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# A hidden curriculum: mapping cultural competency in a medical programme

Caroline Wachtler & Margareta Troein

**Background** Cultural competency can be understood as those learned skills which help us understand cultural differences and ease communication between people who have different ways of understanding health, sickness and the body. Recently, medical schools have begun to recognise a need for cultural competency training. However, few reports have been published that articulate and evaluate cultural competency in medical curricula.

**Aim** This study was performed in order to evaluate the current status of cultural competency training at a medical school in southern Sweden.

**Methods** We used a multimethod approach to curriculum evaluation. We reviewed the published list of learning objectives for the medical programme, interviewed curriculum directors and individual teachers for each term about course content and carried out focus group interviews with students in all stages of the medical programme.

**Results** Cultural competency is a present but mostly hidden part of the curriculum. We found learning

objectives about cultural competency. Teachers reported a total of 25 instances of teaching that had culture or cultural competency as the main theme or 1 of many themes. Students reported few specific learning instances where cultural competency was the main theme. Students and teachers considered cultural competency training to be integrated into the medical programme. Cultural competency was not assessed.

**Conclusion** This evaluation showed places in the curriculum where cultural competency is a present, absent or hidden part of the curriculum. The differences between the 3 perspectives on the curriculum lead us to propose curriculum changes. This study illustrates how triangulation with a multifactorial methodology leads to understanding of the current curriculum and changes for the future.

**Keywords** cultural competency; medical education; curriculum; evaluation; focus groups.

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## Introduction

Culture is currently described as a system of meaning that a group of people share.<sup>1</sup> This system is adaptive and can be taught and reproduced.<sup>2</sup> People tend to experience health and disease from the perspective of their own culture, and create expectations of health care based on these experiences.<sup>3</sup> Communication problems that can lead to inadequate care arise when the patient's culture and the doctor's culture engender different understandings of health care, the body, disease and health.<sup>4–6</sup> Cultural competency refers to

the set of acquired skills that allow for increased insight into and understanding of cultural differences.<sup>7</sup> Flores defines cultural competency in health care as 'recognition of and appropriate response to key cultural features that affect clinical care'.<sup>4</sup> Cultural competency skills include knowing about cultural values and folk illnesses, handling language differences, achieving access to patient beliefs, and understanding one's own system of beliefs and practice.<sup>3,4</sup> Cultural competency can lead to better communication between people who have different interpretations of what is happening. Cultural competency is therefore an important skill for doctors in all countries where immigration has taken place.

A few years ago, the Swedish National Board of Health and Welfare (NBHW) proposed the inclusion of a cultural competency curriculum in all medical programmes in Sweden.<sup>8</sup> However, the NBHW reported only that cultural competency is not a clearly

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### Key learning points

Cultural competency is a hidden part of the curriculum at Lund University medical school. Elements of cultural competency occur in the medical programme, but the subject is not clearly articulated or assessed.

The course objectives and the descriptions of the curriculum given by students and teachers differ. This study illustrates how triangulation with a multifactorial methodology leads to understanding of the curriculum.

Examining the differences between the 3 perspectives on the curriculum can guide curriculum change.

articulated part of the medical curriculum. We undertook this study in order to map cultural competency in the medical programme curriculum at Lund University in Lund, Sweden.

We chose to carry out our study using 3 different perspectives on the curriculum: the planned curriculum as described in the learning objectives, the taught curriculum represented by teacher intentions, and the received curriculum as reflected in student experience. We used these 3 perspectives to examine how cultural competency is taught and learned.

## Methods

The medical programme at Lund University is 11 terms long and problem-based learning is central to the curriculum. Each term class consists of 60–80 students. A 'term director' has responsibility for and supervision over the curriculum for each particular term. The first 4 terms are preclinical with only limited patient contact, and the last 7 terms are primarily clinical. After the fourth term the class is divided between the 2 regional university hospitals.

### The intended curriculum

We carried out a critical reading of the learning objectives published in the medical faculty's handbook *The Medical Programme 2001/2002*. The handbook is updated every year and the learning objectives published in it serve as the official information on what courses cover. Each term of study has its own learning objectives.

The phrase 'cultural competency' did not appear in the handbook. We chose to use the words 'culture', 'background' and 'social factors' as surrogate end-point vocabulary in our search of the handbook for learning objectives with cultural competency as their unstated goal. We also examined the text for learning objectives that might cover cultural competency even if this was not explicit. Both authors evaluated the text separately.

### The taught curriculum

We sent an introductory letter to all term directors with information about our study. One of the authors (CW) then conducted interviews, either in person or via e-mail, during the period June–August 2001. Some other teachers, responsible for specific themes during the medical programme, were also interviewed. All the tutors who were invited to participate agreed to be interviewed.

The interviews were semistructured and formulated according to the methodology described by Britten (Appendix 1).<sup>9</sup> Interviewees were asked to report any teaching during their term that had culture or cultural competency either as the main theme of its content or as 1 of many themes. The term director's opinions about cultural competency in the curriculum were explored. There was also space for any additional topics the interviewee wanted to take up. In general, the interviews took around 20 minutes. CW took notes during the interviews and summarised after every conversation to ascertain that everything the interviewee wanted to communicate had been written down.

### The received curriculum

Because cultural competency is not an explicit part of the curriculum, we decided to use the qualitative methodology offered by focus group interviews to acquire an overview and understanding of student conceptions and experiences of cultural competency training in the medical programme.

We carried out 5 focus group interviews during the autumn term of 2001, 1 with preclinical students only and 4 with clinical students (2 groups from each campus). Eight students were invited to each focus group. Of the 40 students invited, 24 participated. We used a slightly adapted version of a methodology described by Kitinger.<sup>10</sup> Each focus group was made up of 4–8 students, representing 1–2 students from each term class. We deliberately selected our focus group participants by using a theoretical sampling model to find students who represented the entirety of the medical programme and who had experience

with curriculum discussion and evaluation. The students were currently or had been previously active as course representatives or as members of the Curriculum Advisory Committee. We informed the students ahead of time that the focus groups would be about 'how cultural aspects are taken up in the medical programme'.

One of the authors (CW) led all the focus groups. CW is herself a medical student and was acquainted with some of the participants. Each group lasted 1–2 hours. CW used a broad topic guide to facilitate the discussion (Appendix 2).<sup>11</sup> The topics students discussed were: student definitions of cultural competency; their experiences of learning about cultural competency in the medical programme; what these experiences had consisted of and how they had been examined, and whether and how the curriculum should be changed. Interviewer involvement was kept to a minimum during discussions. After each discussion of a particular topic, CW summarised the discussion for participants in order to ascertain that all the information participants wanted to communicate had been presented. CW taped all discussions and took notes. The tapes were transcribed. The interviews are reported descriptively here. Text in quotes is translated from direct citations.

## Results

### Intended curriculum: the learning objectives

We identified 5 learning objectives that were explicitly about cultural competency. Each learning objective appeared in only 1 of 5 different terms' learning objectives, and these 5 were spread over all stages of the medical programme. The learning objectives are reported in Table 1.

We also found 28 learning objectives on subjects where we considered cultural competency to be a possible part of the discussion. These also occurred in various terms' learning objectives spread over all stages of the medical programme. Cultural competency is not an articulated part of these learning objectives, but one

can see that a component of cultural competency could be introduced. An example of this kind of learning objective was 'to be able to give advice on diet to a healthy adult'. One might discuss different cultural ideas about food when learning about diet advice for the healthy adult, but culture is not an articulated component of the learning objective.

### Taught curriculum: teacher intention

Teachers reported 10 instances of teaching that had culture or cultural competency as their main theme. These occurred during the clinical part of the medical programme between terms 5 and 11. The instances are reported in Table 2.

Another 15 instances were reported where cultural competency was 1 of many themes. These occurred during the entire medical programme. Most cultural competency training appeared in connection with teaching about interview technique and the patient–doctor relationship. Cultural competency in combination with ethical discussions and lectures about epidemiology was also part of the taught curriculum.

Teachers felt that cultural competency was 'integrated' into clinical studies, by which they meant that students meet patients with other cultural backgrounds in an unstructured way during their time in the clinic.

Teachers reported that cultural competency is in general not taken account of in examinations. They did report that it could come up as part of an oral, practical examination. Some of the teaching instances had obligatory attendance and students were required to present a relevant case for 1 of the seminars.

### Received curriculum: student experience

Students reported a total of 6 specific instances where cultural competency was the main theme of a curricular element. They were not in agreement about the occurrence of these instances and could give few details. The instances they named are reported in Table 3.

**Table 1** The intended curriculum: learning objectives as reported in the medical faculty's handbook

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Ability to describe and explain psycho-social factors in connection with cancer
Adaptation of the patient–doctor relationship with regard to the patient's person, background, age, gender and reason for visiting
Consideration of gender, social and cultural differences in the disease experience and in symptom description
Understanding of the importance of cultural differences in health care in regard to symptoms, disease and the patient–doctor relationship, as well as knowledge of laws that apply to refugees
Understanding of social factors' impact on health

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**Table 2** The taught curriculum: teacher intention as reported in interviews with course directors

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A half-day symposium with lecture and small group discussion on the definitions of illness, disease and sickness and different models for understanding disease
A seminar on cultural rules about the deceased in transition from death to burial
A lecture on alternative medicine in a historical and cultural perspective
A seminar where each student presents a case that illustrates the role of culture on the patient's understanding of sickness and health and how this can influence the physician's work
A half-day symposium on immigration questions: laws, refugees, practical solutions for health problems, communication
A lecture on how cultural difference influences the disease panorama
A seminar on the situation of women and children in developing countries
A seminar on dermatology in immigrating groups and in dark skin
A seminar on socially and traditionally designated treatments for infection
A lecture on refugee children and trauma

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**Table 3** The received curriculum: student experience as reported in focus group interviews

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An article about cultural differences as part of the pre-clinical interview training
A medical ethics case and discussion about a patient with an immigrant background
A half-day symposium with small group discussion on the definitions of illness, disease and sickness and different models for understanding disease
A seminar on cultural rules about the deceased in transition from death to burial
A half-day symposium on immigration questions: laws, refugees, practical solutions for health problems, communication

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Students also talked about cultural competency as being 'integrated' into the rest of the medical curriculum. During the preclinical terms, students interview patients at a general practice and then meet to discuss their experiences in a small group format. They said that cultural competency could be discussed during this interview training:

'...if someone in the group had a different background or met a patient with another background than themselves.'

They also said that such discussions:

'...felt coincidental and depended on the group's and the tutor's interest.'

During the clinical terms, cultural competency was an 'occasional' component of many lectures, according to the students. Use of an interpreter and understanding of other religions were 2 topics they felt came up often in different learning environments, although not as independent subjects. In addition, students reported that during the entirety of both the gynaecology course and the public health course cultural competency:

'...wasn't represented by 1 specific lecture, but it came up all the time and got discussed depending on the teacher's or student's interest.'

Students felt that cultural competency was also 'integrated' into their practice in the clinical setting. This was because they had the opportunity to meet and interact with patients who came from different backgrounds to their own. Many students felt that they could learn about cultural competency by observing their tutor and:

'...sorting out what you think is good and bad about how they do it.'

They felt, however, that this kind of learning did depend on chance: which patients they met, how much time their tutor had for discussion, how interested the tutor was in discussion and the student's own interest in the subject.

Some students felt that the training they received during the medical programme was in itself adequate preparation for meeting patients from other cultures:

'One has learned about the role of the doctor during the medical programme, not about other cultures. We learn how to behave in a decent way towards all people, to be humble.'

Students said that they had not been examined in cultural competency. Although cultural competency could theoretically appear in 1 of their practical examinations, none of them had experienced this.

## Discussion

### Methods

The medical faculty's handbook *The Medical Programme 2001/2002* is the official sourcebook for what students are expected to know after each term, and therefore an appropriate source of official learning objectives. There is a risk that we may have missed identifying learning objectives that could include cultural competency even if not explicitly named.

We relied on term directors as having full responsibility for and supervision over the entire curriculum of a specific term, and trusted that they would refer us to individual lecturers if they felt uncertain about course content. All term directors were given the same preliminary information, asked the same questions and given the same amount of preparatory and interview time.

Focus groups have been shown to be an appropriate method to build an initial understanding about what kind of knowledge people have about a subject, what they think is important, and how they understand a problem.<sup>10</sup> Focus groups are also a good way to illuminate variation between individuals and groups.<sup>10</sup> The relatively low number of students interviewed in our study may have given a skewed picture of student experience. However, while the participants did report individual experiences, they were also accustomed to discussing the curriculum and relating what they heard from their fellow students. Questionnaires based on our initial focus group findings could add to our information about student experiences and outcomes.

In Sweden it is currently considered politically correct and desirable to be seen as culturally competent. This may have affected the results of our examination of all 3 curriculum perspectives. Such an effect would be difficult to measure but would probably increase reporting of the cultural competency curriculum.

### Results

We found cultural competency to exist in the curriculum at Lund University's medical school. However, the learning objectives, teacher intentions and student experiences gave 3 different pictures of what is taught and learned. Using triangulation between the 3 perspectives shows areas of convergence and incongruity.

#### *Learning objectives and teacher intention*

Of the 5 explicit learning objectives, 3 were met by specific teaching instances. The discrepancy we found

between learning objectives and teacher intention suggests a lack of communication between these 2 curriculum perspectives. There are many more instances of teaching that have to do with cultural competency than those reflected in the learning objectives, but some of the learning objectives are not reflected in the teaching. This means that there is no clear message on how the curriculum should handle cultural competency.

There were many learning objectives that did not mention cultural competency explicitly but which we thought had room for cultural competency discussions. In some cases teachers did not recognise these learning objectives as having potential for cultural competency teaching. It seems there is space in the planned curriculum for cultural competency, but that this is not always utilised.

#### *Teacher intention and student experience*

Students reported fewer experiences of cultural competency training than teachers did. This may be the practical result of students experiencing the curriculum only once while teachers work actively with the curriculum many times. This low reporting could also be related to the absence of assessment in cultural competency.

Both students and teachers felt that cultural competency is 'integrated' into the medical programme. The students' experience of cultural competency as integrated may reflect their exposure to the teaching instances that teachers reported. However, this experience seems to the students to be 'coincidental' and dependant on time and interest from both the student and the teacher.

Students and teachers were in agreement that cultural competency did not appear regularly in examinations but that it was theoretically possible for the subject to arise during the oral practical examinations.

#### *Student experience and learning objectives*

It is difficult to evaluate the type of relationship the student experience of cultural competency curriculum has with the learning objectives set out by the school. The planned curriculum does not give a clear message about what cultural competency is considered to consist of, but only defines individual learning objectives that fall into our category 'cultural competency.' Students do not report their experience of the cultural competency curriculum in the same language in which it is described in the learning objectives. Students speak of 'meeting' and 'being acquainted' with other religions and cultures and learning to use an interpreter. The language of the learning objectives is

concentrated on 'understanding' differences, 'adapting' behaviour to respond to them, and 'understanding' how differences can have meaning for a patient's health.

Some students identify being culturally competent as analogous to being a 'good doctor' who meets and responds to each patient as an individual, a skill they feel they have learned from the medical programme. This reflects a lack of articulation of cultural competency as a separate concept in the intended curriculum.

If cultural competency were assessed it would be possible to measure quantitatively to what extent students achieve the learning objectives. Similarly, interviews or questionnaires that ask students questions about their specific experience with the learning objectives might give more information.

## Conclusion

Cultural competency is not clearly defined in the planned curriculum and the subject is not thematically presented in the taught curriculum. Instead, cultural competency training is present but hidden, 'integrated' in an unstructured way that is described differently by teachers and students. Inclusion of cultural competency in specific educational environments depends on time and interest. There is no verification that all students leave the medical programme with adequate skills and the knowledge required to take care of patients regardless of their background.

Cultural competency is not the only possible 'hidden' subject in the medical curriculum. Other authors have pointed out the need for articulation and evaluation of such topics as communication skills, palliative care, professionalism and medical ethics in the medical school curriculum.<sup>12-16</sup> It may be that these topics, as well as cultural competency, are seen as outside of the body of legitimate 'scientific' knowledge which is considered critical to the student's education and which is examined. If these topics are not considered 'scientific', they are relegated to the arena of unscientific 'common sense', something the student already knows or will learn without extra emphasis in the course of his/her medical training experience. This perspective is problematic because when these topics are relegated to the arena of common sense they cannot be quantified, and evaluation of student skills in these areas is made impossible. In this study we have illustrated how such hidden material can be made legitimate in the curriculum of a specific medical programme. The introduction of a clearer and more broadly articulated definition of

cultural competency in the planned curriculum and expansion and utilisation of the resources already available in the taught curriculum could improve cultural competency training in the medical programme. When previously hidden elements of the curriculum are articulated, refined and defined, outcomes can be measured. Some form of assessment should be introduced.

This is the first study we know of where multiple perspectives are used to evaluate cultural competency curriculum in a medical programme. Goldie *et al.* demonstrated recently the effectiveness of methodological triangulation in a process evaluation of a medical ethics curriculum in a medical programme.<sup>16</sup> Fowell *et al.* used a multifaceted model similar to ours for describing the curriculum in relation to assessment.<sup>17</sup> Curriculum mapping has been advocated previously to 'make the curriculum more transparent to the stakeholders', and to 'demonstrate the links between different elements of the curriculum'.<sup>18</sup> Access to the student perspective on curriculum has been recognised as an important element in both curriculum evaluation and planning.<sup>19</sup> Other authors have discussed the importance of incorporating many perspectives into curriculum evaluation.<sup>20,21</sup> It has been recognised that performing a thorough evaluation of the curriculum can be 'formative', that is, that the evaluation can give direction in future curriculum development.<sup>22</sup>

This study shows that trusting a curriculum evaluation that is based on only 1 perspective can be misleading. Traditional evaluations that report only 1 curriculum perspective can be problematic because other interpretations or experiences of the curriculum are silenced. Using a system like ours, where multiple perspectives are investigated, allows for identification of inconsistencies and consistencies between perspectives. It allows us to ask how the curriculum works now and what we can do to improve it. While total congruency between all curriculum perspectives is unrealistic, it is possible to balance inconsistencies and develop the curriculum to make it more functional. Using this methodology to map the curriculum gives insight into what is taught and learned and gives direction for future development.

## Contributors

CW is a medical student at Lund University. She participated in planning the study, conducted and analysed the interviews and wrote the manuscript, MT is a senior lecturer at the Department of Community Medicine, Lund University. MT participated in

planning the study, analysed the interviews, and co-wrote the manuscript. Both authors approved the final version of the manuscript for publication.

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## Appendix 1

### Course director interviews: questions

- What is cultural competency?
- You have had time to examine the National Board of Health and Welfare's suggestions for inclusion of cultural competency in the medical curriculum. What do you think of the suggestions?
- Is cultural competency part of the curriculum of your course? In what way? How is the subject examined?
- Do you feel that cultural competency can be addressed in other ways in your course? How?



## Appendix 2

*Focus group interviews: questions.*

- What is cultural competency?
- What are your thoughts on cultural competency's place in the medical school education?
- Have you experienced cultural competency training during your time as a student here? What happened? Was it examined? What did you think about it?
- Do you feel prepared for your work as a doctor in regard to cultural competency?
- Do you feel that cultural competency training should be developed in any way? How?