health concerns in the United States.

> We often think of mental health as a domestic issue, in terms of the social problems it raises in our own society. But, in fact, mental health problems occur globally, and with greater movement across borders—whether by choice or by displacement—mental health disorders may not be rooted in any one particular region but may affect others as well (Hrynkow, 2004).

In light of the international medical issues, PAs must be prepared to address global issues. "The recent SARS epidemic highlighted the fact the health issues are becoming more global. All countries are struggling with rising cost and aging populations. No easy solutions are apparent" (Health, 2003). During the time of the SARS outbreak, this PA program had recently secured a clinical site and preceptor in China, for one of its international clinical rotations. News of SARS prompted calls to the program director regarding the safety of the student on the rotation. I observed the director of the PA program reassuring the caller; the medical student returned at the end of a successful rotation, in full health, and graduated during the summer of 2003.

> As PAs increasingly become recognized as health care providers throughout the world, it becomes important for PA students to understand international health care issues. Rotations in other countries provide students with opportunities to gain this experience (Pedersen et al., 2003).

Monitoring the External Environment

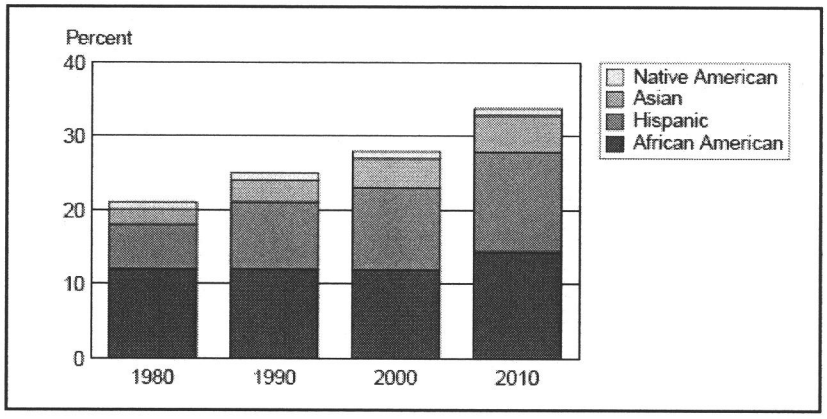
Following scanning, monitoring is the next process in the environmental analysis I conducted. Monitoring is the process of tracking trends, issues and possible events identified in the scanning process (Ginter et al., 2002). For the purposes of this study, I selected three critical areas to monitor: (1) demographic trends, (2) health status trends, and (3) medical education. I selected these areas to track because the other environmental changes seem to hinge on factors related to populations, health determinants, and medical training. More specifically, the limits of this study relate to factors that influence the cultural competence self assessment of PA medical students (e.g. demographic changes, health care access and coverage, and diverse cultures to which they are exposed). In addition, this research explores the factors that influence the medical education environment (e.g. recruitment, applicants, third party payers and costs, information and communication, etc.). Finally, changes in the health

status of the real world ultimately drive curriculum changes (e.g., science and technology, and international medicine).

Demographic Trends

The changes in the percentage of ethnic populations show that Hispanic groups have been increasing since 1980 and are expected to almost triple by 2010. Asian population figures have increased gradually over the last ten years, but it is astounding that African American populations, while increasing slightly, seem to be almost stagnant. There seems to be a similar phenomenon with Native American populations from 1980 to 2000 (See Figure 5.2 below) (Health United States, 2003).

Figure 5.2

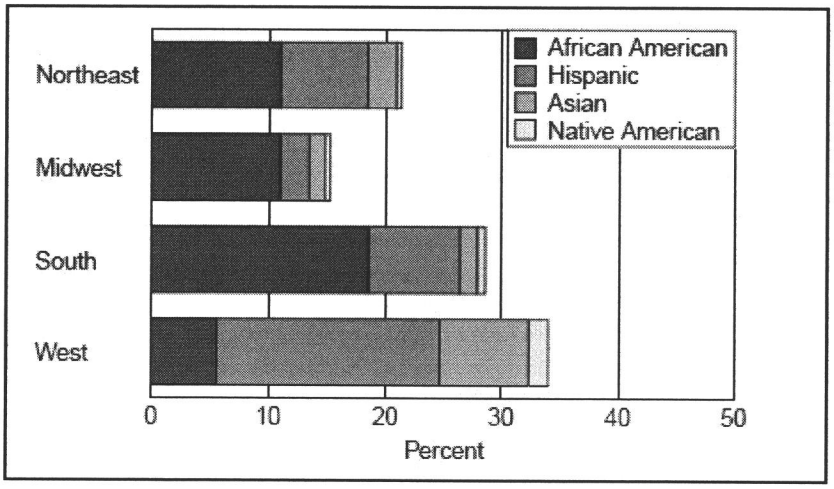


Increasing Diversity of the United States
Source: Health, United States, 2003

Since PA programs must find clinical sites that will offer their students exposure and experiences with diverse populations, it is worth monitoring where diverse populations live in the US. The real story of diversity is regional. When one looks at the percentages, one can see that the majority of Hispanic populations are concentrated in western states of the country. But when one looks at the diversity in the southern and Mid-western states, African Americans represent a clear majority of the ethnic cultures in this area. Therefore, if a PA program wanted to have clinical sites that would expose their medical students to African American populations, finding a preceptor in Texas might be more profitable than looking in Oregon or

Idaho. On the other hand, if a program were interested in developing their medical students to be able to serve Hispanic communities, California or Oregon would present likely places for success (see Figure 5.3) below.

Figure 5.3



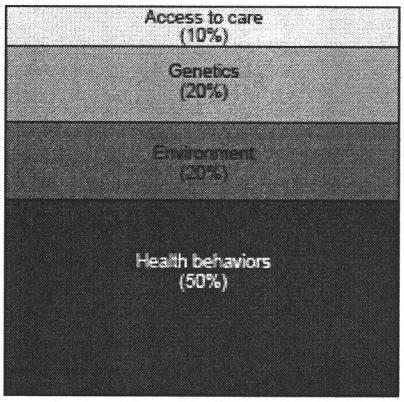
The real story of diversity in 2010 is regional
Source: Health, United States, 2003

Health Status Trends

While tracking the diversity of the nation by regions is important to knowing what clues the environment gives, determinants of health must also be monitored. This aspect of the medical environment includes, in addition to access, genetics and environment itself, behaviors that affect a patient's health. Considering all of these determinants of health now makes the clinical process more complex than just trying to cure someone of a disease. For example, if a patient had a cough, a provider would normally have simply treated for those symptoms; but now the provider has to screen for behaviors, such as smoking, which complicate simple regimens (see Figure 5.4).

> The biomedical model of health care, which focuses on a single causative agent for an illness and is concerned primarily with curing, is necessary but not sufficient. Much more needs to be done to create and implement effective health management and disease prevention programs. Our culture's current focus on wellness is encouraging but is primarily a phenomenon in the wealthier, more educated cohorts of society—which tend to have a better health status anyway (Health, 2003).

Figure 5.4

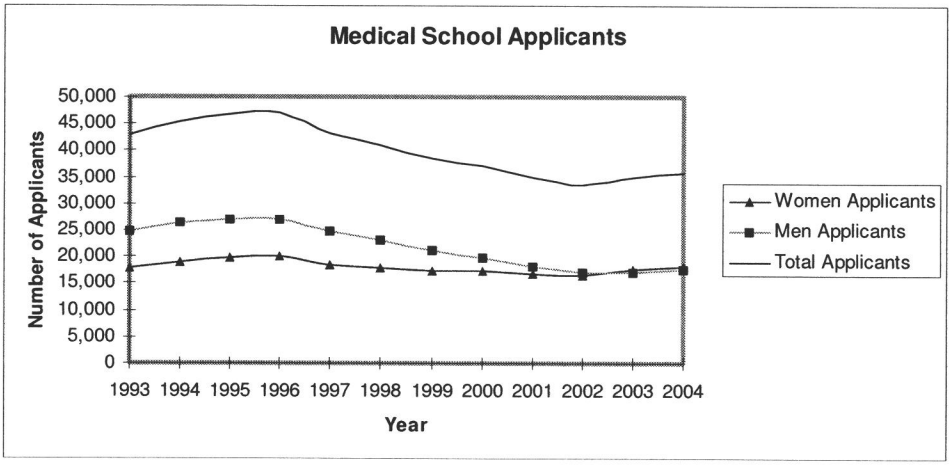


Determinants of Health
Source: Health, United States, 2003

Trends in Medical Education

Having seen the importance of tracking national and regional diversity, and having considered the importance of determinants of health, the tracking of recruitment efforts and strategies in medical education must also be considered in order to understand the clues presented by the environment. The AMA's environmental analysis cited data from the American Academy of Medical Colleges (AAMC) that showed a decline in all medical school applicants from 1993 to 2002 (AAMC American Academy of Medical Colleges, 2004). (See Figure 5.5).

Figure 5.5



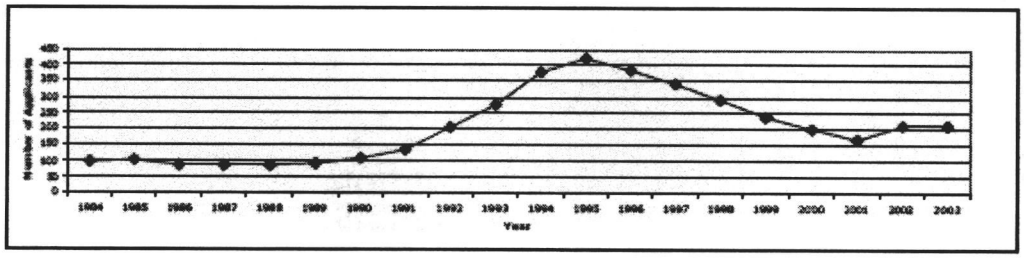
Number of Medical School Applicants by Sex, 1993-2004
Source: Data from the American Academy of Medical Colleges

But according to the Institute of Medicine report…

> Since 1994, the number and proportion of new URM [under-represented minority) medical school enrollees has declined significantly… some evidence indicates that the declines have immediately followed significant policy shifts regarding affirmative action and higher education admissions procedures…. Subsequently, public medical schools in California, Louisiana, Mississippi, and Texas accounted for 44% of the decrease in URM matriculation in medical schools nationwide…in 1997, African American student enrollment in Texas public medical schools dropped 54% (Smedley et al., 2003).

I compared the decline in medical school applicants to average number of applicants applying to PA schools for the same time period and a similar decline was noted (see Figure 5.6).

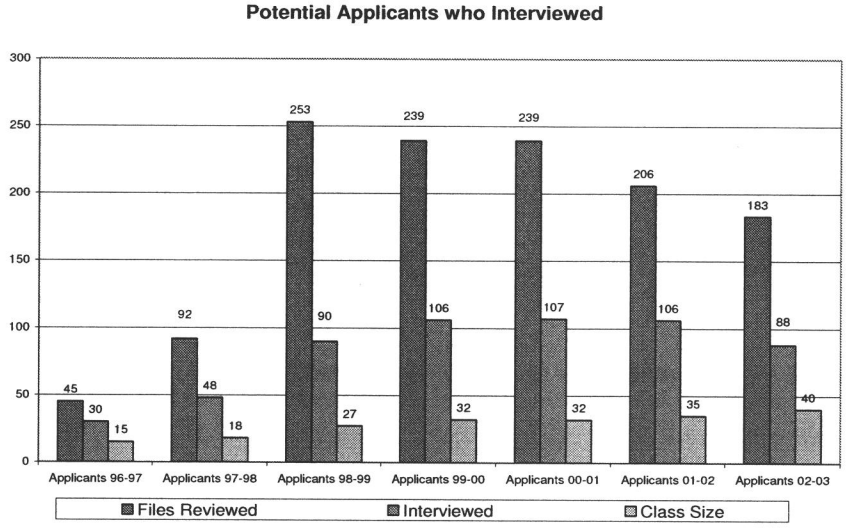
Figure 5.6



Mean Number of Applicants/Program 1984 – 2003
Source: A. Simon in APAP 2005

The PA Program which is the subject of this research monitors the external environment as it relates to those who apply to the program. During the time period when medical schools experienced a decline in applicants, this program, in its infancy, also saw a decline from the 1998-1999 interview periods through the 2002-2003 periods (see Figure 5.7). The first bar in each year shows the number of applicants. The application and interview period runs from October of one year to January of the next year. Those students who are accepted to the program begin in May following the January interviews.

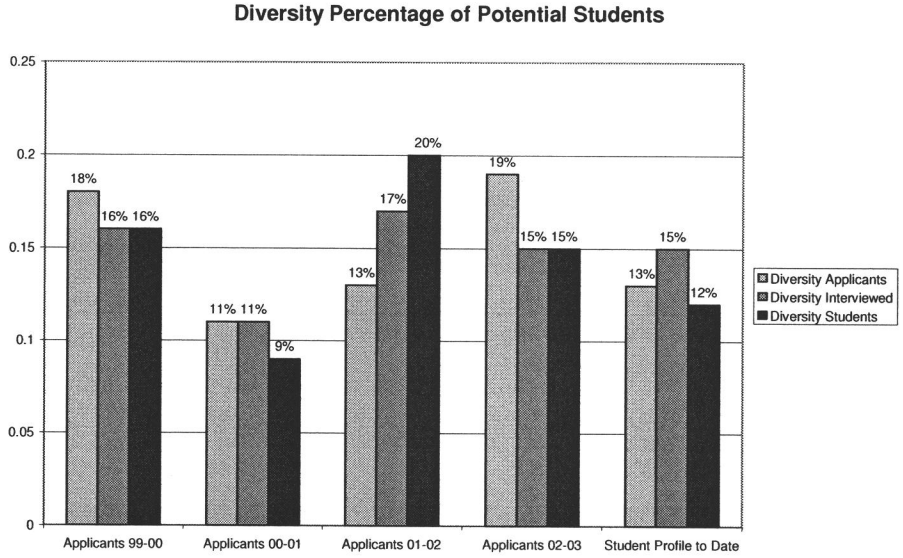
Figure 5.7



PA Program Potential Applicants who were interviewed
Source: PA Program Data

In addition to monitoring the rate of growth or decline in applicants, the diversity of the applicants and candidates is tracked as well by the PA Program in this research study (see Figure 5.8).

Figure 5.8



Diversity of Potential Students Applying to the PA Program
Source: PA Program Data

It is important to note that the APAP began to look at medical education for the PA medical student as it relates to international health issues. From 1999 to 2003 international rotations issues were discussed and strategies formulated by a special task force. The results of this ad hoc committee were summarized in a report presenting goals and objectives, a list of consulting experts, survey results, a list of curriculum topics, and guidelines for developing international rotations in PA programs. A key recommendation was that there be more international rotations (Pedersen et al., 2003).

We have seen that by scanning and monitoring the events taking place in health care, it is possible to get some idea of what might happen if these events continue to occur; and it is the development of such ideas that leads us now to forecasting environmental change.

Forecasting Environmental Change

Looking at the changes in demographics, health status of the population, health care resources, access, and coverage, and international medicine, forecasting environmental change is the process of extending the trends, dilemmas, and events that are being monitored (Ginter et al., 2002).

Demographics

The AMA cites the following trends affected by the changes in US demographics: The US population is becoming more ethnically diverse. Currently 74% of the US population is Caucasian, but that will decrease to about 64 percent by the year 2010. In 2010, Asians will make up 5 percent, Americans 12 percent, and Hispanics will comprise approximately 15 percent of the population (The Institute for the Future, 2003). The emergence of new infectious diseases and reemergence of old [ones] can be traced to changes in population and behavior. It is predicted that providers will be treating more non-English speaking patients, and 50% of their [providers] practice time in the future will be treating patients over 65 (AMA

American Medical Association, 2004). Therefore, it will be important for health care providers to improve their communications with their patients.

Health Status

Health status trends show an increasing percentage of morbidity and mortality related to personal behaviors that are mostly preventable. The leading causes of death are tobacco (400,000), diet/inactivity (300,000), alcohol (100,000), infectious diseases (90,000), toxins (60,000), firearms (35,000), illness associated with sexual behaviors (30,000), vehicles (25,000), and drug abuse (20,000) (AMA American Medical Association, 2004).

Another trend in our country is that obesity is becoming a concern for adults and children. "Approximately 15 percent of children (6-11) and adolescents (12-19) were reported as overweight in 2000, compared to 4.0% in 1970. The increase in overweight status is highest among non-Hispanic black and Mexican-origin adolescents" (S. P. AMA, 2004). These startling changes in the health behaviors of communities, coupled with the diversity of the cultures, make it more evident that cultural competence is important in the training of health care providers (p.9).

Health Resources

Trends relating to health resources include issues affecting the non-physician providers' (NPPs), scope of practice. The Physician Assistant (PA) is considered a non-physician provider (NPP). As the scope of practice for NPPs continues to expand, collaborative practice agreements between physicians and NPPs are growing beyond traditional arrangements (S. P. AMA, 2004). The number of freestanding ambulatory care facilities has increased by 46 % since 1996. The percent of all outpatient surgeries being performed in freestanding facilities increased from 15% to 31% between 1989 and 1999 (S. P. AMA, 2004). Each PA student must complete at least four weeks of the surgery rotation during their second year in PA school (U. S. o. P. A. S. Pacific, 2004). While many PAs are going into surgery as a specialty after graduation, there are still shortages of nurses and pharmacists who also play an important role in the

health care team (p.15). Therefore health care professions will resort to non-traditional recruitment strategies and partnerships.

Uninsured and Underinsured

> Trends also show that a recent jump in the number of uninsured; the growing state fiscal crises that jeopardize Medicaid funding, [and] employer concerns about the rising cost of health care premium will fuel new debates about the role of government versus the private sector in offering health benefits (AMA American Medical Association, 2004).

Furthermore,

> The number of people covered by government health benefits increased from 25.3 percent to 25.7 percent in 2002; [that same year] the number of Americans without health insurance coverage... grew to 43.6 million (up 2.4 million from 2001), representing an estimated 15.2% of the population (AMA American Medical Association, 2004).

As the number of uninsured population increases, Oregon's concern was registered by Sunil Khanna, a member of Oregon's Race and Ethnic Health Task Force, who states,

> For uninsured individuals, the greatest barrier to health insurance is cost. Most uninsured participants consider health insurance far too expensive. As a result, many...have had to postpone seeking health care on several occasions... (Khanna, 2001).

I think we can expect that the cry against high costs and the rising number of uninsured will create increased pressure for health system reform. Costs and expenditure issues may be the most challenging of all the factors related to health care unless there is a paradigm shift in structuring rates and containing cost. Keeping this in mind, it is worth evaluating these important issues by assessing the environmental change.

International Medicine

As the life expectancy increases for domestic populations, the life expectancy for global populations is decreasing, forcing a need for newer communication and technology as tools to keep ahead of the dismal situation in global settings.

> As developing countries become more industrialized they will need to focus on prevention and treatment of non-communicable diseases .... With increased world travel, there is a growing trans-nationalization of health risks and diseases.... [the use of] the Internet will make it easier for medical researchers to collaborate and share

> research data.... Globalization will lead organizations to build alliances with partners around the world (S. P. AMA, 2004).

Assessing Environmental Change

According to Ginter (et al), assessing environmental change is a process that is largely non-quantifiable and therefore judgmental (Ginter et al., 2002). Ginter and his colleagues believe that a health care organization can look at the issues and trends and see them as opportunities or threats (p.74). In a competitive society it is important to look at what opportunities you have in order to be successful, and at the same time be mindful of those factors which pose a threat to your survival. The following key issues were considered for this analysis: population diversity vs. lack of diverse health care resources, the need for high cost diagnostic testing and treatments vs. patients' ability to pay, and a traditional focus based on disease and access to health care vs. a future focus based on health behaviors.

Traditionally, health care has been driven by the ability to cure diseases or illnesses. In most cases the environment was a major contributor to an illness, where the disease was primarily caused by infectious organisms. Conceptually, in many populations environmental exposure is a contributor to the burden of disease (Valent, Little, Tamburini, & Barbone, 2005). As a result, Public Health departments and the Center for Disease Control (CDC) initiatives focused on education and controlling the environment. Together with disease control, the focus was on the increasing diverse populations.

Resources became insufficient because of the lack of health care providers, and inadequate because of growing cultural differences forming barriers in meeting health care needs. These concerns represented major access issues for health care organizations. Following this, government agencies, health maintenance organizations (HMOs), communities and other health care institutions developed policies, initiatives and strategies to improve access and curb health disparities, while trying to limit costs. However, according to the CDC's Determinants of Health, shown earlier in Figure 5.4, access and environmental contributors only make up thirty percent (30%) of the health care "pie." If we consider traditional models, it would mean that we are

focusing and spending the majority of our resources on less than 50% of the problems. But the reality is that there has been a shift in the burden of disease (Health, 2003).

If health behaviors represent fifty percent of the health determinants and access issues contribute to only ten percent of health care problems, then it would make sense to alter our strategies for meeting the health care needs of a diverse population. Health behaviors like alcohol and drug addiction, mental health, sexual behaviors and the behaviors associated with chronic disease make up a complex array of needs among a culturally diverse population. Environmental factors such as pollution, lead poisoning, living conditions, and infectious diseases, coupled with the dynamics of the economic and social climate constitute the need for different approaches. Culturally competent health care resources are needed now more than ever to tackle health behaviors and environmental factors that impact the health care needs of our populations.

Driving Forces in Assessment

Assessing the environment also means to identify the forces that drive the forming of a vision, mission, internal analysis, and strategic plan (Ginter et al., 2002). The issues surrounding demographics, medical education, medical practice, and access to health care are driving forces that have helped to shape the mission and values for this PA program:

> The mission of the Physician Assistant Program is to prepare students to provide quality care for a diverse population in a changing healthcare environment through an education based in primary care medicine with a focus on critical thinking (School, 2005).

Other forces that relate more toward strategic planning involve health care resources; recruitment, and international medicine, as well as access to health care. Strategies for addressing these issues are included in two HRSA-PA Training Grants. The first HRSA funded grant (1999-2002) implemented activities for hiring a diversity coordinator, integrating diversity into the PA curriculum, clinical site selection, and awareness of the PA profession. The most current federally funded grant, covering the period from 2002 to 2005, focuses on objectives and outcomes that involve developing

cultural and community partnerships as part of the strategic planning of the program (P. P. Pacific, 2003). "Objective One" (1) addressed the issue of clinical sites serving medically underserved communities. The outcomes yielded included the fact that 81% of the medical students had 2 rotations at sites serving special needs or disadvantaged populations. Objective two (2) resulted in an increase in the number of minority students and graduates of the program to eighteen percent (18%) of PA students self-declaring as a minority. Objective three (3) was achieved with an increase in the number of graduates who are working in medically underserved or rural communities as their first job to thirty-four percent (34%).

While the first three objectives addressed concerns for the medical education of the students, the next three objectives addressed concerns for faculty and future recruitment for the PA profession. Objective four (4) addressed increasing the number of disadvantaged/under-represented minority (URM) faculty to include lecturers, preceptors, and primary faculty. Only 10.5% of lecturers during 2003 were known to be of disadvantaged or underrepresented minorities, but fifty-five percent (55%) of primary faculty were included as disadvantaged white persons.

Objective five (5) focused on partnerships with high schools to work with students in the Kids into Health Care Careers (KIHC) concepts. This project was the most fun for many faculty, staff and students. Each year about 50 students would visit the PA program and go through hands-on activities, and tours of the cadaver lab and the main campus. Summer activities included partnering with other health related professional schools on campus, in an effort to increase health career options for high school students. Some of the high school students were so excited about this opportunity, that they were willing to get friends to bring them to the PA campus on a school holiday.

The final objective, six (6), was to encourage applicants from Hawaii to apply to the PA program, and develop clinical sites on the Hawaiian Islands. This strategy proved to be very successful since there are no PA education programs in Hawaii or its

islands. As a result three (3) applicants have been admitted to the PA program from Hawaii.

The strategies, implemented by HRSA funded grant objectives, have worked well in developing diversity and community partnerships in order to begin addressing health care needs. Both grants funded strategies that were influenced by the external needs in the health care environment. Opportunities for the PA program and its medical students, for exposure to diverse communities, and for experiences with underserved and uninsured populations, along with the recruitment of URM candidates, came as a result of successful grant efforts.

In addition, to developing diversity and community on the domestic front, the APAP committee on International PA Education concluded in their report that "international clinical rotations are consistent with the mission of PA education", which also suggests, that "PA students and faculty reap the greatest benefit when their host institutions support such activities" (Pedersen et al., 2003). The PA program has been true to this aspect of their mission by establishing international clinical sites in Honduras, Bahamas, China, and Ecuador. Assessing issues related to international medicine helps evaluate the external and the internal aspects of medical education. The next chapter explores these strategies, along with other program activities, from the perspective of an internal analysis.

CHAPTER VI
INTERNAL ENVIRONMENTAL ANALYSIS

The Process

The second phase of the environmental analysis is examining the internal position of an organization. According to Ginter et al, while the external analysis tells what an organization *should be doing*, the process of the internal analysis will allow you the view what a health care organization *can do (Ginter et al., 2002).* It was important in my research to understand the factors within the PA Program that influenced the PA students' medical education. Those factors which influenced candidates to get their medical education from this institution, considering the number of PA programs in the United States, point to the success of the program, and that success is indicative of the program's ability to create value for the medical students (p.140). Ginter et al considered these influences to be *assets* of the health care organization (p. 141). One way of viewing the assets of an organization is to examine its resources, competencies and capabilities.

The process of the internal analysis involved three steps: (1) Identifying the strengths and weakness of the medical students as they relate to the PA program; (2) classifying those strengths and weaknesses according to resources, competencies or capabilities; and (3) evaluating the relevance of these factors in developing cultural competence (p.146). "Resources are the stocks of human and non-human factors that are available for use in producing goods and services" ((Ginter et al., 2002). Collective knowledge and skills possessed by individuals, or critical expertise, comprise the competencies of an organization (p.149). *Capabilities* are determined to be the ability to deploy resources and competencies (p.151).

Identifying Strengths

Beginning with the first step in this analysis, identifying strengths, the strengths of the PA program can be characterized by the factors that give a competitive advantage, that make the program stable, or that make this program

different in terms of the medical students' capabilities (Ginter et al., 2002). The results of the focus groups and in-depth interviews give some insight into what PA medical students can do as it relates to being culturally competent. These *can-do* skills are indications of their cultural abilities and/or strengths of the PA program, as a result of their medical training or other experiences. Following is an examination of key strengths, including (1) community and outreach activities; (2) partnerships, (3) clinical rotations with diverse patients; (4) international rotations; and (5) opportunities to apply medical knowledge--each important in developing the internal analysis.

Community and Outreach Activities

First, outreach and planning efforts like the MLK Jr. Health Fair were beneficial and rewarding, as indicated in the interview with Rosalie...

> ... We did a lot of community activities, either the Martin Luther King Health Fair, which was in the African-American community, and I think we all ... did the lead screening... There was, you know, obviously the workshop that we did about the cultural competence and burning of some beliefs. I think the most effective of those cultural competency talks was having individuals from the community. We had a Native-American woman come in and speak, we had people from the Latino community ... I think as you are exposed to either different ... beliefs systems ... lifestyles you slowly gain ... knowledge about them, but you [move] toward competency.

Partnerships in the Community

Events like Martin Luther King Jr. Day Health Fair required that the students develop partnerships with the Asian Family Center, Legacy Emmanuel Hospital, the Eye Institute, the Sickle Cell Foundation, as well as the Lloyd Center Shopping Mall and others in the community. The media was also involved, as the students received newspaper and radio publicity for their events. It took over two years to build a reputation in this community.

As the Diversity Coordinator, establishing partnerships with advisory members from the community, I helped to get the program's "foot in the door" in many places where previous unsuccessful attempts had been made. Key partnerships were not only with advisory members but, Oregon Health Careers Center (OHCC), Area Health

Education Centers (AHEC), Providence Health System (PHS), and the State of Oregon Office of Multicultural Health.

Students also participated in going to high schools to talk with youth and conduct hands-on activities. Young people where more likely to listen to the PA students than to older faculty since they were closer in age and could relate. Special events were held for high school students to visit the program in Forest Grove. Partnerships and collaboration were fundamental to making presentations and providing hands-on activities for over one thousand high school students in 2004. The KIHC program was selected as a featured seminar at the national conference of the Academy of Physician Assistant Programs (APAP) in Nashville, Tennessee in the fall of 2004.

Clinical Rotations with Diverse Patients

Next, the clinical rotations made a difference for students, especially in diverse communities. Hortense, like many other PA students, spoke of a diverse site with Hispanic patients that was rewarding...

> I...did my family practice rotation up in the Seattle community clinic for three months, which is very diverse. I worked with and treated patients from every continent and many different languages. This rotation was an excellent opportunity in many ways. The exposure of different cultures was excellent as well as understanding different ways to treat these patients that would be most appropriate for their values and beliefs. If I were unsure I would often ask the patient, family members, or other co-workers of similar backgrounds.

Living arrangements for clinical rotations was a challenge at many sites, but it fostered growth. Even though students were challenged with having to find their own lodging in a strange place--where they might not speak the language--and to live there for a four to twelve week stay, this experience made a positive difference in the lives of PA medical students. Such was the case for Marla...

> So I did get to know ... my co-workers pretty well; but the patients not really ever... I was living ... in this really tiny dormitory, and there [were] probably like five other people from the community living there, so I get to know those people, who are also patients. But other than that, it was mostly co-workers. And I really had a chance to get to know them and to kind of break down barriers with them.

Lately, efforts have been made for other students to have the opportunity to experience clinical rotations in Alaska, where there are many Native Americans, Hawaii, where there are diverse cultures, and in Yakima, Washington, where there is a large underserved population.

International Rotations

Many students explained that the international rotations were among the strengths, both of the program and their overall medical education. Hortense summarizes her rewarding experiences in international clinical rotations...

> .... I also chose to do a rotation abroad in Ecuador, as well as Costa Rica on spring break, to see how third world countries practice medicine, and immerse myself in their culture. .... The beginning ... was very challenging because I spoke very little Spanish and I clearly stood out physically being very tall and blond. ... in Ecuador, and patients had waited for hours in a hot clinic with no water or air conditioning. Many had no money, yet they had tried to dress in their best and were so grateful just to be seen. ...many were so understanding of my language skills and even took extra time to be accommodating. I feel these ... were clearly life changing and helped me to continue to grow culturally and become more aware... I am very glad that I was given the opportunity to do rotations in other states and countries, which enabled me to learn and grow in this area of medicine.

The international rotations excited also potential candidates, even though it meant coming up with the cost of travel and lodging for four to twelve week rotations. Exciting stories were told by current students, humorously and proudly at Friday night sessions before interview days. Clinical rotations, international and domestic, provided opportunities for PA students to apply their medical knowledge from the didactic year. The APAP report suggests that

> If PA students' experiences are similar to those documented for medical residents, it is likely that students taking part in international rotations contribute to the flow of new knowledge into American medicine (Pedersen et al., 2003).

One hundred thirty PA programs were surveyed for this report to learn about experiences of other PA programs with international student rotations. Responses from the survey showed...

> ... International experiences were life-changing and reported that students who participated in rotation experiences abroad gained enhanced cultural competence (76%), exposure to global medicine (95%), language skills (67%), and familiarity with missionary work (67%) (p. 222).

Opportunities to Apply Medical Knowledge

Other strengths that can be listed include: (a) application of the students' medical knowledge in the board exam, which is demonstrated by a 99-100% pass rate of board exams for graduates of this program; (b) the Essential Health Clinic, which provided exposure and experiences to the real world of uninsured persons; (c) shadowing other Pas; and (d) opportunities to learn to triage patients. These activities created value for the program. Students had the opportunity to get involved with the community, learn how to make contacts, use their coordination skills, have fun together, and see the "real world." Pictures of these events were posted in the Program display. All of these activities were among the organizational strengths that interested and excited potentially new candidates of the PA program.

Weaknesses

Just as the data from the focus groups and interviews gave insight into the strengths it also provided an open window to the weaknesses of the students and/or the medical program. These weaknesses, or areas that need improvement, can be classified in the following categories: (1) lack of openness to diversity, (2) language skills, (3) being overwhelmed with medicine, (4) interaction with diverse providers, (5) limited exposure to African Americans, Asian and Native American patient population, (6) understanding disease patterns and behaviors of other cultures, and (7) lack of access to diverse faculty. The areas that needed improvement echoed throughout the focus groups and the interviews. I will highlight the top three issues, regarding diversity, language and medicine. Other, latter issues in the above listing, including the lack of diverse providers and faculty; diverse, but non-Hispanic patients;

and disease patterns, will be covered in the recommendations. Comments by the participants help to shed more light on these weaknesses of the students and this medical program.

Lack of Openness

This description of the students about their peer classmates proved to be a perception that had critical impact on the attitudes of the class and their reception of diversity and cultural competence issues. Only nine percent (9%) of the class of 2003 self declared themselves as being of ethnic background and sixteen percent (16%) self declared that they were from medically underserved areas. Limited exposure to diverse peers, within the class, and limited exposure from their area of origin could account for PA medical students' lack of openness to diversity or related subjects. Therefore, members were not always comfortable discussing certain cultural issues when their perceptions may have represented a minority viewpoint. When a critical number of diverse medical students are not represented in the class, a barrier to communication and learning is unknowingly encouraged, producing a lack of openness.

In the interviews some graduates expressed their feelings about the attitudes of their peers. Roscoe was more open about his perception of his classmates, now that he had graduated from the program...

> Some persons, [in my class] ....were not ... open to other cultures, some were not open to cultural competence, nor did they attempt to deal with their own personal biases; some ... were ignorant... [some] persons who had a bias in the class I graduated with ... were mostly Caucasians. ... It's up to you to have an open mind. It's not a real world situation .... Caucasians are not going to be open.

Language Skills

The issue of inadequate language skills was voiced over and over. When the medical students described not being able to communicate as well as they thought they could and having to use interpreters, I detected a sense of insecurity. The two Spanish language courses were not set up to teach students to speak Spanish fluently. However, it is a part of the program curriculum to provide more of a Spanish survival

course, with emphasis on medical history. It is a pass/no pass course and attendance is mandatory. The second level course is a two-week intensive Medical Spanish and Tropical Medicine course held in San Jose, Costa Rica. Many students found this course to be quite helpful, but it was only two weeks of immersion. The students desire to give the best medical care relies upon good communication. Many times they were not always sure of whether they had been understood. Priscilla explains it this way...

> ... I think exposure is sometimes limited by language, and a lot of the rotations that are available ..., you can only go to if you speak their language. ... at Virginia Garcia Health clinic, you can only go there if you are Spanish-speaking. I think I understand why they need to do that, but at the same time I think it is a disservice, because I think that exposure is what's going to get you some cultural competence ...or more motivated to work with other communities. In our program you are just not going to be exposed to them unless you already have that skill that way ...

Overwhelmed by the Medicine

PA students realize when they come into the program that it is twenty-eight months. They are told how difficult it will be in the first year. They are encouraged even to take refreshers on anatomy and physiology and medical terminology before they start. Current and former students coach them prior to entering, and some even give words of wisdom to friends who have started the program during the first year. But with all of the refreshers, coaching and encouragement, and their high intelligence and medical experience, PA medical students are still overwhelmed with the amount of information that is required. This seems to make students feel that cultural issues are in competition with time spent on learning medicine. Some students like Timothy, registered their frustration from being overwhelmed by trying to add the cultural learning to the medicine during his twenty-eight months education.

> ...I took this medical Spanish in hopes of trying to catch a few words here and there that may help me along the way. But I was always hesitant to devote a lot of time into trying to learn the language because I felt so overwhelmed by the content of medicine .... I was here to learn how to ... diagnose and treat.... If I do not know medicine, knowing Spanish is not going to do me a damn bit of good. So my focus was learning what I needed to learn to be able to treat that person, you know, whether through an interpreter, or whatever.

Timothy's comments not only show areas for improvement for the program, but they also reveal an attitude related to his level of openness to becoming culturally competent.

Weaknesses and negative attitudes can permeate the processes and strategies that are implemented to develop culturally competent professionals and, therefore, impact the self-assessment of a medical student's cultural competence. Since an internal analysis gives an indication of the value that is created by an organization, that perceived value can be negated by weaknesses if not offset by sufficient strengths. Understanding the strengths and weaknesses of the program and the cultural abilities of the medical students helps to move this study toward classifying which strengths and weaknesses are resources, competencies or capabilities.

Resources

Resources can be classified as a strength or a weakness and may be tangible or intangible. Ginter and colleagues consider resources to be the "stocks of human and non human factors that are available for use in producing...services" (p.149). First I evaluated the resources that are strengths, since any strength that an organization possesses helps to sustain a competitive edge. Since there are 135 PA Programs around the country, it is important that any PA medical program maintain a competitive edge. In light of the results from the external analysis, it is important to examine the resources that meet the needs which are appropriate for the current and future health care environment.

Classifying the strengths of the medical students or program activities will also help to discover resources for developing cultural competence. The community activities and partnerships spoken of above provided an intangible resource that created value in student involvement and exposure to diverse communities. As the Diversity Coordinator I was also a resource to the program, community, and medical students. My position created value, by linking a predominantly white institution to opportunities with the under-represented minority (URM) communities in the university's back door (i.e. Washington County), as well as thirty miles away in an

urban setting in Portland and other locations for recruitment. I also connected community lecturers and participants for cultural activities and panel discussions with PA students. The diverse clinical and international rotations also provided a tangible and intangible health care delivery resource for the communities being served. Access to health care through direct patient contact, treatment, and medications, creates value for underserved communities. These clinical opportunities also create experiences for the medical students that cannot be replicated in urban, all white, private pay delivery systems.

Identifying the resources that need improvement gives a picture of the concerns that can threaten the continued success of medical students. There are three areas of weakness that, because they are limited, reduce the value of the program: (1) openness to diversity, (2) access to clinical rotations that have more non-Hispanic patients (also African American, Asian, and Native American), and (3) diverse PA faculty, preceptors and providers. These three components, though limited at this time, can become assets and resources for involvement, exposure and experience the real world. Without these resources, the competency is not there, and the capabilities of the medical students, is short-circuited.

Competencies

"The collective knowledge and skills possessed by individuals, called competency, may be a source of sustained competitive advantage for the organization" (Ginter et al., 2002). The list of strengths and weaknesses can be further explored to determine what critical expertise is possessed by the PA medical students and the PA Program.

Medical Competencies

The main competency for the students is their medical knowledge, which has been demonstrated by the ninety-nine to one hundred percent PA certifying board pass rate. This medical expertise along with their medial research abilities is an asset for the program that has been beneficial to both students and preceptors who have

provided opportunities for research in their clinics or offices. This competency is also validated by the preceptor evaluations for each student.

Language

Other than English-speaking language skills is a competency with which some students came to the program. Some students spoke fluent Portuguese, Russian and Mandarin. But these skills were hardly used in the clinical rotations. A Spanish language class was conducted by adjunct faculty from the Spanish Department of the university. This was mainly "survival Spanish," which many students felt was not adequate for them in the real world.

Cultural

Making an effort to assess cultural competency was and is a competency of the Program. The key issue behind this investigation was whether the cultural competence self assessment of the medical students indicated cultural competence. My investigation explored the strengths and weaknesses of the PA students' cultural abilities. I have further explored the descriptive definitions for cultural competence as voiced by PA graduates and medical students in focus groups and interviews. It is at this point, that I have compared the theoretical definition or idea of cultural competence with the ideas of the medical students. Before reporting this in detail, however, I would like to continue identifying competencies, specifically in relation to faculty and staff and international rotations.

International Rotations

The APAP recommendations are given to PA programs interested in international rotations. Their recommendations include strategies for identifying experts and core competencies for consultants in advising capacities. The Director of this PA program studied in this research was among those from three mentioned programs to consider contacting the APAP for guidance in this area. As the APAP recommends:

> Ideally, those designated as experts [in the area of international rotations] should have experience with, and an understanding of legislative, regulatory, and health policy issues in both the United States and those countries they hope

> to serve. The ideal candidate is a PA educator or a practicing PA with international experience, expertise with international training courses, and an effective speaker experienced in presenting to international delegations, and a culturally sensitive person who displays qualities of open-mindedness, diplomacy, patience, and tact. The experts should be capable of serving as resources for countries interested in the PA concept. ...Experts would be able to discuss core competencies and role delineation—in primary, secondary, and tertiary care settings—for PA programs in the United States.

The critical expertise of the program was also through faculty. The PA Program sought diversity in its students, but was only able to hire an African American as the Diversity Coordinator. In six years, five positions (faculty and staff) had been vacant, and all five positions were filled with white males or females. I believe that this was one of the shortcomings of the PA program, yet not unusual. Monitoring and reporting the outcomes of cultural competence objectives helped to get commitment and focus strategies in order to increase diverse lecturers for the PA students as well as to make changes in the recruitment and admissions process. However, the inability to hire diverse PA faculty is one of the weaknesses of the program.

Additional cultural expertise was supplied with the services of an adjunct faculty member, later added to the program, from the School of Education. This person, of Hispanic descent from Texas, is bilingual, with prior teaching experience at the another medical school in the state. A diversity curriculum was developed and presented to the PA medical students along with conducting Brown-bag sessions on cultural issues. However, even with the introduction of a person of color in the classroom there were behaviors responding to the lack of openness to diversity and cultural competence.

Competencies of Faculty and Staff

It is important to note that PA staff and faculty possess competencies for the positions they held. The PA Program Director had competencies in the areas of business, as well as medicine; she was a certified physician assistant (PA-C) with an MBA. Her business skills were necessary in order to lead the charge for fiscal strategic planning, encourage the use of technology, champion diversity development,

international rotations, foster problem based learning (PBL) and evidenced based medicine (EBM), as well as the start up of a new, competitive and innovative PA program in the Pacific Northwest.

Problem Based Learning

The Academic Coordinator provided medical expertise in the area of Problem Based Learning (PBL) in an effort to provide creative learning of medicine that was more practical. "Problem-based learning cannot be considered as an experimental method in medical education. It has probably been more thoroughly studied and evaluated than have the traditionally accepted educational methods used in medical school (Barrows, 2000)." "PBL is a curriculum development that utilizes real world problems to develop diagnostic and medical skills to solve patient problems" (Stepien, Gallagher, & Workman, 1993). Stepien proposed using small groups that are facilitated by faculty, as students use critical thinking skills for determining better solutions. While the PBL courses allowed critical thinking of real life situations, the fullness of cultural competence was not a part of this strategy. There was some intent with the use of ethnic characteristics, but the case studies and scenarios had not been utilized to their full capabilities, according to the Academic Coordinator.

A part time faculty member, who later became full time with the PA Program, was a professor in pharmacology. The program had been sharing this professor with the School of Optometry. This position provided medical students with expertise in chemistry, medications and treatments in their first year. This professor most recently became fully in charge of the university's efforts toward sharing their own pharmacy program with other participants. This is an example of how the university is capable of using human resources and their competences to initiate new competitive strategies.

Capabilities

Having looked at resources and competencies, I now turn to the area of capabilities. Ginter and colleagues propose that a "health care organization's ability to deploy resources and competences, usually in combination, to produce desired services is known as its capability" (Ginter et al., 2002). The resources and

competencies of faculty and staff were deployed to bring about change and improvement to the program. Those capabilities are demonstrated in the coordination of resources of for diversity development, making connections with community partners for Kids into Health Careers, establishing a free clinic (EHC), and developing domestic and international rotations.

Diversity Development

The cultural competence of the Diversity Coordinator has been an asset to the program, helping to provide successful implementation of programs, curriculum development and guidance to the organization. My professional experiences in business, state government and the community contributed to my role in writing grant objectives, strategies and implementation. Monitoring the development of cultural competence and diversity development with the CCSAQ was part of the grant implementation. Key roles also included development of a diversity curriculum and Kids into Health Careers program (KIHC), development of recruitment avenues for diverse candidates, guidance, and in-house consulting on how to respond to sensitive cultural issues in health care. My understanding of Oregon Health Plan (OHP) issues and health disparities in migrant and underserved Hispanic populations also contributed to reestablishing a clinical relationship between the PA Program and Virginia Garcia Clinic. I recall the following incident between this local clinic and the PA program...

> Prior to coming to this private institution, I had worked for the Office of Medical Assistance Programs (OMAP) conducting training, developing strategies, policies and relationships with communities, health plans and physicians. Through this experience, including specific experience with the Virginia Garcia Clinic, I understood many of the Clinic's values, the issues faced by migrant workers and uninsured, but mostly I had critical knowledge of the Oregon Health Plan (OHP) clients and issues in Washington County. I also had a knowledge and understanding of the critical need for cultural competence, and for Spanish interpreters at this clinic. When I came to the PA program, I found that a critical, clinical rotation had been jeopardized by sending a student that could not speak fluent Spanish. This breach had caused friction and a serious break in the relationship between the preceptor and the school. I recognized the importance of maintaining and developing new clinical sites, like this one, that would allow experiences with Migrant patients and the uninsured. Proactive intervention requiring cultural sensitivity and

> knowledge of the culture was necessary. Efforts to bring understanding and reestablish the relationship were successful.

Other efforts to coordinate community resources and competences were exhibited through advisory committees, PA Applicant Support and the Kids into Health Careers Program.

Free Clinic in Washington County

From the perspective of the medical students, they exhibited capabilities in integrating some cultural knowledge and outreach in their planning and coordination of the MLK Jr. Health Fair. Their participation in the African American Wellness Village, The Essential Health Clinic and other community events was also a demonstration of their ability to develop partnerships and linkages in the community.

The establishment of the Essential Health, a free primary care clinic, is a true community collaboration with partners from Pacific University [School of Physician Assistant Studies Program], Tuality Healthcare, Providence Health Systems, Virginia Garcia Memorial Health Center, and the Washington County Department of Health and Human Services (Washington, 2005).

Responding to the needs of the community also benefited the medical students in that the free clinic provided a place for medical students to shadow other health professionals, use some of the Spanish language skills as well as volunteer their time during their medical education. The leadership of the PA program coordinated the resources for this partnership to take place.

Leadership of the Program

The leadership of the PA program had the ability to make improvements constantly, as quantitative evaluations were made at the end of each course and each graduating class. For example, PA students received training on "Professionalism" during the first week of orientation; opportunities to "shadow" other PAs during the first year and more opportunities to volunteer at the Essential Health Clinic (free

clinic). Those who were in the class of 2002 did not have these opportunities during their education. A lot of activity was spent correcting and making improvements based on input from the medical students, faculty and staff. This program took pride in being responsive to its stakeholders. Administrative calendars were reviewed almost weekly. Admissions processes were reviewed and preceptors and former students were coordinated as part of the admissions committee.

Different strategies were instituted following a year when the number of applicants was critically lower than expected. The concern was for the fiscal health of the program if they didn't have enough students. In order to compete with their neighboring rival, another PA program in the area, interviews were scheduled one month earlier than in previous years. Early acceptance policies were also instituted. These were sound strategic moves which proved to be successful in the recruitment of qualified applicants. With the ability to combine resources and competencies by implementing strategies for improvement, it is important to evaluate the relevance of these capabilities to the development of cultural competence of the medical students.

Evaluating Relevance to Cultural Competence

Ginter et al suggest that there are four issues to consider in evaluating the relevance of the environmental analysis to the development of cultural competence (Ginter et al., 2002). These four aspects cover determining (1) the value of the PA program by the students; (2) the rareness of the program in relationship to other PA programs; (3) how easy or difficult it is to replicate the features of the program; and (4) the sustainability of the PA program.

Value

First is the question of *value*. Do the resources, competences and capabilities represent value to the students? From the qualitative data students expressed their own pride in possessing medical knowledge, a competency that, basically, they came to the PA program to gain. Their competency level of speaking Spanish was an added feature, but was not adequate. Therefore the competency was not gained and probably

wasn't intended. It allowed most students to recognize how much more Spanish they really needed, as in the case of Rosalie from the Class of 2003...

> ... right now, [my] language definitely needs to be augmented and I'm going to a Spanish language workshop in a couple of months to help that because I have an intermediate Spanish [language level] and ..., in Spanish fluency right now. ... often times [I] bring in one of the bilingual nurses when I want to reinforce what I've said, to make sure they [the patient] understood .... And ...continue ... letting them know that I'm open to being corrected ...

The resources gained from experiences, exposure and encounters with the real world gave students some cultural capabilities. Some graduates have used these community experiences to coordinate similar events in other states. Many of the graduates recognize the need for more understanding, more knowledge and more exposure to diverse cultures and diverse providers. Even though the real value seems to have been determined after graduation, determining value before coming to the PA program had to do with location (beautiful Pacific Northwest, close to family and friends), the diversity development focus, the international rotations, and the attitude and pride of the faculty and staff.

There are other factors that can be counted as value for PA medical students, it is in a smaller school setting, the faculty and staff are accessible and personable, and the program is more like a family. These are intangible factors that do not show up in graphs or paper, mission, or the website. When students are struggling or ill or have family issues more care seems to be taken in an understanding fashion.

Some students have been directly recruited through a PA Applicant Support Program developed by the Diversity Coordinator to provide extra attention to strengthening the skills of potential PA students. This program comes from a commitment to increase the number of PAs working and living in Oregon. The sense is that if PAs originate in Oregon they will be more likely to remain in Oregon or the Washington area after graduation. This also builds a base of mentors for future PA students in the program and for preceptors and alumni activities. The value of this program is that as a result of candidates' participation, they develop stronger and more

competitive skills for admissions and ultimately are admitted. Very few PA programs possess this type of program. This applicant support program is a rarity in large graduate programs that offer the Masters of Science degree.

Rareness

The second determinant of relevance is *rareness*. Is this PA program the only one that possesses the resources, competency or capability or do other competitors possess them?

This PA program seems to be the only program with a Diversity Coordinator and a diversity development program. This was voiced at a National APAP conference when the program directors and coordinators were entertaining issues and concerns for the future. This PA program also has a comprehensive international rotation program that is a model for other PA programs. Guidelines for International Rotations for Physician Assistant Students were developed with the help of experts, among whom the Program Director of this program was prominent (Pedersen et al., 2003). Few programs have the arsenal of international rotations that this one can boast about.

A few PA programs have s Spanish language or cultural component to their curriculum. Several programs have included cultural health care issues into curriculum modules. But there is no standardization. Very few programs participate and provide the experiences, exposure of the community that this one does. Many urban PA programs have the diversity within their local area, but many times don't have a strong mix of rural, diverse, and white underserved populations.

Ability to be "Imitated"

The third feature of relevance questions how difficult it is to duplicate the resources, competencies or capabilities. The medical competencies and domestic rotations with diverse patients can be duplicated and are in other PA programs across

the country. The Spanish language classes are a result of access to competent resources in Spanish speaking faculty in the greater university. This too can be duplicated, but duplication would also require a significant involvement with the focus of the mission, commitment, and understanding of external health care needs. Outreach and community activities which give PA students exposure to diverse populations would seem to be a facet that can be duplicated. When Isaiah graduated he was influential in getting two other PA programs in Connecticut, to begin having similar activities for PA day.

> I feel good... Actually, I gave a lecture to the PA students at [two programs here] and both those programs have started a PA Day as part of their... community, and now they're doing that in a big mall in Connecticut. Both the programs get together and the students go there and that's widely attended. Last year was a really good successful year...

The pipeline of awareness to the PA profession through the use of Kids Into Health Care concepts can also be duplicated. This is a program that was originally started by the Bureau of Health Professions (BHPr) in 2000 as a way to meet health resource needs in the future. The key issue in duplicating this activity as a resource would be not only to have the competency, but the capability. Being able to adequately deploy necessary resources would depend on funding, and commitment as well (Pedersen et al., 2003).

The international rotations can probably be duplicated if funding is obtained, and fiscal resources, along with the guidelines recommended by the APAP, are followed. But being capable of deploying the competencies and resources would require that both the funding (a resource) and the human resources were available. Having a person on staff with the diplomacy and the ability to arrange for English-speaking contacts, along with making the appropriate connections with other countries requires considerable financial capital and commitment from the university as a whole, as well as APAP support (Pedersen et al., 2003). Subcommittees and organizations within the PA profession are strategically focused on assisting programs to duplicate international rotations.

> ... there are a number of AAPA committees, councils, and caucuses interested in global health. One of these groups is Physician Assistants for Global Health

(PAGH), whose mission is to cultivate the "cross-cultural awareness and delivery of PA services to domestic and international health professional shortage areas" (p.230).

Sustainability

Ginter and colleagues suggest asking the question "can the resource, competency or capability be maintained over a period of time?" (Ginter et al., 2002) This is a key question as health care organizations and medical programs must be able to maintain a competitive advantage and remain in business. With the close of the second HRSA grant and limited funding, this PA program has gone through many changes in the last class year. These changes directly impact some of the very factors that influence value, rareness, and ability to be imitated.

Last year there was a change in program directors, which could mean a change in commitment to some of the efforts already started. A change in management style and competencies can have an effect on the capabilities of the program. The program director was the key person to orchestrate the international rotations and had hired all personnel/faculty. The PA program became a part of the College of Health Professions, which as a strategic move, solidified the fiscal strength of the PA program. In a time when small programs can become vulnerable in a volatile health care market of competition with programs, this was a good move.

Will the focus for cultural competence and diversity be understood and sustained? This remains to be seen. The concluding of the current HRSA grant funding and the unknown possibility of a new grant award will affect the resources and competencies maintained with the diversity coordinator position. In order to continue the current activities, it has been proposed to write these responsibilities of the diversity coordinator into the faculty position descriptions. An adjunct faculty member with a diverse ethnic background from the School of Education has been teaching the diversity curriculum for the past two years. This move demonstrates the program's capability to continue the diversity curriculum with another resource of

diverse ethnic background. But this change was also made under the last administration.

Clinical rotations that provide PA medical students with experiences and exposure to diverse and underserved patients are sustainable and a core value. As additional support has been hired with a part-time clinical coordinator, this faculty team will continue to be instrumental in gaining more clinical sites with underserved populations.

When a program has integrated cultural competence facets throughout the curriculum, mission, goals, and values it is had to remove these. The individuals may be removed but the work that they have done and developed would be hard to dismantle without disrupting the entire program.

Integrating diversity development included developing the following areas into the PA program over a six year period: (1) a change of mission and values to reflect a commitment to diverse cultures in underserved areas, (2) a PA applicant support program which focuses on developing the strengths of URM and rural candidates from Oregon and Washington; (3) incorporating questions regarding the candidates ability to synthesize cultural competence and diversity in the admissions process, in both the application and the interview process; (4) the awarding of the Community Service Scholarship to first year students who have demonstrated a commitment to diversity and plan to work with diverse underserved communities after graduation; (5) the diversity curriculum; (6) diversity brown bag sessions; (7) guest lecturers who are from diverse backgrounds; (8) outreach to PAs of color from the Oregon and Washington (Vancouver, WA) area, those of African American, Native American, Asian and Hispanic descent; (9) partnerships with diverse communities (African "American Health Coalition, the Essential Health Clinic, Washington County, the State of Oregon, Virginia Garcia Memorial Clinic, the Oregon Society for Physician Assistants, Oregon Health Careers Center, Area Health Education Center); (10)

clinical rotations in areas with patients who are among underserved and diverse population; and (11) international clinical rotations.

Since the previously mentioned items are integrated well into the PA program, failure to sustain them may not be noticeable at first but they would soon leave gaps in the program. An added safe-guard that supports sustainability is the successes of this program which have been documented, presented nationally, given recognition and awards by community partners in county government and non-profit agencies. Maintaining leadership that has the capabilities to deploy the necessary resources to give this PA program its competitive edge will be crucial in sustaining its ranking among other PA programs around the country and in the Pacific Northwest. Gaps in the program can seriously undermine the development of culturally competent providers and therefore, jeopardize the meeting of health care needs for underserved populations. The next chapter is a further discussion of the implications of the findings and the analysis of this research involving the cultural competence self assessment of PA medical students.

CHAPTER VII
REFLECTIONS AND DISCUSSION

Reflections

Using qualitative methods, this research was designed to gather data from Physician Assistant medical students and graduates from a Physician Assistant Studies Program in Forest Grove, Oregon in order to answer the questions about how medical students self assess their own cultural competence. This is a predominantly white institution and medical program that set out to prepare health care providers to meet the needs of culturally diverse communities. For six years this medical program implemented strategies for accomplishing this end. A key aspect of measuring outcomes was the use of a Cultural Competence Self Assessment questionnaire (CCSAQ) as part of the diversity curriculum. The results of that quantitative instrument showed that there was a change in the self assessment scores for medical students from orientation to graduation. The examination of this change in three graduating classes (i.e. Class of 2002, 2003, and 2004) ultimately became the impetus for this research.

As the researcher in the field I had the opportunity to work with the medical program's faculty, staff and students during this six year period, learning from the program and developing an understanding of the impact of environmental factors in the development of cultural competence. Reflections of this project extend from 1999 to 2005, observing key turning points for the institution and the medical students. Graduation was such a turning point for each class--it was a time for awards, for recognition of accomplishments, and also a time for re-evaluation of what went well and what did not go so well.

By the time I began, the diversity development project had become an area of pride for the faculty, staff and students. One main goal at this time was to integrate diversity into the PA program--and not to have it as an "add-on." My experience in this area of diversity development in institutions, which have not done this

traditionally, leads me to watch out for the "danger areas." The danger of an add-on program is that if there is ever a money crunch or change of focus, diversity efforts are the first things to be eliminated or considered to be expendable. When there is a commitment to diversity development, sustainability is one approach that must be considered at the beginning. Sustainability is only successful when management decisions are made based on an understanding of the transformation that must take place in the system, i.e. the whole PA program, people and systems have to adapt.

Adaptive management is "the ability to make decisions based on willingness, understanding and capacity or ability to learn from social environments that result in sustainability of actions to meet the external and internal needs of an organization" (Gunderson & Holling, 2002).

> When an organization is willing to take appropriate action, in this case, diversity development, and has the ability or capacity to change (usually financial and human resources) as well as develops an understanding of the political climate, and the needs of the community, both externally and internally to the organization, then appropriate actions can be implemented (Stohs, 2002).

For the past six years this organization has been successful in adapting to meet the needs of the health care environment through creative efforts and hard work.

Collection of Data

The collection of data represented an evaluation, at a micro-level perspective, of the results of interrelated activities in developing diversity, and inspecting cultural competence in the medical students. When the focus groups were set up, from my position as the diversity coordinator among the faculty and student populations, I was monitoring the attitudes of the class of 2004 as well as the results of previous CCSAQ data. I sensed that there was a difference in the attitudes of this class as opposed to others. One part of my thinking was that I really could not tell what was happening with the class of 2004, since I was not teaching their class. I sensed negativism from course evaluations and discussions with the program director and the new adjunct faculty that had been brought in to teach the class. Because of the negative climate I decided to take an objective approach and have outside facilitators conduct the focus

groups. The information that was given would not have been provided by the students if I or any faculty had been present.

Focus Group Discussions

The facilitators observed and validated the negative attitudes of this class. They also made the observation that the medical students had a very low level of cultural competence, as indicated by their responses to questions and their attempts at defining the concept. The facilitators also picked up that something had happened. Names of individuals had been identified by the participants during the discussions. Only when reviewing the transcripts was I able to identify a name mentioned that I was not familiar with. In reviewing all three transcripts from the focus group discussions (FGD) there was a common thread about the same incident or situation that caused the medical students to take on a negative attitude, more than usually registered in the previous classes.

After further investigation through follow up interviews, I was able to identify the name and situation that impacted this class so strongly. According to one of the students, a guest lecturer, during an off campus session, made a presentation to the class and introduced current events addressing media stereotypes and social ills affecting culture in the community. Students were also harshly reminded of their limited diversity, presuming that they were mostly white [students]. This lecturer was Caucasian and held a high position within the community. The students did not feel comfortable enough to dispute the information or enter into a dialogue with the individual. But conversations of a sensitive nature proceeded in the vans after the class concluded, as students returned to program facilities. There was not an outlet for addressing the issues of hegemony and triggered biases. The insensitivity of the lecturer and the lack of debriefing added to the negative feelings, so that every time diversity was mentioned, it was a "sore spot."

I recognize that diversity and dealing with cultural competence is a sensitive subject. The incident alluded to was not the only factor that explained the negative attitudes. But the hurt and disappointment that I felt took me a while to get over. I felt that there would always be areas that you cannot control, but this is a place where it is

important to take steps to safeguard the processes, protect the people and be open and willing to make corrections. I felt helpless to make corrections. The process of correction had been a focus of the program, but now it seemed like we had an issue that could not be addressed in a timely manner. I wondered if the students would get past this situation. Looking back over events that took place that year, I could see that there was a possibility that that would not happen soon. In view of this incident, one observation participants made during the focus groups was that they were glad that the focus groups had taken place and wished that they had taken place earlier. A request was made by participants, expressing a desire to see the report from the research, with the hope that their recommendations would make a change.

In-depth Interviews

In-depth interviews with individual members of the classes of 2004, 2002, and 2003 did not yield the sense of negativism that the collected groups expressed in the focus group discussions. The participant who graduated in 2004 was honest about their own shortcomings in developing cultural competence. They echoed that they thought they knew more and did not want to be perceived that they didn't know. Observing their CCSAQ scores showed that they actually declined over the two plus years.

Those who participated from the class of 2003 also gave their honest perspectives about their own shortcomings and how the program helped them to see that. They admitted that they were still learning, even though their CCSAQ scores showed that they had increased in their level of cultural competence self-assessment. Of the three graduating classes, the class of 2003 was the only one where the scores went up. This shows the inconclusiveness of the quantitative measurement. But as a tool it demonstrated that involvement and exposure makes a difference with medical students.

Graduates who participated from the class of 2002 demonstrated being farther along on the cultural competence continuum scale than those of 2003 and 2004. These individuals expressed that they really didn't know what they initially thought they knew, and were not knowledgeable in areas on the CCSAQ. They further indicated

that the more exposure and experiences they had, the more they found out that they didn't know. It was also interesting to note that their definitions for cultural competence had more to do with the practice and the asking of questions before starting to treat patients, than with general thoughts of what cultural competence means in theory. Participants from the class of 2004 were more likely also to get involved with teaching others, either at other PA programs or teaching other medical practitioners. These reflections along with the results of the analyses lead me to the conclusions of this research.

Discussion

This study examined the cultural competence self-assessment of Physician Assistant medical students. In doing so, students' perceptions of the definition of this concept were also examined as an indicator of cultural abilities the medical students had attained. The students' definitions revealed some common areas along Cross's continuum of cultural competence (cultural blindness, for example). A common theme was also found in their change in assessment, noting that PA medical students had initially thought they knew more about other cultures at the beginning of the PA program. While this change was attributed to their cultural exposure prior to entering the PA program and during the didactic training it was mostly influenced by their experiences and encounters with the real world during their clinical rotations. This would suggest that the students self assessment was based more on activities that they performed (i.e. behavior) and not on passive learning (i.e. cognitive learning) as Campinha-Bacote (1999) suggests. This assessment was consistent with all participants, which would say that the didactic, diversity training alone was not the reason for the change between their pre and post cultural competence self assessment.

When participants' definitions were examined, findings showed that the students had a low level of understanding of cultural competency and therefore, their cultural abilities were limited as well. These limitations negatively affected their valuing the patients as a part of their learning process. Even though an environmental analysis indicated that the program had definite strategies to address external health care concerns, the internal capabilities of the students did not move as far toward

developing cultural competence as one would expect. Notably, there was a difference in how graduates, now working as PAs (in contrast to graduating students, not yet practicing), valued what they could learn from their patients and the program. Encountering what they were not taught and what they didn't learn brought them to accept some realities now that they were in the medical practice.

Participants' assessment and claim was that as PAs, they had to apply the learning, and gained more knowledge from their patients and the environment, preceptors (clinical rotations) and in class instruction. It's one thing to be exposed for a day or so, or have a week long experience testing out your language skills, but to be immersed in the culture for four weeks to three months is an encounter with a different life style, belief system, economics, barriers, challenges, and appreciations of the people that you serve.

To encounter poor whites in rural settings, who had limited health care, challenged the expectations of the PA medical students on clinical rotations. Encountering global cultures, that prior experience only included reading of or visiting exotic, cultural places. But now, this would-be health care professional live among them [the underserved, drug seeking, low income and uninsured]. This brought about a change in the self awareness and knowledge of the PA medical student.

International rotations served to not only provide access to care for global communities and underserved populations. Many had to change their approach and ask questions. Some questions were not answered the way the students expected. Some preceptors did not respond the way students expected. The *familiar* environment of home, friends, and cohorts were not always a phone call away. Sometimes communication was by email. To some, this encounter was described as "isolation." This kind of encounter could not have been reproduced in the pure classroom setting.

The environmental analysis was necessary to validate the context of the program and the experiences and exposure of the students to the real world. Even though students and graduates identified some cultures that they were not exposed to (e.g. African American patients), they saw this as a weakness of the program's

capabilities. But all of the participants who were able to go on international rotations expressed that this experience was a strength of the program, even though there were challenges to them personally.

One of the challenges expressed by informants was that the medical environment was controlled, primarily, by faculty, adjunct faculty, preceptors and staff. All students went to the same classes, had to study with groups and were required to do 12 months of clinical rotations. International clinical rotations were determined by clinical faculty and the medical student's ability to pay to go to Honduras, Ecuador, China, or Bahamas.

From one standpoint, students whom faculty felt would be appropriate were selected for that particular rotation. Students had some control in that if they did not want to go on an international rotation and could not afford it, they would not be sent. But from the perspective of local and domestic clinical rotations, students did not really get to choose--hence the "forced choice" method of selection for clinical rotations. Moreover, when the arrangements were made and their assignments given, they were to report to a particular preceptor, and they were to work the schedule as dictated by the preceptor for that particular rotation. Being evaluated for their work in the real world, and confronting health care issues in the medical environment contributed to the change in their self assessment.

As a result of scanning the environment to see what clues there are for what PA students should be able to do, several things were observed. First, the environmental analysis showed demographic changes in then populations were evident along with the need for health care resources. Participants actually witnessed and admitted to the need for diverse preceptors and providers to meet the needs of underserved and minority patients. Even language differences in diverse Hispanic populations showed participants that their skills need to be augmented, hence their own assessment of what they could do was impacted by how much they did or didn't know. Second, participants' admission that they did not have the best understanding of Medicaid and Medicare payment situations (third-party payers) impacted their self assessment of what they could do.

Third, participants were mindful of their own desires in medical education as it relates to repayment the cost of loans. Some participants indicated that while they would like to go on the international rotations the cost was prohibited. This of course impacted their opportunities to have an encounter with the real world global communities. It can also be concluded that issues relating to intercalation medicine such as, access, and health determinant, underserved populations and language did influence their self assessment. The extreme me social conditions that patients were experiences themselves impacted the students perception of themselves. Participants commented on issues of the underserved, diversity, language, the poor conditions of than how these factors influenced their self assessment.

Just as the external environment influenced the self assessment of the participants, so did the internal environment. Those things which students can do included their medical competencies and their use of resour4ces of the PA programs well as being capable of deploying their own resources through planning and involvement with diverse communities.

This measurement revealed other gaps in the process of moving from theory to practice, one of which is the "hidden curriculum" of medicine (Wachtler & Troein, 2003). In Lempp and Seale use the term hidden curriculum in their medical education article to denote the set of influences that function at the level of organizational structure and culture including, for example, implicit rules to survive the institution, such as customs, rituals, and taken for granted aspects (Lempp & Seale, 2004). This describes the attitude of some preceptors as indicated by participants, when preceptors gave the rule that being concerned about cultural issues was not necessary if the medical students learned to be a good PA. This counter principle impacts the medical environment of students.

When cultural skills are necessary, but the preceptors are not culturally competent or opposed to spending time in this area, this gap can be a hindrance to the students' development of cultural competence. This example was given by several participants who revealed a hidden component of their clinical training which influenced their development and understanding of cultural competence. In this case

the attitude of the preceptor may have been hidden to the program but it was apparent to the student.

Most hidden influences that result in gaps are more subtle. For instance, it is also important to understand that there is a perception that medical students are taught to "*fix* people." As one student indicated, this means that something is wrong with the patient. This attitude would be contrary to seeking information and learning from the very person you are trained to *fix* or treat, and therefore, contributes to another gap between theory and practice.

Evidence suggests that the environment, experiences and encounter with the real world must be included to fill the gap. The gap must continue to be bridged with students practicing in international and domestic locations and diverse settings, with rural and underserved populations. Language is not the only factor with which to prepare students, but it certainly helps. Alternatives opportunities, including some exposure to Arabic or Mandarin languages could be offered or encouraged through partnerships or electives. Even though the Hispanic population is the fastest growing population in the country, other Muslim, African and Asian cultures are also growing in this country and must be treated as well. At the same time, changes in domestic health care must be considered and Physician Assistant practices developed accordingly.

As populations live longer, it will be incumbent upon PA students to be able to diagnose and treat aging patients who are from all social and economic backgrounds. Overlooking diversity in aging forms more gaps in the transformation. Gaps in the process imply that protocols are necessary for integrating cultural training in the medical education process to achieve praxis of cultural competence. The next chapter gives the conclusion and recommendations based on this research.

CHAPTER VIII

CONCLUSION AND RECOMMENDATIONS

Conclusion

The main objective for this research study was to discover why PA medical students self assess their cultural competence lower at graduation than when they entered the PA program. My suspicions were that the medical students thought that they knew more about diversity than they really did. While this was only an opinion prior to the beginning of this investigation, analysis of the data from focus group discussions and in-depth interviews and follow up conversations revealed more specific answers to this question. PA medical students really did think that they had more knowledge about different cultures, specifically Hispanic and African American cultures and some Asian cultures. This explanation was consistent with responses from all participants from the class of 2004, 2003, and 2002.

There were three secondary objectives. The first was to discover what factors influenced their cultural competence self assessment. I was able to conclude from the analysis of the focus group transcripts and in-depth interviews that there were three key components that influenced the students self assessment. These three components of their medical education included exposure, experiences, and their encounters with the real world. All three components contributed to the participants' self-awareness that "they didn't know."

Since all students shared the same didactic exposures to diverse community involvement, activities, and planning, it would make sense that the exposure to diverse cultures created a new awareness for all of the students, regardless of graduating year or prior experience. Exposure to diverse cultures was well integrated into program activities and values as indicated by the internal environmental assessment. It seems reasonable to recognize that consistency in inter-cultural exposure contributed to their self assessment. As Locke suggests, "obtaining competence in cross-cultural

relationships is best described as a life-long, ongoing process rather than a product of a knowledge or previous experience" (Locke, 2003).

Following the didactic year, PA medical students experienced diverse cultures and underserved populations in clinical settings, which also contributed to the PA medical students self assessment. These experiences involved the PA students with underserved populations in rural and international settings. In comparison to activities during the didactic year or prior to entering the PA program, these experiences had more impact. PA Medical students were involved directly with the lifestyle and habits of families. Some medical students discovered the shallowness or depth of their language skills, requiring more training and assistance. It can also be concluded, that prior cultural awareness or knowledge gave a false sense of understanding of the people and cultures that they were treating. Instead of the students leaving the environment and go back to their own homes, which were comfortable and without signs of poverty and underserved, they had to remain in the real world.

This immersion and encounter with the real world was the third factor that impacted the students' self-assessment. If the exposure to diverse cultures, different languages, and experiences in medical settings with underserved and diverse populations had not made a change before, now the immersion in the real world made an imprint on their PA medical education. It can be concluded from the participant's dialogue, comments in focus group discussions and interviews that the international clinical rotations provided a learning and encounter with the real world. This change in environment, even from urban to rural or domestic to global, affluent to the underprivileged had an impact on their self assessment. While each encounter was different, all of the encounters served to make a difference in the self awareness and ultimately their cultural competence self-assessment.

The final objective of this research was to determine if the change in self assessment was indicative of cultural competence. While it can be concluded that change in self assessment had actually occurred, for the above reasons, it can also be concluded that change in the quantitative results really portrayed a level of development on a cultural competency continuum, but not cultural competence itself.

It seems that participants from the classes of 2002 and 2003, who have already graduated and are practicing, have a better understanding of the definitions of cultural competence that relate both to Kula's and Cross' definitions than those who had not yet graduated and were not yet in the field of practice (Class of 2004). It may be that at the time participants from the class of 2004 were interviewed that they were still operating from a theoretical perspective of cultural competence with their own definitions.

There exists a theoretical meaning of cultural competence (using various definitions). However, there is a need to move from the theoretical to an operational definition, namely delivering culturally competent care. It is clear that there is a gap between the theory and action or practice of cultural competence. The translation of an idea or theory into practice or action is *praxis*. The gap between theory and practice seems to close when the following events occur. First there must be an accepted operational definition of cultural competence that is associated with medical practice, and not just knowledge, understanding and awareness.

Next there must be an identification of external clues in order to show what health care providers or medical students should be doing. It is also important to take inventory of the internal assets of the medical program in order to create value and demonstrate the ability to deploy medical and cultural resources and competencies. Deploying these resources and competencies must include providing cross-cultural exposure, experiences and real world encounters that bring the medical student to a self awareness. This honest assessment of one's self leads to the recognition by the medical student that he/she "doesn't know."

My findings show that the Cultural Competence Self Assessment (CCSAQ) was not a true indicator of cultural abilities to practice medicine or the desire for continuous learning, but did in fact provide indicators of exposure, experiences and encounters that influenced a change. Scores being higher or lower than the initial administration of the CCSAQ instrument is not indicative of practice. Even if medical students come into a medical program with a certain level of cultural knowledge, the

true test comes when they put that knowledge – together with their attitudes and skills – to work, as they are exposed to diverse underserved populations.

Recommendations

In the praxis model, protocols can be established to help bridge the gap between the theory and practice of cultural competence. These protocols and recommendations happen in an environment. So, first, medical education programs must consider the external and internal environments in order to understand and focus on what the students should be doing, as well as what they can do. The internal organization of the PA program should then be organized to deploy the abilities and competencies of the program and its students in order to meet the demands of the diverse health care patient population. This includes understanding and being prepared to diagnose and treat illnesses according to health determinants. What might this look like?

Protocols for Action

1. The PA program must first integrate an operational definition of cultural competence into curriculum objectives, activities, and clinical skills. It is important that students be encouraged to take an interest in developing cultural competence and recognize their need to learn from other cultures.

2. There must be monitoring of the medical student's ongoing development along the cultural competency continuum. Focus groups and small interactive group sessions can be used in this manner.

3. Develop cultural knowledge alongside medical knowledge as it relates to health disparities, health determinants and appropriate interventions and treatments will foster competences necessary for practicing in a culturally competent manner.

4. The PA program, faculty, medical students and preceptors need to continuously analyze the external environment for changes in health care through scanning, monitoring, forecasting and assessing issues, trends and values relating to the health care needs of diverse domestic and global communities. These clues should be gathered in order to identify what they should be teaching, learning and practicing. (This can be part of a research component.)

5. The medical program must gain internal assets by developing cultural resources (relationships, partnerships, and collaborations) and abilities commensurate with the external health care needs. They also need to take opportunities to practice using their medical and cultural skills to serve the community.

6. Students must also be exposed to and experience cultural and ethnic diversity through their cohorts as well as being under the teaching of diverse faculty and preceptors, while the program develops relationships that foster learning from diverse community members and underserved populations.

7. Medical curriculum must include exposure and role plays with diverse cultures, the implications of the uninsured, illnesses or health care issues, including social behaviors and issues affecting socio-economic status.

8. Students and faculty need to encounter the challenges and experiences of the real world of health care in urban settings, where many diverse cultures live, rural settings where underserved communities, including aged and Caucasian populations reside, as well as many immigrant populations.

9. A critical protocol for developing self awareness involves self examination and reflecting on one's own limitations and biases in the context of immersion in another culture, therefore PA medical students should be encouraged and supported in cultural immersions internationally and locally.

10. Resolve the conflict of time, between medical requirements and cultural requirements in the curriculum by incorporating culture components into case studies, pharmacology, psycho-social courses, and problem based learning and evidence based medicine curriculum.

This disparity between theory and practice narrows when a physician assistant medical program integrates the external environmental clues into their medical training while demonstrating student and program capabilities to deploy medical and cultural resources and competencies. Monitoring the progress through qualitative and quantitative means along with identifying and resolving internal weaknesses will help to address deficiencies in the process. However, failure to address hidden curricula issues will undermine the process and widen the gaps that currently exist. Considering these factors, following these recommendations can move an organization from theory to practice by developing protocols for action. From the results of this study we can see evidence of closing the gap between the theory of cultural competence and culturally competence practices.

BIBLIOGRAPHY

AAMC American Academy of Medical Colleges (2004). *Medical Applicant data from "FACTS - Applicants, Accepted Applicants and Matriculants by Sex; 1993-2004*. Retrieved March 24, 2005, 2005, from http://www.aamc.org/data/facts/2004/2004summary.htm

AAPA American Academy of Physician Assistants (1998-2005). *Information About PAs and the PA Profession*. Retrieved April 10, 2005, from http://www.aapa.org/geninfo1.html

AAPA American Academy of Physician Assistants (2003). *Reduced Resident Hours Call for Creative Solutions*. Retrieved March 25, 2005, from www.aapa.org/gandp/housestaff.pdf

AMA, American Medical Association (1999). *Cultural Competence Compendium.*

AMA, American Medical Association (2004). *2004 Health Care Trends An Environmental Analysis Report:* . Chicago, IL: American Medical Association.

AMA, American Medical Association (2004). *2004 Health Care Trends An Environmental Analysis Report:* . Chicago, IL: American Medical Association.

AMA, American Medical Association. (1994). Culturally Competent Health Care for Adolescents.

American Psychological Association. (2002). *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*, 2005, from http://www.apa.org/pi/multiculturalguidelines/definitions.html

Association of Physician Assistant Programs (2005). *A Report of the Association of Physician Assistant PA Programs National Recruitment Strategies Task Force*. Alexandria, Virginia.

Babbie, E. (2004). *The Practice of Social Research* (10th ed.). Belmont, CA: Wadsworth Div of Thomson Learning, Inc.

Barrows, H. S. (2000). *Excerpt from Problem-Based Learning Applied to Medical Education*, from http://www.pbli.org/resources/ProblemBased.htm

Betancourt, J. (2003). Cross-cultural medical education: conceptual approaches and frameworks for evaluation., *78*(6), 560-569.

Betancourt, J., Green, A. R., Carrillo, J. E., & Owusu Ananeh-Firempong, I. (2003). Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. *Public Health Reports, 118.*

Brown, P. J. (1998). *Understanding and Applying Medical Anthropology*. Mountain View, CA: Mayfield Publishing Co.

Campinha-Bacote, J. (1999). A Model and Instrument for Addressing Cultural Compentence in Health Care. *Journal of Nursing Education, 38*(5), 203-207.

Cohen, E., & Goode, T. D. (1999, 2003). *Policy Brief 1: Rationale for Cultural Competence in Primary Care*. Retrieved April 13`, 2005, from http://gucchd.georgetown.edu/nccc/documents/Policy_Brief_1_2003.pdf

Colby, R. (2005, May 5, 2005). *Oregonian.*

Cross, T., Bazron, B., Dennis, K., &, & Isaacs. (1989). *Towards A Culturally Competent System of Care Volume 1*. Washington, DC: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Denzin, N. K., & Lincoln, Y. S. (1998). *Strategies of Qualitative Inquiry*. Thousand Oaks, CA: SAGE Publications.

Gilbert, M. J., & Puebla-Fortier, J. (Eds.). (2003). *Principles and Recommended Standards for Cultural Competence Education of Health Care Professionals*: California Endowment - A Partner for Healthier Communities.

Ginter, P. M., Swayne, L. E., & Duncan`, W. J. (2002). *Strategic Management of Health Care Organizations* (4th ed.). Malden MA: Blackwell.

Goode, T. (2001, Fall/Winter 2001). The Role of Self-Assessment in Achieving Cultural Competence. *The Cultural Competence Exchange,* 4.

Green, A., Betancourt, J., & Carrillo, J. (2002). Integrating social factors into cross-cultural medical education. *Academic Medicine, 77*(3), 193-197.

Gregg, A., & Dehn, R. (1999). An Analysis of Clinical Evaluation Methods in Physician Assistant Education. *Perspective on Physician Assistant Education, 10*(4), 185-193.

Gunderson, L. H., & Holling, C. S. (2002). *Panarchy*. Connecticut: Island Press.

Health. (2003). *Health and Health Care 2010: The Forecast, the Challenge* (2nd ed.). Princeton, NJ: Jossey-Bass.

Health United States. (2003). *Chartbook on Trends in the Health of Americans.* (Statistical Report). Hyattsville, Maryland.

HRSA Health Resources and Services Administration. (2001). *Cultural Competence Works*: US Department of Health and Human Services.

HRSA Health Resources and Services Administration (2005). *Health Careers Opportunity Program Definition*. Retrieved Mar 20, 2005, from http://bhpr.hrsa.gov/diversity/definitions.htm#Cultural%20Competence

Hrynkow, S. (2004). Lawmakers Focus on Global Mental Health. *Neuroscience Quarterly, 2005*(April 2, 2005).

Kagawa-Singer, M., & Kassim-Lakha, S. (2003). A Strategy to Reduce Cross-cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes. *Academy of Medicine, 78*, 577-587.

Kalet, A., Pugnaire, M. P., Cole-Kelly, K., Janicik, R., Ferrara, E., Schwartz, M. D., et al. (2004). Teaching Communication in Clinical Clerkships: Models from the Macy Initiative in Health Communications. *Acad Med, 79*(6), 511-520.

Khanna, S. (2001). *Options for Universal Health Coverage in Oregon: A Focus Group Study* (Phase II Final Report). Corvallis: Oregon State University.

Kula, N. (2002). *Final Report: A Diversity Strategy for the Central East (Whitby) Mental Health System* (Final). Simcoe York, Ontario Canada: Central East Mental Health Implementation Task Force.

Latiff-Bolet, P., Ligia. (2003). *Cultural Competence Plan 2003-2005*. Retrieved June 8 2003, from http://www.state.sc.sc.us/dmh/cultural_competence/cultural_plan.htm

Lazarus, E. (1990). Falling through the cracks: contradictions and barreirs to care in prenatal clinic. *Medical Anthroplogy, 12*(3), 269-287.

Legler, C. F., & Stohs, S. M. (2003). Integrating Diversity into a Physician Assistant Program. *Perspective on Physician Assistant Education, 14*(1), 31-36.

Lempp, H., & Seale, C. (2004). The hidden curriculum in undergraduate medical education: qualitative study of medical students' perceptions of teaching. *BMJ*(329), 770-773.

Lewin Group, Linkins, I. T., MacIntosh, K., Bell,W. S. J. & Chong, U. (2002). *Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile*, from www.hrsa.gov/omh/cultural/1.htm

Locke, D. C. (1992). *Increasing Multicultural Understanding: A Comprehensive Model* (Vol. 1). Newbury Park, CA: Sage Publications, Inc.

Locke, D. C. (2003). Improving the Multicultural Competence of Educators. In P. B. Pedersen & J. C. Carey (Eds.), *Multicultural Counseling in Schools* (pp. 171-189). Boston, MA: Allyn and Bacon.

Marquez, J. (2003). Diversity Education in Physician Assistant Programs. *PERSPECTIVE ON PHYSICIAN ASSISTANT EDUCATION,, 14*(2), 116-117.

McNees, M. A. (2001). *Culture, Communication and Health Care: The Development of Cultural Competence in Primary Health Care.* Unpublished PhD Dissertation, New School University, Brooklyn, NY.

Ochoa, K., Evans, M. A., & Kaiser, S. A. (2003). *Negotiating Care: The teaching and Practice of Cultural Competence in Medical School. A Student Perspective.* Retrieved Dec 2004, from http://wwww.med-ed-online.org

OHD Oregon Health Division. (2001). Happy and Health-wise: Measuring Health Related Quality of Life. *CD Summary, 50*(17).

OMB Office of Minority Health. (2002). *Conceptualizing Cultural Competence and Identifying Critical Domains*, from http://www.hrsa.gov/omh/cultural/sectionii.htm

OMH, Office of Minority Health (2003). *Section II Conceptualizing Cultural and Identifying Critical Domains*, from http://www.hrsa.gov/omh/cultural/img/section2.gif

Orlandi, M. (1992). *Cultural Competence for Evaluators: A Guide for Alcohol and Other Drug Abuse Prevention Practitioners Working With Ethnic/Racial Communities.*

Pacific PA Program. (2003). *Cultural and Community Partnership Highlights 2002-2003*. Retrieved Mar 28, 2005, from http://www.pacificu.edu/pa/diversity/2003.cfm

Pacific University School of Physician Assistant Studies. (2004). The Curriculum. Forest Grove: Pacific University.

Pedersen, K. J., Hooker, R. S., Legler, C. F., Kortyna, D. E., Harbert, K. R., Eisenhauer, W. A., et al. (2003). A Report on the Findings of the Ad Hoc Committee on International Physician Assistant Education. *Perspective on Physician Assistant Education, 14*(4), 220-232.

Rapp, D. E. (2004). *Medical Studetn Selection: The Key to a Lasting Model of Cultural Competency*. Retrieved Dec 2004, 2004, from http://www.med-ed-online.org

Richards, L. (2002). *NVivo: Using NVivo in Qualitative Research* (3 ed.). Melbourne, Australia: Sage Publications.

Rossman, G. B., and Sharon F. Rallis. (1998). *Learning in the Field: An Introduction to Qualitative Research*. Thousand Oaks, CA: SAGE Publications, Inc.

Salmon, P. & Hall, G. (2003). Patient empowerment and control: a psychological discourse in the service of medicine. *Social Science & Medicine, 57*(10), 1969, 1912p.

Schlossberg, M., & Zimmerman, A. (2003). Developing Statewide Indices of Environmental, Economic, and Social Sustainability: a look at Oregon and the Oregon Benchmarks. *Local Environment, 8*(6), 641.

School of Physician Assistant Studies (2005). *Our Mission*. Retrieved Mar 28, 2005, from http://www.pacificu.edu/pa/

Singer, M., & Baer, H. (1995). *Critical Medical Anthropology.* Amityville, NY: Baywood Publishing Co, Inc.

Smedley, B., Stith, A., & Nelson, A. (2003). *Unequal Treatment Confronting Racial and Ethnic Disparities in Health Care*, from http://www.nap.edu/catalog/10260.html?onpi_newsdoc03202002

Stepien, W., Gallagher, S., & Workman, D. (1993). Problem-Based Learning for Traditional and Interdisciplinary Classrooms. *Journal for the Education of the Gifted, 16(d4)*, 338-357.

Stohs, S. M. (2002). *Diversity Development Project School of Physician Assistant Studies Program* (Final Report). Forest Grove, OR: Pacific University.

Suchman, A. L., Williamson, P. R., Litzelman, D. K., Frankel, R. M., Mossbarger, D. L., & Inui, T. S. (2004). Toward an Informal Curriculum that Teaches Professionalism. Transforming the Social Environment of a Medical School. *J Gen Intern Med, 19*(5p2), 501-504.

Sullivan Commission. (2004). *Missing Persons: Minorities in Health Professions.* from: www.sullivancommission.org

Suro, R. & Passel, J. (2003). *The Rise of the Second Generation: Changing Patterns in Hispanic Population Growth.* Washington, DC: Pew Hispanic Center.

Taylor, J. S. (2003). Confronting "Culture" in Medicine's "Culture of No Culture". *Acad Med, 78*(6), 555-559.

The Institute for the Future (2003). *2010 The Forecast, The Challenge* (2nd ed.). San Francisco, CA: Jossey-Bass.

Trevalon, M., MPH, Melanie. (2003). Components of Culture in Health for Medical Students' Education. *Academy of Medicine, 78*, 570-576.

US, Department of Health and Human Services (2000). *Healthy People 2010. 2nd ed. With Understanding and Improving Health and Objectives for Improving Health.* Retrieved November 2000, from http://www.health.gov/healthypeople.

Valent, F., Little, D.A., Tamburini, G., & Barbone, F. (2005). *Burden of disease attributable to selected environmental factors among Europe's children and adolescents*. Retrieved Mar 26, 2005

Wachtler, C. & Troein, M. (2003). A hidden curriculum: mapping cultural competency in a medical programme. *Med Educ, 37*(10), 861-868.

Washington County Department of Health and Human Services (2005). Everyone Everyday: A History of Protecting Your Future. Hillsboro, OR: Washington County DHHS.

Wolcott, H. F. (2001). *Writing Up Qualitative Research* (2nd ed.). Thousand Oaks, CA: SAGE.

Woloschuk, W., Harasym, P. H., & Temple, W. (2004). Attitude change during medical school: a cohort study. *Med Educ, 38*(5), 522-534.

APPENDICES

APPENDIX A

Bios of Focus Group Facilitators

Group 1 Facilitator

Andralene L. Allen, MBA, is the Program Manager of Employee Retention for Providence Health System, Oregon. Her responsibilities include developing and implementing programs that maximize retention and development of human capital. She earned her Master of Business Administration (MBA) degree in 2004 and her Bachelor of Science (BS) degree in 1994, in Business Management and Communications from Concordia University, Portland, Oregon. Andralene is a member of the Society of Human Resource Management and the American Society of Healthcare Human Resource Administration. She has over 15 years of progressive experience in Human Resources holding positions of increasing responsibility.

Group 2 Facilitator

Michele Neptune, LCSW, is currently the Manager of Providence Employee Assistance Program (EAP) -Oregon Region. She earned her Master's in Social Work degree from Portland State University and a Bachelor of Science degree in Psychology from Colorado State University. Michele joined Providence Health System Employee Assistance Program in July 1991 as a staff counselor then, moved into an account manager role in 2000. Michele is a presenter on various workplace and personal topics such as *Improving Communication on Work Teams* and *Dealing with Depression*. She has been a facilitator for Providence Health System Diversity Education classes since 1998.

Group 3 Facilitator

Hector R. Roche, MSW, is currently the Manager of Staff Development and Training for Multnomah County Health Department. He received his Master of Social Work (MSW) degree in 1982 from Jane Adams College of Social Work at the University of Illinois in Chicago and received his Bachelor of Arts (BA) degree in Sociology in 1975 also from the University of Illinois. Since the early 1990's, Hector has worked as an organizational development consultant, trainer, and coach on issues related to diversity and cultural competence; leadership; strategic planning; community collaboration. Hector has over 30 years of experience as a Social Worker, consultant, coach, and trainer. Early in his career, Hector worked as a clinical Social Worker in a variety of health care arenas including acute care, Pediatric and Adult Physical Medicine and Rehabilitation, Home Health, and Hospice. He also served as a Family Therapist for children at risk of being placed outside of the home. Hector is committed to creating a world where people live in community with each other.

APPENDIX B

List of Participants (Pseudo-Names)

Table B-1

Pseudo-name	Gender	Class	FGD No. INTRVW
Bernice	Female	2004	1
Whitney	Female	2004	1
Mohammed	Male	2004	1
Warren	Male	2004	2
Esther	Female	2004	1
Marla	Female	2004	2
Eldridge	Male	2004	1
Cassandra	Female	2004	1
Mitch	Male	2004	2
Timothy	Male	2004	3
Marla	Female	2004	1
Jacob	Male	2004	3
Bridgett	Female	2004	2
Heidi	Female	2004	2
Roxanne	Female	2004	2
Priscilla	Female	2004	3
Barbara	Female	2004	3
Hortence	Female	2004	3
Interviewees			
Roscoe	Male	2003	Interview
Carlotta	Female	2003	Interview
Marla	Female	2004	Interview
Hortence	Female	2004	Interview
Isaiah	Male	2002	Interview
Rosalie	Female	2003	Interview
Berlina	Female	2002	Interview
Barbara	Female	2004	Interview

List of Participants According to their PA Graduating Class

APPENDIX C

Profile of Participants' Graduating Class

Table C-1

CLASS	DIVERSITY*	% OF CLASS SPK SPANISH*	LIMITED /SOME SPANISH*	OTHER LANGUAGES*
2002	16% 5/32 (2Hispanic, 3 Asian/Pac.)	45%	23%	21%
2003	9% 3/32 (3 Asian/Pacific Islander)	43%	0	14%
2004	20% 7/35 (3 Hispanic; 1Filipino,1 NA, 1Asian,1Black)	65%	30%	10%

CLASS	GRADUATING CLASS SIZE	AVG AGE	GENDER %M/F	FROM MED UNDERSERVED AREA*
2002	29	27.8	47/53	12.5
2003	28	31.5	41/59	16
2004	31	28	40/60	20

CLASS	LAST 45 HRS GPA	SCI GPA	AVG MOS. EXP	% OUT OF STATE
2002	3.5	3.26	45	72
2003	3.52	3.36	53	81
2004	3.38	3.28	56	57

* SELF DECLARED

Profile Information of Participants' Graduating Class
Source: PA Program Data

APPENDIX D

Informed Consent Document

Project Title:	Developing Cultural Competence Protocols in an Educational Environment
Principal Investigator:	Sunil Khanna, Ph.D., Department of Anthropology
Research Staff:	Sheryl M. Stohs, PhD. Graduate Student, Environmental Sciences Graduate Program – Interdisciplinary Studies

PURPOSE

This is a research study. The purpose of this research is to find out how Physician Assistant students self assess their ability to serve and support individuals and families of diverse communities. Physician Assistant (PA) graduates (Class of 2002, 2003) and third year PA students (Class of 2004) of Pacific University School of Physician Assistant Studies Program are being invited to participate. The knowledge gained from focus group discussions and interviews will inform us regarding concepts, practices and applications for developing effective protocols for training culturally competent health care professionals. The results of this research study will be used to help bridge the gap between medical training and professional practice in delivering culturally appropriate health care services to diverse communities.

The purpose of this consent form is to give you the information you will need to help you decide whether to be in the study or not. Please read the form carefully. You may ask any questions about the research, what you will be asked to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear. When all of your questions have been answered, you can decide if you want to be in this study or not. This process is called "informed consent". You will be given a copy of this form for your records.

We are inviting you to participate in this research study because you are either a third year PA student or a graduate of Pacific University Physician Assistant Studies Program (Class 2002, 2003 and 2004). The researcher(s) expect that 27%-35% of the PA graduates or third year PA students will participate in his study.

PROCEDURES

The following data gathering procedures are involved in this study:

_____ **Focus Group Discussion** (1.5 hours) - a special kind of organized discussion or series of discussions, guided by a few specific questions, to gain a deeper understanding of participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. Audio recordings of the sessions will be used for transcriptions purposes only.

_____ **In-Depth Interviews** (45 minutes – 1 hour) face to face interviews, one-on-one with the researcher in a discussion guided by a few specific questions, to gain a deeper

understanding of participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. Audio recordings of the sessions will be used for transcriptions purposes only.

_____ **Email Interview open-ended questions** (45 minutes). Online discussion with the researcher, responding to a few specific questions, to gain a deeper understanding of participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. Responses submitted by participant will be maintained by the principal investigator and the student researcher and kept in a password protected file.

_____ **Telephone Interviews** (45 minutes – 1 hour) Telephone interviews, one-on-one with the researcher in a discussion guided by a few specific questions, to gain a deeper understanding of participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. Audio recordings of the sessions will be used for transcription purposes only.

If you agree to participate in the study, check the method above that you wish to be involved in.

- Timeframes (i.e., starting and ending) will be strictly honored.
- Copy of the Informed Consent to Act as a Research Participant will be provided to all participants.
- Guidelines will be given prior to the start of the session.
- Debriefing will follow sessions to clarify findings and summarize.
- Follow up will be done with interviewees to validate responses.
- No names will be used in report of findings.
- Audio Recordings of the session will only be used for the purpose of transcription of comments.
- Audio recordings will be erased or destroyed at the completion of this study.
- Transcriptions will be done by the student researcher or a paid transcriptionist for this study.
- Transcriptions and other written documents will be maintained in password protected files only by the principal investigator and the student researcher.

RISKS

There are no foreseeable risks for participants in this research study. Some of the questions may be embarrassing, especially if members of the focus group do not share similar beliefs.

BENEFITS

There may be potential personal benefits to you, a health professional, as a result of participating in this study. These may include having a collective understanding of other PA medical students who self assess their own abilities to serve and support health care needs of diverse individuals and families. The researcher anticipates that society may benefit from this study by understanding the activities, involvement, and knowledge necessary for medical students to develop an ability to serve diverse communities. Hence,

there is an expectation that this study will help fill a gap to decrease health disparities in our communities.

COSTS AND COMPENSATION

You will not have any costs, nor will you receive any compensation for participating in this project.

CONFIDENTIALITY

Records of participation in this research project will be kept confidential to the extent permitted by law. Where appropriate, coded or pseudo names will be used to protect the identity of participants. In the event of any report or publication from this study, your identity will not be disclosed. Results will be reported in a summarized manner in such a way that you cannot be identified.

AUDIO OR VISUAL RECORDING

By initialing in the space provided, you verify that you have been told that audio recordings will be generated during the course of this study for transcription purposes only. Focus group discussions/interview sessions will be recorded for this purpose, but your name or other identifying information will not be reported in this study. The transcriptions will be done by the researcher or paid transcriptionist and recordings will be erased or destroyed after the completion of the study.

_____ Participant's initials

VOLUNTARY PARTICIPATION

Taking part in this research study is voluntary. You may choose not to take part at all. If you agree to participate in this study, you may stop participating at any time. For portions of the study involving focus group discussions, or in-depth interviews, the participant is free to skip any questions that s/he would prefer not to answer. If you decide not to take part, or if you stop participating at any time, your decision will not result in any penalty or loss of benefits to which you may otherwise be entitled. Any data collected from the participant prior to withdrawal may be included in the study results.

QUESTIONS

Questions are encouraged. If you have any questions about this research project, please contact: **Sheryl Stohs (Student Researcher) at 503-352-3068 and stohss@onid.orst.edu or Sunil Khanna, PhD (Principal Investigator) at 541-737-3859 and skhanna@oregonstate.edu.** If you have questions about your rights as a participant, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator, at (541) 737-3437 or by e-mail at IRB@oregonstate.edu.

Your signature indicates that this research study has been explained to you, that your questions have been answered, and that you agree to take part in this study. You will receive a copy of this form.

Participant's Name (printed): _____

_____ _____

(Signature of Participant) (Date)

POTENTIAL FOR FOLLOW-UP STUDIES

- There is a chance you may be contacted in the future to participate in an additional study related to this project. If you would prefer not to be contacted, please let the researchers know, at any time.

RESEARCHER STATEMENT

I have discussed the above points with the participant or, where appropriate, with the participant's legally authorized representative, using a translator when necessary. It is my opinion that the participant understands the risks, benefits, and procedures involved with participation in this research study.

_____ _____

(Signature of Researcher) (Date)

APPENDIX E

Letter of Solicitation

[Name]
[Address]
[City, State, Zip]

Cultural competence has been the subject of concern for health care providers, social scientists, health care organizations and policy makers largely due to demographic changes and health disparities. With this in mind, it is important that health care professionals are able to serve and support individuals and families from diverse communities. This is such an important matter that we value your opinion and ideas in understanding the issues that relate to medical education of health care professionals.

We would like to invite your participation in a research study. The purpose of this research is to find out how Physician Assistant students self assess their ability to serve and support individuals and families of diverse communities. Physician Assistant (PA) graduates (Class of 2002, 2003) and third year (PA) students (Class of 2004) of Pacific University School of Physician Assistant Studies Program are invited to participate. The knowledge gained from focus group discussions and interviews will inform us regarding concepts, practices and applications for developing effective protocols for training culturally competent health care professionals. The results of this research study will be used to help bridge the gap between medical training and professional practice in delivering culturally appropriate health care services to diverse communities.

The following data gathering procedures are involved in this study:

Focus Group Discussion (1.5 hours) - a special kind of organized discussion or series of discussions, guided by a few specific questions, to gain a deeper understanding of participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. Audio recordings of the sessions will be used for transcriptions purposes only.

In-Depth Interviews (45 minutes – 1 hour) face-to-face interviews, one-on-one with the researcher in a discussion guided by a few specific questions, to gain a deeper understanding of participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. Audio recordings of the sessions will be used for transcriptions purposes only.

Email Interview open-ended questions (45 minutes). Online discussion with the researcher, responding to a few specific questions, to gain a deeper understanding of

participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. Responses submitted by participant will only be maintained by the principal investigator and the student researcher and kept in a password protected file.

Telephone Interviews (45 minutes – 1 hour) Telephone interviews, one-on-one with the researcher in a discussion guided by few specific questions, to gain a deeper understanding of participants' views and experiences, their feelings, perceptions, beliefs, knowledge, and attitudes about the topic being investigated. No telephone audio recordings will be done, only transcription will be done by the student researcher.

The comments you provide in focus group discussions/in-depth interviews will be kept confidential, to the extent permitted by law. Special precautions have been established to protect the confidentiality of your responses. There are no foreseeable risks to you as a participant in this project; nor are there any direct benefits. However, your participation is extremely valued.

This letter will be followed up by phone call providing dates and times for focus groups discussions/interviews. If you would like to participate in this study please return the enclosed form in the self addressed envelope by [indicate date].

If you have any questions about the survey, please contact us at (503) 352-3068 or by e-mail at stohss@onid.orst.edu . If I am not available when you call, please leave a message and I will call back. If you have questions about your rights as a participant in this research project, please contact the Oregon State University Institutional Review Board (IRB) Human Protections Administrator at (541) 737-3437 or by e-mail at IRB@oregonstate.edu.

Thank you for your help. We appreciate your cooperation.

Sincerely,

Sheryl M. Stohs

Participation in Research Study

Focus Groups Discussion/ In-depth Interviews

(Check all that apply)

Yes I would like to participate in the research study [ ]

I would like to participate in focus group discussions [ ]

I would like to participate in an in-depth interview [ ]

Interview by telephone [ ] or Face to face [ ]

I would like to participate by email [ ]

Name (to be kept confidential) _____

Phone number (s) _____

Email address: _____

Address: _____

City, State, Zip:

_____

Year Graduated from Pacific University PA Program _____