

# Promoting Cultural Awareness: A Faculty Development Workshop on Cultural Competency

Franco A. Carnevale, Mary Ellen Macdonald,  
Saleem Razack, Yvonne Steinert

An interdisciplinary faculty development workshop on cultural competency (CC) was implemented and evaluated for the Faculty of Medicine at McGill University. It consisted of a 4-hour workshop and 2 follow-up sessions. A reflective practice framework was used. The project was evaluated using the Multicultural Assessment Questionnaire (MAQ), evaluation forms completed by participants, and detailed field notes taken during the sessions. The workshop was attended by 49 faculty members with diverse professional backgrounds. Statistically significant improvements were measured using the MAQ. On a scale of 1 to 5 (5 = *very useful*) on the evaluation form, the majority of participants (76.1%) gave the workshop a score of 4 or 5 for overall usefulness. A thematic analysis of field-note data highlighted participant responses to specific activities in the workshop. Participants expressed a need for faculty development initiatives on CC such as this one.

**Keywords:** cultural competency, faculty development, interprofessional, reflective practice, workshop

## **Sensibilisation aux cultures : atelier de formation sur les compétences culturelles s’adressant au corps professoral**

**Franco A. Carnevale, Mary Ellen Macdonald,  
Saleem Razack, Yvonne Steinert**

Les auteurs ont présenté et évalué une formation interdisciplinaire sur les compétences culturelles (CC) s’adressant au corps professoral de la Faculté de médecine de l’Université McGill. Le projet consistait en un atelier de quatre heures et deux séances de suivi. Il a été évalué au moyen du Multicultural Assessment Questionnaire (MAQ), de formulaires d’évaluation remplis par les participants et de notes détaillées prises lors des séances. La formation a été suivie par 49 professeurs aux antécédents professionnels variés. Le MAQ a permis de relever une amélioration notable des compétences. Sur le formulaire d’évaluation, la majorité des participants (76,1 %) ont accordé à l’utilité globale de la formation une note de 4 ou 5 (sur une échelle de 1 à 5, 5 = *très utile*). Une analyse thématique des notes d’observation a permis de mettre en lumière les réactions à l’égard d’activités précises. Les participants ont exprimé le besoin de suivre des activités de formation professionnelle sur les CC comme celle-ci.

**Mots clés :** compétences culturelles, perfectionnement du corps professoral, interprofessionnel, pratique réflexive, atelier

## **Introduction**

Cultural diversity is growing in many industrialized countries. For example, the 2011 *Canadian National Household Survey* revealed that 46% of the Toronto population and 40% of the Vancouver population were born outside Canada; Canada's foreign-born population represented 20.6% of the total population, the highest proportion among the G8 countries (Statistics Canada, 2011). A 2002 Institute of Medicine report highlighted racial and ethnic disparities as a serious concern for health care (Institute of Medicine, 2002). Research demonstrates that culturally competent health care improves health outcomes and reduces disparities (Flores, 2005; Kumagai & Lypson, 2009; Razack, Bhanji, Ardenghi, & Lajoie, 2011). As a result, cultural competency (CC) has become an important component of the training of health-care professionals (HCPs) (Azad, Power, Dollin, & Chery, 2002; Canadian Association of Schools of Nursing [CASN], 2014; Dogra, Giordano, & France, 2007; Wong & Agisheva, 2007) and the provision of health care (Frank et al., 1996; Taylor, 2003) in both Canada and the United States.

CC training programs have been linked to improved outcomes. These include improvements in HCP-patient communication (Committee on Pediatric Workforce, American Academy of Pediatrics, 1999; Kagawa-Singer & Kassim-Lakha, 2003); HCPs who are better prepared to work with patients of different cultural backgrounds (Kagawa-Singer & Kassim-Lakha, 2003); reductions in health disparities (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003; Kumagai & Lypson, 2009; Razack et al., 2011); and improvements in health outcomes, such as better adherence to treatment (Schilder et al., 2001), improved pain management (Narayan, 2010), and better disease control (D'Eramo-Melkus et al., 2004; Metghalchi et al., 2008). As a result of these outcomes, professional licensing bodies have recognized CC. For example, North American accreditation requirements now include CC training curricula — for instance, Royal College of Physicians and Surgeons of Canada (Razack et al., 2011); Canadian Association of Schools of Nursing (2013); and Association of American Medical Colleges (Association of American Medical Colleges & Association of Schools of Public Health, 2012). Similarly, faculty development CC programs are gradually emerging (Ferguson, Keller, Haley, & Quirk, 2003; Kamaka, 2001).

CC training models are aimed at promoting the development of knowledge, skills, and attitudes to recognize and respond to different cultural perspectives on health and illness (Pedersen, 2008). These models commonly foster an in-depth understanding of the culture of medicine as well as the provision of care (Chin & Humikowski, 2002; Taylor, 2003; Wachtler & Troein, 2003). Key issues in the development of CC knowl-

edge, skills, and attitudes are (a) how to foster a change in HCP attitudes towards CC, (b) how to increase HCP knowledge about different cultural groups (including an understanding of the inequities and adverse health outcomes among some marginalized populations) while avoiding stereotyping, and (c) how to facilitate HCP communication with patients from different cultural backgrounds (Betancourt, 2003; Webb & Sergison, 2003). Webb and Sergison (2003) argue that CC is a process beyond a simple increase in knowledge, whereby the individual also develops greater self-awareness.

Notwithstanding these efforts and outcomes, CC training is very limited in undergraduate and postgraduate training across the health professions (Azad et al., 2002; Peña Dolhun, Muñoz, & Grumbach, 2003; Wachtler & Troein, 2003; Webb & Sergison, 2003). There are many challenges in developing effective CC training programs. One is fitting new content into already overstretched curricula (Anderson et al., 2003; Azad et al., 2002; Betancourt, 2003; Chin & Humikowski, 2002; Crosson, Deng, Brazeau, Boyd, & Soto-Greene, 2004). Another is the fact that culture is seen by HCPs as both an obstacle and a challenge, a domain that is difficult to construe as a competency module to be readily added to existing medical knowledge (Macdonald, Carnevale, & Razack, 2007). This may be partly explained by research illustrating that cultural variation can fundamentally shift how health and medicine are understood across cultural groups (Good, 1994; Kleinman, 1988, 2004; Lindenbaum & Lock, 1993). Consequently, there is no standard model for CC training in health sciences education (Green, Betancourt, & Carrillo, 2002; Peña Dolhun et al., 2003). In the programs that do exist, there is often a lack of evaluation methods to assess their effectiveness (Crosson et al., 2004; Wachtler & Troein, 2003). Further, CC can never be a “one size fits all” approach to cultural groups; how one responds competently to one culture may not be sound for another (Kleinman & Benson, 2006; Taylor, 2003). An additional challenge is introducing an effective training program that meets the guidelines for good clinical practice and fits into current curricula (Anderson et al., 2003; Azad et al., 2002; Betancourt, 2003; Chin & Humikowski, 2002; Crosson et al., 2004).

In our own work we have found that HCPs feel unprepared to teach CC to medical trainees and desire faculty development training in this area (Macdonald et al., 2007). The present study was inspired by these findings.

The aim of the study was to develop, implement, and evaluate an innovative interprofessional faculty development CC workshop in the Faculty of Medicine at McGill University. The workshop was innovative in its use of reflective practice and action science as instructional and research methodologies for advancing CC. Although this interdisciplinary

workshop is pertinent for nursing, the initiative is directed more broadly at the health professions in general. This article is addressed to an interdisciplinary audience.

## **Methods**

### ***Theoretical Orientation***

A particular challenge in CC education is that culture is construed in many different ways (Macdonald et al., 2007). We drew on the work of the anthropologist Clifford Geertz (1973), who has defined culture as “a system of meaning shared by a group of people, learned and passed on from one generation to the next. Culture includes beliefs, traditions, values, customs, communication styles, behaviors, practices, and institutions. Culture has a significant influence on how the individual experiences both health and disease, influencing an individual’s health beliefs, expectations, behaviours, activities and medical treatment outcomes” (quoted in Macdonald et al., 2007, p. 465).

There is no widely accepted definition for CC. For the purposes of this study, CC is defined as the knowledge, skills, and awareness required for attending to cultural components of clinical practice. The competency concept of “attitudes” is replaced by “awareness,” as the latter is a central attitude of concern in CC education.

The research framework selected for the study was action research, an approach that employs an iterative, cyclical process of fact-finding, planning, action, evaluation, and revised planning (Argyris, Putnam, & McLain Smith, 1985; Peters & Robinson, 1984; Reason, 1994). In action research, *action science* is viewed as a methodology that incorporates *reflective practice* through self-aware double-loop learning as an instructional and analytical technique (Argyris et al., 1985; Argyris & Schön, 1974; Schön, 1983, 1987). The merits of reflective practice in fostering more effective practice in health care have been documented (Epstein, 1999; Frankford, Patterson, & Konrad, 2000; Lebensohn-Chialvo, Crago, & Shissiak, 2000; Shapiro & Talbot, 1991; Stange, Miller, & McWhinney, 2001).

### ***Design***

In our previous work we conducted a pilot project in the Department of Pediatrics at McGill University to identify CC training priorities using resident and faculty focus groups (Macdonald et al., 2007). A workshop for residents was then developed to promote cultural awareness, the aim being to increase residents’ knowledge about local cultures and resources and encourage self-reflection and awareness of cultural issues in medical practice (Macdonald et al., 2007).

We then launched a faculty development initiative to build upon our main finding, namely that faculty do not feel prepared to teach CC to students and trainees. Potential participants for training were faculty members from all disciplines, departments, and schools within the Faculty of Medicine at McGill University, including medicine, nursing, and physical and occupational therapy. Potential participants were invited to take part through the Web site of the Faculty Development Office, on-campus flyers, and e-mail announcements.

In preparation for the workshop, we held training sessions for four faculty members, who then served as facilitators of small-group discussions in the actual workshop. The preparations included background reading and instruction to help orient the facilitators to our learning objectives and the reflective practice learning model described above.

We designed a 4-hour workshop, which began with a plenary presentation, *Cultural Competency: Evidence, Models and Frameworks for Improved Health Outcomes*. This described the importance of CC in clinical practice and discussed useful models and frameworks for teaching and evaluating CC, balancing cultural knowledge, skills, and awareness, and identifying tools to incorporate cultural awareness into one's day-to-day teaching. Subsequently, two 1-hour small-group activities introduced participants to ways of building skills for promoting CC in their work using reflective practice for both a teaching and a practice framework. The workshop ended with a large-group wrap-up. (See Appendix 1 for an overview of the workshop and small-group exercises.)

Two 90-minute follow-up sessions were conducted 3 and 6 months after the workshop. These sessions included advanced discussions of reflective practice strategies for promoting CC, participants' feedback on the workshop, and discussion of participants' experiences in supporting CC development among trainees.

### **Data Collection**

We used a mixed methods design to collect and analyze data, using three primary data sources: the *Multicultural Assessment Questionnaire* (MAQ), an evaluation form administered at the end of the workshop and after each follow-up session, and detailed field notes.

The MAQ is a 16-item Likert-type scale designed to measure CC knowledge (six items), skills (six items), and attitudes (four items) (Culhane-Pera, Rife, Egli, Bake, & Kassekert, 1997). Respondents were asked to rate their mastery of different areas related to CC on a five-point scale (1 = *no mastery*, 5 = *excellent mastery*) (Crandall, George, Marion, & Davis, 2003; Culhane-Pera et al., 1997; Thompson et al., 2010). Ratings for each item are summed to provide a total MAQ score, with a range of 16 to 80. Examples of MAQ items include the following: Define culture

and list various factors that influence culture; Discuss important cultural influences of particular patients; Inquire about beliefs, practices, and values for patients and families as pertinent to medical problems; Consider cultural information in making diagnostic and therapeutic plans; Work with interpreters in an effective manner; Appreciate the heterogeneity that exists within and across all cultural groups and the need to avoid overgeneralization and negative stereotyping; Be aware of own cultural beliefs, values, and practices that influence self as a cultural person. The MAQ is regarded as having face validity (Crandall et al., 2003). To date, more robust validity measures for the MAQ have not been reported. This tool has exhibited strong reliability, with Cronbach's alpha measures of internal consistency of greater than 0.88 (Crandall et al., 2003). The MAQ has effectively measured statistically significant changes in CC with sample sizes as small as 12 for trainee education programs (Crandall et al., 2003). Thus the MAQ is a reliable and valid instrument for measuring changes in CC in the context of an education program, although it has been previously used primarily for trainee education rather than for faculty development.

The MAQ was administered before the workshop and 3 months after the workshop to assess the development of CC. Post-workshop measures were obtained by mail before the first follow-up session was conducted.

An evaluation form was administered at the end of the workshop and after each follow-up session for participants to rate how well the activity fulfilled the stated objectives as well as particular learning needs.

Detailed field notes were taken by four research assistants during the workshop and the follow-up sessions to identify participants' beliefs and values related to CC. Field notes are extensive records of observations, written in a journal, noting themes that are verbalized, non-verbal expressions, interactive dynamics, and other contextual phenomena relevant to the study (Emerson, Fretz, & Shaw, 1995).

### ***Ethical Considerations***

All participants consented to take part in the study. While the workshop was part of our research study, participants who did not wish to contribute to the research could choose not to complete the study instruments. Voluntary participation and confidentiality were respected. Ethical approval was obtained from the Institutional Review Board of the Faculty of Medicine at McGill University.

### ***Data Analysis***

All qualitative data from the evaluation form and field notes were examined using thematic content analysis (Denzin & Lincoln, 2005) to identify the principal themes underlying the data. The quantitative data from

the MAQ and the evaluation forms were analyzed using non-parametric statistics. To validate the preliminary findings, member checking was conducted with three senior faculty members (a 90-minute group meeting was arranged with a convenience sample of three senior faculty members who participated in the workshop), during which preliminary themes were critically examined and integrated into the quantitative results.

### Results

The workshop was attended by 49 participants: 25 physicians, 10 nurses, and 14 other faculty members with backgrounds in education, counselling, nutrition, sexology, and physical/occupational therapy.

#### Multicultural Assessment Questionnaire

All participants completed the MAQ before the workshop (i.e., pre-workshop). Of these, 26 (53.1%) returned completed MAQ forms sent to participants 3 months after the workshop (i.e., post-workshop). Of the 26 completed pre- and post-workshop MAQs, *t* test analyses revealed that there was a statistically significant increase in post-workshop scores ( $p < 0.001$ ) (Table 1).

Table 1 <i>Statistical Analysis of MAQ Scores</i>					
Pre- and Post-workshop MAQ Scores (N = 26)					
	Pre-workshop		Post-workshop		
Mean	43.3		48.4		
Median	44		49		
Range	25–55		27–60		
Paired-Samples <i>t</i> Test (N = 26)					
Variable	N	Mean	Standard Deviation	Average Standard Error	
Difference in score	26	5.11	5.35	1.05	
H <sub>0</sub> : difference in score = 0	T	Df	Significance (bilateral)	Average Difference	Confidence Interval (95% Difference)
Difference in score	4.87	25	0.000*	5.11	[2.95, 7.27]
* Binomial test (bilateral): sign 0.000					

<b>Table 2 Reasons for Participating</b>	
<b>Theme</b>	<b>Data Exemplars</b>
<b><i>Thematic category I: To improve own clinical practice</i></b>	
To learn how to be culturally sensitive	To integrate cultural competency into my practice and teach peers and students
To learn what other HCPs think about culture and diversity	Discussion on how to decrease cultural misunderstanding between HPCs
To better understand patients' needs and provide better care	Patients' cultural background affects their understanding of health concepts
<b><i>Thematic category II: To improve teaching</i></b>	
To learn a cultural competency teaching model/framework	I've had to learn about culture in my career on a case-by-case basis, through trial and error. Now, I'd like to be able to guide students in this. I'd like a model or framework to help me do this.
To learn how to teach learners from abroad	Part of this process is explaining Canadian culture to trainees from abroad. We also have to be aware of why they are here. Often, it is to get the training to go back to their country to be a neurosurgeon there, so this means that they are not interested in any kind of assimilation. They do not want their wives to go through any acculturation process because they are just going to go back to their country, so this means that their wives do not drive, often do not learn our languages . . . they are basically stuck in the house. Therefore, these residents have to tend to their families quite a bit.
Important to learn from one another and from learners too	I learned a lot from residents from different cultures.  Important to tap into staff and to recognize what we can learn from each other.
Various teaching aims	To learn about how culture influences patient encounters and how I can help students work in a culturally sensitive way.  We need leaders who are comfortable being challenged to set examples for students and residents.

Theme	Data Exemplars
Case-by-case/informal	Reflecting, discussing case-by-case, making the students aware with case studies
Challenging stereotypes	Challenging stereotypes — try to discuss alternative perspectives of doctors
Interpretation practices	Often, family members are doing the translation — not appropriate — should use an interpreter.
Various other practices	<p>The interpreter should not only translate but also function as a cultural broker.</p> <p>We're always looking to integrate culture in our interactions.</p> <p>Don't always have very much time and it takes a lot of time to listen and be culturally sensitive.</p> <p>Tolerance; students should be able to pronounce their patients' names, be able to adapt to the culture, including the food. <i>The Canada Food Guide</i> . . . now you can get a personalized food guide on the Internet.</p>

### **Evaluation Form**

Of the 49 participants, 46 completed a workshop evaluation form immediately after the workshop. On a five-point scale (5 = *very useful*, 1 = *not at all useful*), the majority of participants (76.1%) indicated an overall score of 4 or 5. Most participants (84.8%) indicated that they would recommend the workshop to their colleagues. Positive comments included “thought provoking,” “eye opening,” and “good framework.” Participants indicated that the workshop motivated them to “learn more about different cultures,” “inform [myself] and colleagues about resources, readings,” “prepare case reports for discussion/teaching purposes,” “read more about culture and discuss this with residents,” and “look out for strategies to incorporate in teaching, mentoring, clinical practice and test them.” Only one participant provided negative comments.

### **Field-Note Data**

From our field-note analysis, it is clear that participants had two main motivations for attending the workshop: (1) to improve their own clinical practice, and (2) to improve their teaching (Table 2). Faculty acknowledged that to promote CC in their teaching, they needed to first develop

<b>Theme</b>	<b>Data Exemplars</b>
Diversity of individual identities	How complex we are — people may actually define you by only one of those labels.  We identify with so many different groups and we don't know how that affects our practice.
Religion and identity	Important not to be judgemental about other people, especially Muslim people. Not all Muslims are the same.
Gender and identity/default identities	How many women put down “woman” as an identity? Most women raised their hand. How many men put down “man”? No men raised their hand.
Demonstrates profound impact of culture on behaviour	The behaviour of foreign residents is not due to a lack of awareness about Canadian culture but is associated with the structure of their entire belief system.  Addressing cultural insensitivity appears to be an ethical imperative.
Seeing the familiar in the unfamiliar	Got to see what was similar between us — helps the other person to relate to you and see things through your eyes.
How do we relate to this practically?	Good exercise to use with students to sensitize them to culture and their own culture.
Education is key in promoting openness to culture	The most important thing is education — allows people to become open to others, to different cultures.
Importance of context	Identity is contextual and also changing over time.
Motherhood and identity — seeing the familiar	In many cultures a woman's main identity is being a mother. If you have children, the person knows that you understand them.
Other	Professional arrogance — that is common among HCPs.  Feeling stereotyped by my language — made to feel different from the majority culture.

their own CC in clinical practice, as this is a recently recognized competency that they did not learn in their professional education. To develop CC in their own practice, participants reported, they needed to learn how to be culturally sensitive, learn what other HCPs think about culture and diversity, better understand the cultural basis of patient needs, and provide better care. To improve their teaching, participants stated, they had to learn a CC teaching model/framework, learn how to teach learners from abroad, and learn from other faculty and learners.

When asked to describe how CC was currently addressed within their curriculum, participants reported that it was informally, on a case-by-case basis, in clinical teaching (Table 3). A principal aim in their teaching was to challenge cultural stereotyping. A common clinical practice examined in their teaching related to working with interpreters, examining the issues that need to be considered in the context of linguistic barriers.

Several themes were identified from participants' responses to the small-group exercises (Tables 4 and 5). Participants described their

<b>Theme</b>	<b>Data Exemplars</b>
Our lack of awareness of problematic assumptions about patients	We assume that patients want information about their care, condition, and that they want to do whatever they can for their health, but I don't know. Can we always assume that? I don't think so.
We need to be more aware of the patient's perspective	I had an experience with a Jehovah's Witness. That experience really changed me. I really was able to see their perspective.
Our understanding of others (patients) is affected by our own views/identities	Helped me realize that we all have identities and that even the way we understand other identities is affected by our own identity.
Complexity of culture (beneath the surface)	You realize the impact of culture on practice. It's important to look beyond, under the surface. I don't think it takes that much more time.
Other	How can we find a common ground?  It's important to realize that we may fumble at times but we can learn from that.  Listening skills are important — really listening.

“discoveries” regarding personal identity (e.g., individual identities are inherently diverse; gender and religion influence personal identity; culture has a profound impact on behaviour; it is important to seek the familiar in the unfamiliar and vice versa; education is key in promoting openness to culture; examining context is important in understanding culture) as well as patients’ cultural perspectives (e.g., we are unaware of problematic assumptions we have towards patients; our understanding of others is affected by our own views/identities; culture is complex — there is much more to it beneath the surface).

Participants reported that the workshop helped them to better understand the impact of ethnocentric assumptions and to listen more openly (Table 6). They had a greater appreciation of how culture affects the way that people view things and the impact of clinicians’ use of language, terms, or labels. Participants described how some simple symbols (e.g., white coat) can perpetuate complex power dynamics. They questioned how and when to accommodate cultural differences. Participants also reported that the presence of other health professions affected the workshop discussion (e.g., illuminating the nurse’s role in communicating with patients).

Table 6 <i>Identifying Teachable Moments</i>	
Theme	Data Exemplars
<i>I: Dr. Armstrong Scenario</i>	
Impact of ethnocentric assumptions	Dr. Armstrong’s viewpoint was ethnocentric. He made a lot of assumptions.
Need to listen/attend more openly	Always be open and prepared to deal with diversity.  Emphasize listening and communication.
Realizing how culture affects the way people view things	People from different cultures see things differently; things mean different things to different people.
Impact on generational differences (between teacher and learner)	Appears to be a generational issue with Dr. Armstrong; he seems “old boy.”  Standards must be founded on principles, many of which are changing. The younger generations do not see wearing a tie as important for professional decorum.
<i>Continued on next page</i>	

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Theme	Data Exemplars
<b><i>I: Dr. Armstrong Scenario</i></b> (cont'd)	
White coat – complex power dynamics	<p>I don't like the white coat but I want them to see me as professional. I decorate the lab coat to seem less "doctor."</p> <p>Sometimes the white coat is expected by the patient and he can be offended if you're different.</p>
How/when to accommodate differences?	Tense discussion about how much HCPs need to accommodate the needs of their patients.
Other	<p>It's important to learn from students.</p> <p>How to evaluate students on cross-cultural competency — which standards to teach?</p>
<b><i>II: Dr. Butterfield Scenario</i></b>	
Impact of language/ labels	Find out why he used those labels. Regarding the students in his class who were upset, maybe, being the children of immigrants, it was because they were insulted.
Other	<p>The language used in the examples can be seen as degrading.</p> <p>Stereotyping can be pervasive; we readily take our assumptions for granted.</p> <p>Given the difficult nature of the job, factoring in variables such as culture can be overwhelming.</p>
<b><i>III. Nursing Student Scenario</i></b>	
Physician-centredness of workshop participants	Physician-centredness of the group begs the question: would they have seen merit in the scenario had there been no nurses present?
Seeing nurse's sense of duty to patient	Respect the nursing student for feeling a sense of duty towards the patient.
Questioning extent of nurse's role in communicating with patients	Physicians find it controversial for anyone other than doctors to decide what information patients receive.

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In describing the lessons drawn from the workshop, participants referred to the need for more teaching about culture and further discussion to determine how to teach CC in their own context (Table 7). They also highlighted the benefits of teaching with cases, cross-cultural clinical practices that need to be reviewed, and the need for CC to be addressed early in education.

<b>Theme</b>	<b>Data Exemplars</b>
Need to direct more teaching towards culture	Cultural misunderstanding among HCPs is a priority. We need to place more emphasis on cultural diversity when we teach.
Need to further determine how to teach cultural competency in one's own context	We need more understanding and preparation on the topic before we feel confident to move to a teaching role. Further curriculum development and more scenarios for teachable moments seen as useful. Can be done when sitting with residents, to clarify that they can't be making assumptions.
Benefits of teaching with cases	Prefer to teach students about CC with scenarios or case-by-case, looking for the teachable moments.
Reviewing specific cross-cultural clinical practices	Would like to use interpreters as cultural brokers. Patients need to know the alternatives — that they will die if they don't agree to treatment.
Realizing how much I (still) have to learn about CC	I realize how much I don't know about different cultural groups and how much I have to learn.
Needs to be addressed early in education	Introduce the idea of cultural competency early in the curriculum.
Principles to take home	Respect — with respect come openness, understanding, and being open to differences.
Other	It's important for program directors and people who have influence to be involved in this. Students can teach us so much about how this can be facilitated.

### ***Follow-up Sessions***

Few participants attended the two follow-up sessions. The principal reason given for this low response rate was time constraints. Six participants (five nurses and one sexologist) attended the first follow-up session and three (all nurses) attended the second. Participants in these follow-up discussions said that they realized how unaware they had been of different cultures and identities. They appreciated the value of role-play exercises in education and the importance of interpreters in facilitating communication with patients in their practice. They also discussed concerns about whether formal training might be perpetuating stereotyping as well as difficulties in using “teachable moments” in practice to impart culturally important messages to students. These data supported the findings from the CC workshop.

### **Discussion**

The importance of CC training in health sciences education is being increasingly recognized (CASN, 2013; Taylor, 2003). While it is well demonstrated that faculty have a significant impact on trainees’ awareness, knowledge, and understanding of cultural issues (Dogra et al., 2007; Wong & Agisheva, 2007), the translation of complex theoretical and empirical CC knowledge into culturally competent clinical education continues to pose instructional design and implementation challenges (Engebretson, Mahoney, & Carlson, 2007). Promoting faculty development in CC is thus a priority.

Our study succeeded in a number of important areas. First, it confirmed the need for CC training, evidenced by 49 faculty members devoting a half-day of their time to attend the workshop. Second, participants’ learning appeared to be enriched by the use of a reflective practice framework and an interprofessional design, evidenced in the overwhelmingly positive workshop evaluations. Third, we were able to achieve statistically significant improvement in CC mastery in a relatively small time frame (i.e., a 4-hour workshop). Where we were least successful was in attracting participants to the subsequent sessions; the main reason given for non-attendance was “lack of time.” We speculate, based on the highly positive feedback regarding the workshop, that participants also did not perceive a need for further instruction at this time. Finally, our data demonstrate that the workshop advanced participants’ understanding of their own clinical practice as well as how they might strengthen their teaching of CC.

The interprofessional design of this program fostered insight into the ways in which various health professions relate culture to practice and education. As participants disclosed their views and practices related to

culture, they learned about the commonalities and differences faced by participants from other professions, increasing their understanding of how CC education and practice can be promoted. Moreover, the meaningful exchanges among participants suggest that CC education can also serve as a focus for promoting interprofessional education among faculty and students. In fact, we subsequently organized a series of interprofessional education workshops for undergraduate students in all our programs for health professionals, which fostered strong exchanges among students as well as faculty members who participated as facilitators.

The relation of reflective practice to CC education was particularly innovative. Reflective practice is an effective framework for operationalizing knowledge, skills, and awareness about culture in clinical education. Participants demonstrated significant engagement in advancing their own CC by examining their particular understandings of culture, as well as critically reflecting upon their current teaching practices to identify ways in which the CC of their students might be better developed.

The limitations of the study should be acknowledged. Our study was based on one specific educational initiative in one academic setting. Multisite studies comparing different educational approaches should be conducted. Participation was voluntary. It is possible that faculty who attended the workshop were more committed to CC education than those who did not. Also, the small number of participants in the follow-up sessions limited the study's examination of this initiative's impact over time. Finally, although a difference was observed between pre- and post-workshop scores, it should be noted that this was not a randomized controlled trial or an experimental study with a control group. Therefore, it is difficult to ascertain the degree of change in the score that can be uniquely attributed to the workshop. We acknowledge the possibility that the change could be partly due to maturation and history.

In designing this faculty development initiative we sought to balance depth with feasibility. Our multi-session program was compromised by participant retention. Future research should examine the merits of extended CC faculty development programs and corresponding strategies for ensuring participant retention. Future research should also examine the impact of faculty development programs on the development of CC among trainees of faculty participating in such programs.

## **Conclusion**

This article has described an innovative faculty development workshop and its favourable impact on CC, evaluated through diverse types of data. The workshop was particularly innovative in its interprofessional design and underlying reflective practice framework.

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*Franco A. Carnevale, RN, PhD, is Professor, Ingram School of Nursing, McGill University, Montreal, Quebec, Canada. Mary Ellen Macdonald, PhD, is Associate Professor, Division of Oral Health and Society, Faculty of Dentistry, McGill University. Saleem Razack, MD, FRCPC, is Pediatric Intensivist, Montreal Children's Hospital, and Associate Professor and Assistant Dean of Admissions, Equity, and Diversity, Faculty of Medicine, McGill University. Yvonne Steinert, PhD, is Director, Centre for Medical Education, Richard and Sylvia Cruess Chair in Medical Education, and Professor, Department of Family Medicine, McGill University.*

<b>Appendix 1 <i>Educating for Cultural Awareness:</i> <i>Description of Workshop</i></b>
<b>8:30 Interactive Plenary</b> <b>CULTURAL COMPETENCY: EVIDENCE, MODELS, AND FRAMEWORKS FOR IMPROVED HEALTH OUTCOMES</b>
<b>9:30 Small-Group Session I</b> <b>SKILL BUILDING FOR TEACHING CULTURAL AWARENESS</b> <i>Activity: <b>Introduction of Participants</b></i>

**Activity: Reasons for Participating**

Participants were asked to describe why they chose to attend this workshop.

**Activity: What I Am Currently Doing**

Participants were asked to describe what they were currently doing to teach CC.

**Experiential exercises:** to enable participants to *experience* exercises that they may wish to use with their students and to *reflect* upon their utility.

**Activity: Who Am I? The Complex Nature of Identity**

Participants were asked to (a) write four or five groups to which they felt the most sense of belonging and shared identity, (b) consider the ways in which they were stereotyped and viewed as “different” by the majority culture within each group, (c) examine the ways in which each identity predisposed them to positive and negative social discrimination.

**Activity: Making the “Strange” Familiar**

**Exercise 1:** Participants were asked to construct a list of features of the “culture” of an inpatient Clinical Teaching Unit (e.g., norms, meanings, beliefs, customs, traditions, practices) and formulate strategies to make their culture better understood by outsiders.

**Exercise 2:** Participants were asked to describe a medical situation where they were (a) practising within a familiar setting but encountered a person or persons who were strange to them, or (b) in a medical situation where they were seen as strange. What was strange? What was familiar? Participants then prepared a synthesis that outlined the types of differences reported and the similarities between them and others.

**10:45 Small Group Session II**

**BECOMING AGENTS FOR CULTURAL CHANGE**

Teaching and Learning Exercises: To *identify* teachable moments and to *find* new opportunities for teaching and learning CC

**Activity: Teachable Moments**

For each of the three scenarios below, participants were asked to (a) identify the “teachable moment” from the point of view of cultural awareness, and (b) discuss how they might positively contribute to trainees’ growth as a professional around these issues by helping them identify the “strange and the familiar” in the patient/family perspective and to find common ground with which to develop a therapeutic alliance.

**I. Dr. Armstrong scenario.** A noted physician and scholar gave a lecture on professionalism to residents during which he presented a list of “professional attributes” relating to appearance (e.g., white coat, tie, clean-cut); decorum (e.g., language, confidence, eye contact); integrity (e.g., honesty, directness, sincerity); and humanism (e.g., caring, empathy, concern). Continuing with the scenario, several residents questioned the “appropriateness” of these attributes across diverse cultures and religions. Dr. Armstrong was unprepared for the comments that were made and felt disconcerted, as he had not intended to raise such concerns (adapted from Thille & Frank, 2006).

**II. Dr. Butterfield scenario.** An instructor asked participants to work on various case studies, including “treating an HIV-positive gay man,” “effectively dealing with an illiterate black patient,” and “language difficulties with uneducated immigrant patients.” Several gays/lesbians, African Canadians, and children of immigrants were represented in the classroom and were upset by the stereotypical nature of the case studies used. Dr. Butterfield responded to the complaints saying that the students were being too sensitive (adapted from Thille & Frank, 2006).

**III. Nursing student scenario.** Diane is a nursing student who is concerned about Mrs. S., a 65-year-old immigrant Greek woman who has metastasized breast cancer that has been resistant to treatment. The treating team concluded that palliative symptom control is the only reasonable option to be considered. Mrs. S. knows very little about her condition. Her husband and son have insisted that all information be provided only to them, indicating that it is common in their culture to protect patients from bad news. Diane is shocked that the treating team has gone along with this and has indicated to her instructor that she feels an obligation to talk to her personally about her condition.

**11:45 Small-Group Discussion**

**SUMMARY OF LESSONS LEARNED**

**12:00 Wrap-up Plenary**

**SYNTHESIS OF PRINCIPAL LEARNING POINTS**

*Activity:* Open discussion with participants about how they planned to promote CC education. Participants were asked to identify “take-home messages” and how they could take these back to their own settings.

**12:30 Adjournment**