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A CASE STUDY OF THE TREATMENT OF CULTURAL DIVERSITY IN MEDICAL EDUCATION

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by

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This dissertation is dedicated to the memory of my grandparents, Clarence Barnes and Dexter Scrivner, whose personal dignity and independence give honor to my Appalachian heritage, and to my parents, Ed and Wanda Barnes, who have inspired me to continue my education and to respect the values of all people, and to my wife, Carole, and daughter, Shannon Marie, for their love and encouragement.

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A CASE STUDY OF THE TREATMENT OF CULTURAL DIVERSITY IN MEDICAL EDUCATION

Abstract

The available research on the treatment of cultural diversity in medical education focuses on predoctoral curricular endeavors which assess communication between physicians and patients. Cultural differences addressed in medical education research feature socioeconomic distinctions between physicians and patients more than disparities of ethnic interactions. In the current literature, consideration of concepts of culture and multicultural influences relative to the training of medical students is minimal. Cultural differences are recognized in the course of instruction, but they are often presented as stereotypes and not as important treatment resource variables. The transition of medical students into physicians is optimally a process which dissipates ethnocentrism held by the majority. Cultural diversity in medical education is a varying phenomena affected as much by students' and faculty attitudes as exposure to cross cultural patient populations.

The status and consideration of cultural diversity in medical education at the present time raises key questions which are addressed in this study: What role does cultural diversity play in the teaching of medical students? How is cultural diversity manifested or constrained in medical education via curriculum or faculty attitudes? The purpose of this study is to describe the treatment of cultural diversity in the general curriculum of a representative medical school in the context of interaction between faculty/staff and students. The description constitutes a case study of how cultural diversity becomes incorporated into the required core curriculum and elective clinical training. It also reports on the degree of attention given cultural diversity in faculty-student discourse and advising at each level of medical education.

The methodological approach in this study is qualitative analysis utilizing ethnographic data gathering techniques of observation, participant observation, document collection and interviewing. A Likert-scale survey administered to the medical students provides quantitative data on their responses to issues of culture, Appalachian and African American health, socio-cultural barriers, and ethnic minority group access to health care. The data reflect the experience and beliefs of the study participants regarding cultural diversity in medical education. Suggestions are made for enhancement of cultural diversity in medical curricula and medical students' experiential learning.

CHAPTER I

INTRODUCTION

In 1984, a project panel of medical educators in affiliation with the American Association of Medical Colleges (AAMC) developed an instructional mandate for all medical students concerning knowledge, skills, values, and attitudes. Among the task forces was a Working Group on Personal Qualities, Values, and Attitudes, which determined that physicians should be dedicated to, sensitive to, and socially conscious of all patients regardless of ethnic or socioeconomic status (SES) (AAMC Monograph, 1986). The Working Group further recommended that medical student preparation in these areas should be accomplished through appropriate, multi-disciplinary role-modeling by faculty and ongoing exposure to cultural diversity. The quality of student interactions with ethnic minorities and underserved persons as patients was identified as a current shortcoming in medical education. The AAMC Report did not establish instructional guidelines for these objectives, nor did it specify how cultural differences and psychosocial aspects of medicine should be incorporated into students' academic or

experiential preparation.

The status and consideration of cultural diversity in medical education at present raises key questions which need to be addressed by medical schools:

What are the key concepts of culture in clinical medicine?

How do cultural differences among medical students affect the teaching of medical students and their cultivation of cultural sensitivity?

How is cultural diversity manifested or constrained in medical education via curriculum, faculty attitudes, student interactions, and environmental variables?

Are cultural differences and the ability to make "cultural assessments" in patient care recognized adequately and conveyed to medical students?

The University College of Medicine (UCM), a pseudonym, is an institution obliged to adhere to standards set by the AAMC since its inception, including recommendations made in

the 1986 AAMC Report. Both the faculty and the student body at the University College of Medicine reflect cultural diversity in that members of ethnic minority groups are present (i.e., African-American, Asian-American, Hispanic, Appalachian), and encounter and learn from similarly diverse patient groups.

The status and interaction of these groups is not succinct, although instances of both stereotyping and sensitivity are demonstrated regularly toward each group by faculty and students. The presence of minorities among the UCM faculty and students gives compelling significance to the AAMC recommendations for sensitivity to all ethnic populations.

University College of Medicine is located in a metropolitan area (Central City, a pseudonym) populated predominately by whites of European heritage, as well as two large minority groups, African-Americans and urban Appalachians. Members of these minority cultures also make up the largest portion of individuals who are without medical insurance and adequate access to the mainstream medical care systems nationally (Friedman, 1991) and in Central City (Handell, 1991). These individuals' incidence of health care problems and need health care at the

University Medical Center are unabated. Medical education at UCM in terms of didactic instruction is implemented under a standard that omits physicians' responsibility to include conceptual knowledge of culture and cognizance of their patients' ethnicity in health assessments. When the impact of cultural differences to the etiology of illness is addressed by the UCM faculty in non-clinical course instruction, the context is theoretical and without practical application to local ethnic populations. The UCM predoctoral curriculum is based primarily on the biomedical model of disease, wherein cultural diversity and other psychosocial aspects of illness and treatment are omitted. Students' acquisition of knowledge about treating local ethnic populations occurs through observation of culturally sensitive instructors. Students' own development of cultural sensitivity occurs at random through a variety of sources apart from the formal curriculum, but including faculty role models and mentors.

Teaching medical students at UCM through scientific, culturally-disassociated constructs of disease has been an theoretical antecedent at UCM. Conversely, elements for change in UCM student admissions criteria and curricula conducive to cultural diversity are identifiable, including

the school's attempts to admit larger numbers of minority students, increase the percentage of minority teaching faculty, and assessment of educational diversity in predoctoral instruction. The content and environment of UCM medical education entails a dichotomy of fundamental science, historical ethnocentrism, and growing awareness of cultural diversity in the demographics of students, faculty, and regional population. Reconciliation of these elements in UCM's program is viewed as a challenge to the future of this institution by the Dean's Office and a majority of faculty/policymakers.

Cultural Diversity in Medical Education at UCM

In 1989, the UCM Dean responded to the precedent AAMC Reports and Recommendations for improving medical education with respect to "personal qualities, values, and attitudes" by appointing a Task Force on Educational Diversity. The assigned mandate was to investigate both the sources and depth of focus given to cultural diversity in the UCM predoctoral curriculum. A review all pre-clinical courses for cultural content and references was conducted and course directors consulted over a six-months period.

In 1990, the Dean's Task Force on Educational Diversity

determined that cultural diversity awareness and teaching have been negligible. To address minimal focus on cultural diversity, the Task Force recommended development of a new course addressing multi-ethnic values. The thrust of the Task Force recommendations for increasing cultural diversity at UCM was based upon input and teaching of visiting lecturers representing key minority groups in Central City: African-American, Appalachian, Jewish, Russian, Slavic, and Asian-American. Contact persons deemed experts in the areas of cultural diversity addressed by the course were identified by the Task Force to aid design and implementation. All of the named cultural consultants were non-physicians except one, an African-American city director. The majority of consultants named were members of the University of Central City faculty or spokespersons from community ethnic enclaves. Each consulting ethnic group member was asked to serve as a resource to the UCM students and instructors beyond a formalized presentation of culture and medicine. To date, the preclinical course on cultural diversity has not been implemented.

Although no evaluations have been made as to the Task Force's utility and outcomes, this study will provide insight into its necessity and the broader treatment of

cultural diversity at UCM.

Research Focus

The purpose of this study is to describe the treatment of cultural diversity in the general curriculum at the University College of Medicine and in the context of interaction among medical students, with faculty and clinical preceptors, and with patients. This study examines how cultural diversity becomes incorporated into a required core curriculum and elective clinical training. It further reports on the degree of attention given cultural diversity in faculty-student discourse and individualized advising during each year of medical education. Interpretive emphasis is placed on the principle local patient populations, African-Americans and urban Appalachians, inclusive of students' awareness and faculty consideration of their respective cultures.

Much of the antithetical climate in medical education toward culture and medicine and lack of consideration of cultural diversity in predoctoral curricula has been influenced by clinical medicine authorities' view that these issues are avocational and extraneous (Bickel, 1981, Kleinman, Eisenberg, & Good, 1978). The omission of

culture-specific teaching of language and listening skills to medical students has been a factor of poor support of cultural diversity and faculty who espouse the role of culture and medicine by the teaching institutions (Stein, 1982). The traditional emphasis in the Year 1 and Year 2 predoctoral curriculum on pathophysiology without any training about or exposure to ethnic minority patients leads students to prioritize knowledge of diseases over culture and human values (Marcus and Marcus, 1988, Sue and Sue, 1981).

The neglect of medical education to address non-biological components in the physician-patient relationship is often manifested in physicians' misunderstanding and misdiagnosing of ethnic patients (Bickel, 1987). For example, in the case of African-American patients, the effects of racism may be so minimized and ignored by white physicians that the characteristics of stress, anger, and fear associated with their sociocultural milieu are diagnosed as pathological (Bell, et al., 1981). Appalachian patients' response to examination and treatment by impersonal physicians who generate language barriers will often be reticence, introversion, or stoicism. Based on this behavior, the

non-Appalachian physician may determine an Appalachian patient is somaticizing his physical problems and unable to care for himself. Ethnic patients whose slow or disoriented response to medical instructions due to poor physician communication may earns them a label of "non-compliance" (Plaut, 1988, Sue and Sue, 1981). In such cross-cultural medical encounters, the irony and error comes as the insensitive physician judges these patients' responses as "inappropriate" (West, 1992).

As chronic and SES-linked health problems of cardiovascular disease, drug abuse, and AIDS become more concentrated in ethnic and racial minority populations, physician-patient interactions which necessitate cultural understanding increase in proportion at clinical facilities throughout the country (Heckler, 1985). Too many physicians demonstrate that they are unprepared to cope with cultural issues which arise in medical encounters to patients' detriment (Bickel, 1987). There is a need for more preparatory medical courses which address the sociocultural and ethical dimensions of patient care. This component of medical education must be deemed crucial to clinical skills and professional competence of students as they become practitioners (Emanuel & Emanuel, 1992).

The information provided through this investigation of cultural diversity at UCM will contribute to future UCM students' heightened sensitivity to cultural differences and patient ethnicity. The generation of new questions and qualitative data on cultural diversity at UCM will enhance teaching faculty and staff responses to ethnic minority student cultural bearing and majority culture student awareness. African-American, and urban Appalachian patients encountered in the course of UCM students' clinical training will be better served through students' enhanced cultural awareness.

CHAPTER II

LITERATURE REVIEW

A review of the literature provides a fundamental understanding of culture and medicine. The integration of cultural diversity and issues of cross-cultural health care in medical education, however, is not broadly addressed. Since the mid-1980's with marked increases in the numbers of new immigrants in the U.S. and renewed attention toward indigenous ethnic populations, the deteriorating health status and rising mortality of ethnic minority populations have received broader consideration in the literature. However, a proportional emphasis on ethnic minority health and cultural issues is not evident in U.S. medical school curricula.

For purposes of this study and with regard to its setting, a review of the literature pertaining to Appalachian and African-American health and health behavior was also conducted. The primary parameters of the literature review include medical education, cultural

diversity in the practice of medicine, cross-cultural health care delivery, and health care issues facing Appalachians and African-Americans.

Medical Education and Cultural Diversity

A major survey of medical school deans and faculty by Bickel (1987) revealed that an excessive emphasis on teaching clinical medicine and practical therapeutic skills is creating an erosion of physicians' ability to examine their values in relation to those of patients, to communicate effectively with patients, and to show sensitivity toward cultural and social issues in patient care. As a consequence, medical students tend to apply their knowledge of disease toward people without realizing that potential failures may be associated foremost with their own behavior and not patients' lack of compliance. Moreover, the ways patients communicate with health care providers (e.g., physicians) depend a great deal on cultural contexts and the values which the patients hold. A dilemma arises when physicians responsible for the health care of patients from cultures different from their own are ignorant of patients' values or decline the need for interpersonal respect of patients' ethnicity.

Medical students who manifest ethnocentric perspectives in clinical interactions harm the ethnic patient as much as stereotyping, though it is more subtle (Byrd, 1990). For example, Kim (1983) has concluded that most students are drawn to medicine with a concern for socio-cultural values and global health issues which become secondary to idealized high technology four years later. When students perceive physicians' diagnostic and treatment focus are pathology-based and unconcerned with cultural and environmental factors related to the presenting illness, the patient is diminished.

A study of medical students' stereotypes of patients in clinical decision-making (Johnson et al., 1986) found that the students ascribed both positive and negative traits to patients on the basis of demographic characteristics--age, sex, ethnic heritage, socioeconomic status, and physical traits. The ability to formulate quick, accurate judgments about patients is typically stressed in medical education. Such expedience is an asset given the large amount of biomedical knowledge which must be considered. However, when students incorporated socio-cultural information contexts in the clinical decision-making, they demonstrated stereotypical judgments toward patients. Johnson and

colleagues (1986) concluded that medical students must be made aware of their ingrained stereotypes which likely influence their perceptions of patients and the nature of care given.

Brodsky's (1983) study on culture and disability behavior affirmed that cultural insensitivity in clinical settings is as injurious to ethnic minority patients as racial stereotyping occurring in the broader social milieu. For example, physicians encountering incapacitating psychological conditions in some Hispanic patients may not be willing to accept the possibility that "susto" or fright disease is a causative factor which goes beyond folk maladies. Their refusal to validate "susto" or ridicule the patients' desire to consult a "curandero"--traditional healer is offensive and divisive. Further, in response to physician advice to Southeast Asian mothers on post-natal care, instructions for hygiene of the birth canal would be refused by some based on their belief that chilling effects of water is injurious to the newborn. Physicians who show impatience with these culturally-rooted reactions invoke mistrust and resentment in their ethnic patients whether or not the rationale is understood. The study concluded that cross-cultural differences could be better managed by all

health professionals prior to their certification if the issues were integrated into predoctoral and experiential training.

According to Hendricson's (1988) survey of 144 U.S. medical school curriculum committees, the majority of medical students are indoctrinated on the need to understand different therapeutic approaches for patients based on variables of gender, age, familial health history, and pathologic symptoms. There has been much less emphasis on humanistic values in medical education (Bickel, 1987). Courses addressing non-biological components of the patient-physician relationship (e.g., culture, ethnicity and interpersonal dimensions of patient care) challenge the ethnocentric orientations medical students often bring from secondary and baccalaureate schools (Clark, 1983). At minimum, students ought to learn that quality clinical care cannot take place unless the care provider is prepared to deal with barriers of communication, power, and contextual understanding with patients who are culturally different. This suggests that medical schools must re-evaluate traditional criteria for a "comprehensively trained medical student" and even the standards of physician competence in a multi-cultural community (Brodsky, 1987; Muller, 1984).

Cross-cultural Health Care Delivery

Geertz, (1973) contends that the problem of cross-cultural barriers in medicine and other interactive situations originates in the providers' inability or unwillingness to view culturally different people outside of their own self-image. Marcus and Marcus (1988) maintain that neither medical schools nor physicians themselves can continue to uphold the role of "gatekeepers of health care" while they exhibit a dearth of cultural knowledge and sensitivity. There must be a broad rethinking of the concepts of cross-culturalism and ethnicity as they relate to the practice of medicine.

On a fundamental level, uni-dimensional, technological approaches to health care might be modified against the need for more cultural relativism or a mutual respect of values (Spradley and McCurdy, 1984). Patients who differ from physician caregivers by custom, color, ethnicity, or socio-economic status can no longer be seen or treated as exotic, difficult, or non-compliant when advice is not followed or is misunderstood.

The art of effective use of language and sensitive listening to patients' health beliefs is often considered peripherally in elective, non-clinical courses such as

Medical Ethics and Medical Interviewing in introductory medical school curricula. These courses are traditionally designed to teach basic decision-making and interviewing skills with minimal attention toward helping students understand patients and their experiences in illness (Mao, et al., 1988). Patient history-taking is a vital skill integral to the quality of care rendered in cross-cultural encounters. In traditional training regimens, medical students are expected to derive the nuances of physician-patient communication through didactic lecture or simulated patient contact (Coombs, 1988). When the instructional focus is on physician behavior, excepting attitudes and values expressed by patients, the contextual aspects of the encounter are diminished. With few exceptions among medical school Introduction to Clinical Medicine programs, appreciation of the patients' ethnic and cultural orientation are lost in the interest of didactics and expediency (Poulton, et al., 1986).

Students' appreciation of cultural sensitivity towards ethnic minority patients can be cultivated through physician role models, but exemplary physician conduct with patients occurs essentially on a one-to-one basis, not by replication in classroom sessions (Irby, et al., 1986) Faculty and

residents in clinical settings with students, fail as role models when they omit the psychosocial and noncognitive (cultural) dimensions of patients (Reichsman, et al., 1978). Medical students have the most to learn from direct demonstration of exemplary professional characteristics, in particular, showing respect, concern, and sensitivity to patients of all backgrounds and socio-economic status (Irby, et al, 1986).

For physicians to become more reflective in cross-cultural delivery of care as well as in their expectations of ethnic patients, more deliberate emphasis on issues of culture will be required before they leave from medical school. Kay (1987) notes that the ability to provide culturally sensitive health care is dependent upon students' early and consistent acknowledgment of cultural issues within the physician-patient relationship. In fact, the essential task of physicians treating patients from diverse ethnic minority groups is to determine the subtle point where culture and its manifestations end and clinical illness begins.

A small but increasing number of physicians involved with culturally diverse patient populations propose basic principles of practice as follows: 1) pursue understanding

of illness expressed in context of culture, 2) determine what kinds of treatment are considered by the patient to be appropriate and acceptable within his or her cultural framework, 3) determine what variations exist in patterns of family response to illness across ethnic groups, and 4) learn to recognize concepts of illness and health held by patients from different cultural backgrounds (Anderson, 1985). These principles, based on the experience of physician-patient cross-cultural encounters affirm that removing cultural and ethnic barriers to health care delivery should be part of the training of all medical students (Anderson, 1985).

Given this approach to preparing medical students for culturally diverse health care delivery, the question arises: how can medical students be trained most effectively?

In their prospective review of behavioral and cross-cultural medicine, Marcus and Marcus (1989) suggest that every opportunity for students to interact with ethnic and culturally diverse groups while they acquire clinical and practical skills should be pursued. It is not necessary

for physicians to become "impromptu medical anthropologists or cultural psychologists," but they must be willing to expose their students to new socio-cultural environments while "sharing the contexts of the experience." Student preceptorships with community-based physicians offer myriad opportunities for observation of competent and culturally sensitive clinical conduct. Thereafter, students should be given chances to meet and interact with patients on their own followed by constructive feedback from the clinical supervisor. Feedback is most effective when students understand the evaluative criteria and are prompted quickly and empathetically. As their acceptance of the physician preceptor grows and there are multiple occasions to observe respect treatment of ethnic patients, students tend to better instill desirable traits in themselves (Pierce, R. et al., 1967). This approach to engendering cultural sensitivity in medical training may be initiated in the classroom, but is more likely actualized in the field with culturally diverse patients, their families, and their communities (Anderson, 1985; Price, et al. 1988).

Learning about cross-cultural health care delivery in the preceptor physicians' office or clinic in a culturally diverse, underserved community is an alternative means of

bringing medical students face-to-face with ethnic minority patients. Their direct exposure may depend upon interviewing opportunities permitted by the preceptor and by the preceptor's own valuing of sensitivity toward his or her ethnic minority patients, though restrictive student apprenticing is the exception. Preceptor physicians are peremptorily screened by medical school departments which offer primary care training to students in the field. A carefully administered placement program will know preceptor physicians' patient populations in advance and thus will be capable of coordinating training with preceptors who focus on cross-cultural care delivery (Price, et al., 1988). Including the potential for association with a negative role-model preceptor, field-based training and patient encounters serve as a primary resource for students to discover the significant connection between culture and health care delivery (MacPherson, 1990).

Appalachian Health Care Issues

Health care disparities and group health status of Appalachians are closely linked with the socio-cultural context in which they live, both in their home region and in post-migration urban settings. Appalachians and their

health issues are considered in this study because they represent a principal ethnic population encountered as patients by UCM medical students and teaching faculty, the majority of whom are non-Appalachian.

The literature on Appalachian culture since the eighteenth century has deemed Appalachians responsible for their own poverty and educational shortcomings from inherited socio-cultural deficits (Branscome, 1974). The cultural disadvantages and negative qualities ascribed to Appalachians, called "the Appalachian Syndrome," includes their compromised health status and physical inferiority (Nyden, 1978). Despite the unwarranted victim-blaming in this perspective, Appalachians have, in fact, reflected a higher incidence of chronic disease ailments as compared with the majority, non-ethnic population (Friedl, 1983).

In his definitive ethnography of Appalachians and health, Friedl (1978) first observed that limited education has created a barrier in communication between Appalachian patients and health care providers. "Miscommunication detracts from the quality of care received, and in many cases alienates the patients completely from the health care system" (Friedl, 1978 at 65). An additional hindrance for Appalachian patients' access, treatment, and education is

frequently associated with language differences. Accent, colloquial vocabulary, and conceptual meaning are all cross-cultural variables which affect cognitive and symbolic understanding. Physicians and mental health professionals who make no attempt to overcome communication gaps both alienate, and fail their Appalachian patients (Beaver, 1986).

The fact of urban Appalachian patients' need to take more time in medical interviews is viewed as a problem by attending physicians and by hospitals who are inclined to serve the greatest number of people in the shortest time. The disinclination of physicians to conduct extended periods with Appalachian patients results in less time developing rapport and personalism, less time gaining familiarity with the patient's family, and less time spent risk-reducing self-care, all of which are important to Appalachians (Friedl, 1978, Helton, 1988). Oppenheimer and Oldendick (1988) determined that Appalachian migrants now residing in "port-of-entry" cities require more culture-conscious health care physicians knowledgeable in culture-specific language and willing to use simple medical terms or graphic aids when giving instructions.

Environment: A recent epidemiologic assessment of the health status of a predominantly Appalachian community in Central City determined that local industry pollution was associated with increased incidence in inflammatory, intestinal, and respiratory diseases in child residents. The data was obtained through correlation of Central City Children's Hospital patient admissions with residency in the specific exposed Appalachian neighborhoods (Central City Appalachian Council Task Force Study, (CCAC), 1990). The Task Force Study concluded that young Appalachian children growing up in the Lewistown neighborhood (pseudonym) were generally unhealthy and that many of their health problems are environmentally related. The CCAC study recommended that the Central City Health Department and area medical professionals take immediate action to treat local Appalachian residents with health problems, assist those individuals "at risk" for physical impairment, and investigate means to eliminate the pollution sources (Central City Appalachian Council Task Force Study, 1990).

Research studies dealing with Appalachian health issues are represented by the work of Watkins (1978) and Friedl (1978), who reviewed health practices of migrant populations in central midwestern city. The high degree of importance

rural Appalachians have traditionally given to home remedies, folk medical practices, and faith healing is often continued once the families relocate to the cities. Although the Appalachians observed by Watkins were aware of modern medicine, their access to it was hindered by bureaucratic and economic barriers.

Given Appalachians' inclination toward stoicism and independence (Mynatt, 1992; Jones, 1974), use of advanced medical procedures occurs more often in crisis situations. A conscious avoidance of institutional medical care and procedures by urban Appalachians is evidenced by their frequent presentations with late-stage disease, (cancer, diabetes, hypertension, Alzheimers), consequently "tolerating the morbidity of illness over submission to a culturally insensitive health care system" (Mynatt, 1992; Keefe, 1988). The efficacy of preventive measures is also complicated when Appalachian patients are confronted by impersonal, objective-oriented physicians, who think in terms of the future rather than the present, and offer no collaborative strategies or justification (McCoy, et al., 1989; Branscome, 1976).

Beliefs and values: Appalachian migrant families

interviewed by Friedl (1978) also encountered health care barriers despite being in an urban environment with ample resources. Fundamental differences in expectations between the Appalachian patients and city-based physicians created feelings of mistrust and fear, and typically led to poor clinical outcomes due to lack of patient compliance. For example, urban Appalachians as a regional ethnic people tend to exhibit traits of self-reliance, pride, familism, personalism, fatalism, respect for authority, and a belief that they will be treated patiently and courteously by physicians (Jones, 1979; Plaut, 1988). Alternatively, non-Appalachian physicians typically expect their urban Appalachian patients (as with all patients) to comply with clinical instructions and ask questions about details they don't understand (McCoy, et al., 1989).

Appalachians migrants' frustration with contemporary urban settings worsened, as Stekert (1971) observed, when confronted with negative stereotypes held by from physicians. Health status within the majority of 106 families studied was compromised as a result of cultural alienation. Culture-specific beliefs and values were uniformly ignored or discounted by attending physicians more intent on the expediency of the clinical visit (Stekert,

1978).

Keefe (1988) and Plaut (1988) both observed that rural Appalachians' mental health problems have been ignored or poorly managed due to cultural insensitivity and ethnocentrism among medical providers. Looff, (1977), a physician experienced in the care of rural and urban Appalachians, has confirmed that their cultural values and lifestyles steeped in familism, fatalism, stoicism in manner and speech, and "self"-orientation act to cut them off from practitioners outside from the culture.

Appalachians acquire illness and manifest symptoms of illness in different ways than urban physicians and mental health specialists expect. Members of the culture who complain of "nerves" may in actuality, refer to a host of serious mental health problems such as conversion reactions, hysterical personality disorder, and not merely simple anxiety (Feine, 1988, citing Looff). Appalachian women who express the need to protect their male children even as adults, have been labeled as pathogenic (Looff, 1977). Mental and emotional problems in Appalachian patients presenting as physical maladies may be easily misdiagnosed and treated as such due to the traditional medical model which prioritizes a "cure" over preemptive counseling

therapy (West, 1990).

Keefe's (1988) study of Appalachians' mental health problems was generated out of recognition that their cultural conception about causes and symptoms of physical pathology matched the ambivalence shown toward mental illness. Given the "ethic of neutrality" within Appalachians' response to mental illness, concepts of mental health used by mainstream medical professionals differ to the extent that communication gaps prevent effective treatment (Hicks, 1976). By this interpretation of Appalachian values, the "ethic of neutrality" has four restrictions: a) one must mind one's own business, b) one must not be assertive, c) one must avoid authority over others, and d) one must avoid argument and seek agreement (Hicks, 1976). Crisis intervention attempted by mainstream mental health professionals may be ineffective due to Appalachians' expectations that their emotional problems can be addressed concurrently with interrelated physical and socioeconomic problems (Looff, 1971).

Plaut's (1988) qualitative observations of Appalachians in medical encounters held that non-Appalachian health care providers must be sensitive to their own perceptions of health and illness and all interventions given. Assessment

of Appalachian clients which is not family-oriented and attentive to cultural characteristics of self-sufficiency, religion, and personalism conflicts with their observed and expressed beliefs and values (Feine, 1988). Denial or ignorance of the Appalachian cultural value foundation is detrimental to the development of their trust toward physicians and mental health professionals (Cole, 1988). To implement an appropriate therapeutic approach, there should be initial determination of the client's familial relationship and each member's understanding of the illness. The impaired physical and emotional status of either parent or a single child, or grandparents or extended kin involves each member in support and emotional solidarity (Keefe, 1988). Although attitudes of stoicism and fatalism may influence the Appalachian patient's recovery, that individual's family participation in the treatment process can be facilitative and a focal point for physician-patient collaboration (Friedl, 1978; Stekert, 1971). The establishment of trust and respect for the family unit are at the core of therapeutic interventions with Appalachians by physicians as well as the elimination of cultural misperceptions (Plaut, 1988; Looff, 1977).

Harper (1984) contends that urban Appalachian families

may not relate well to theoretical explanations of treatment and find concepts of preventive medical care especially difficult to accept. Health-oriented decision-making with a long-term goal of prevention is not traditionally recognized or practiced by urban Appalachians in Central City and other port-of-entry cities for Appalachian migrants (Oppenheimer, 1988), yet many urban Appalachians more readily rely on tonics and elixirs of their own formulation for purposes of wellness or health maintenance--often referred as "keeping 'right' with myself" (Mynatt, 1992). In actuality, they are ingesting liquids with medicinal quality for purposes of wellness. A description of the practice to a culturally uninformed health care provider will have no meaning (Mynatt, 1992; Helton, 1990).

Handell (1988) and Younger (1988) have proposed that the bureaucratic and procedural complexities of urban hospitals and health clinics manifest an impersonal and culturally insensitive front toward ethnic minority patients and families. For lower SES Appalachians in Central City needing health care, an encounter with impersonal hospital staff thrusting forms and demanding financial data is intimidating (Helton, 1988). The likelihood that the Appalachian patient or family will deal with facility staff

member who knows or cares about their ethnic orientation will be minimal (Barnes, 1990). The Central City health care delivery posture and structure has consequently hindered both access and continuity of care for Appalachian in need of immediate medical treatment.

Plaut (1988) has suggested that short-term interventions and rapid response by physicians could enhance Appalachians' views of the health care system, but that individual care providers will have to "earn the respect of their Appalachian patients" with each case. Physicians' frequent affirmative feedback which recognizes patients' progress and family cooperation has a motivating effect on Appalachians' health care compliance because it affirms and validates the role of family. The Appalachian patient, family members and physician who function in concert for the patient's recovery support each other's legitimacy and identity (Dillard, 1983; Friedl, 1983).

Practices and behavior: The literature on health problems of urban Appalachians and their accessibility to health care is minimal. According to Oppenheimer's (1988) demographic study of urban Appalachians, their probable actions and behavior toward reducing major health risks are

distinct from those of the non-Appalachian white population. Based on self-report and observation, the principal diseases and hazards which stimulate Appalachians' toward self-care, are respiratory disease, heart disease, accidental injury. Given Appalachians' heritage of labor in the agriculture, coal-mining, and lumber industries, it is a congruent clinical finding that their heart disease and accidental injury rates exceed that of those of non-Appalachian whites and blacks. The rates of lung and oral carcinoma among Appalachians are elevated compared with other cancer sites indicating strong association with their tradition of tobacco use. Appalachians' attempts to reduce cancer risk through smoking cessation are rare (UCM Tumor Registry Report, 1988; Friedl, 1978).

Appalachians tend to be silent about health issues which are sexual in nature and will pointedly refrain from approaching a physician or asking for medical advice despite an existing problem. McCoy and Watkins (1981) note that in deference to the rich tradition of folk medicine practiced by their mountain kin, urban Appalachians will actively prepare and consume home remedies to treat most ailments, including sexual dysfunction, sexually transmitted disease, burns, depression, and insomnia. As the course of more

conventional treatment by physicians is effective, McCoy and Watkins (1989) advise that the patient, family members, and those who know the patient may be persuaded with due respect to omit any remedies which do not work.

In spite of Appalachians' exposure to health information (e.g., nutrition and blood pressure monitoring) in many urban settings, recent ethnographic studies of migrated Appalachians (Helton, 1988; Barnes, 1990) indicated that preferred food choices are high in fat, salt, meat, and caffeine and that motivation to lower blood pressure was nil if it required lifestyle changes. Even Appalachian residents at high risk for chronic ailments such as heart disease and diabetes are reluctant to follow preventive steps or seek assistance from health care systems until an emergency arises (Davidson, 1991; Friedl, 1983).

African-American Health Care Issues

A review of the literature on African-American cultural characteristics relating to health outcomes or relationships with the health-care system shows two recent comprehensive studies (Greenburg, 1990; Manton, et al., 1989). Both reports point out that the mainstream medical profession continues to exclude blacks and poor Americans as patients

and peers and continues to support patterns of institutional racism and class bias. A legacy of cultural misinterpretation and misunderstanding on the part of professional health care providers--including physicians has been a primary detriment to African-American health status (Manton, et al., 1989; Willis, 1989; Byrd, 1990).

Attempts to rectify the declining health index for metropolitan-based African-Americans have been made by the city health departments in alliance with "role-model" African-American physicians (Handell, 1987; Minority Health Care Intervention Programs Report, 1987). In each case, an imperative for successful health care interventions has been "culturally sensitive" communication on the part of physicians and other health care providers. This element has been found uniformly lacking in physician-patient relationships occurring at all public health care facilities in Central City (Younger, 1989; Oppenheimer, 1990).

African-Americans have experienced the worst health history of any ethnic group in the United States (Health and Human Services Report on Black and Minority Health, 1988; Byrd, 1990). The health prognosis for African-Americans on fifteen leading causes of death falls below the same indicators for whites. Many of these deaths are preventable

with known, basic, cost-effective medical treatments. African-Americans and their health issues are considered in this study because they represent a principle ethnic population encountered as patients by UCM medical students and teaching faculty, of whom the majority are Caucasian.

Environment: A comparison of African-Americans and whites of on the critical health index, longevity, reveals five to seven fewer years of life expectancy for African-Americans than for whites (Health and Human Services Report on Black and Community Health, 1988). Health statistics for African-American residents of Central City follow the national trends in most morbidity and mortality categories--heart disease, cancer, respiratory disease, diabetes, hypertension, stroke, low birthweight infants, nephritis, and toxic lead levels (Central City Health Department Report, 1987). According to a health risk survey by the University of Central City Institute for Policy Research, African-Americans residing in greater Central City are at higher risk for being overweight and less likely to use seatbelts. The survey also found that all persons with minimal education and low family incomes were at higher risk levels for chronic diseases than those with college training

and above average incomes (Bishop, 1986).

Hitchcock (1991) reviewed Health Risk Appraisal surveys taken by 153 African-American and white volunteer patients at Central City Health Department clinics and found significant differences in health risk predictors as follows: African-American subjects reported consuming more alcohol, smoking more pipes, and using seat belts less. Hitchcock qualified her findings, stating: (1) assessment of health risk of African-Americans and whites should reflect the customs and values of each group, (2) predictors for African-Americans and whites differed and therefore each population should be approached differently for health care, and (3) poor socioeconomic status of African-Americans and whites was the strongest consistent predictor of higher health risk status. There is no documentation that African-Americans' poorer health outcomes are determined by inadequate health knowledge or non-compliance with medical advice, rather, disparities in health care delivery to African-Americans are increasingly associated with underlying socio-economic factors (Boyce, 1991; Weddington and Gabel, 1991).

Review of national health statistics reports (National Institutes of Health Report on Black and Minority Health,

1988), reaffirms that African-Americans have experienced the worst health history of any ethnic group in the United States. The health prognosis for African-Americans on fifteen leading causes of death falls below the same indicators for whites (U.S. Department of Health and Human Services, 1987). Many of these deaths are preventable with known, basic, cost-effective medical interventions (American Cancer Society Monograph, 1986; Wagner, et al. 1982).

Byrd (1990) stresses that African-Americans are segregated, demographically, economically, and socially, primarily within our nation's economically-depressed inner cities. African-Americans have endured generations of sub-standard health care, restricted preventive health opportunities, and alienation from a majority culture and class-based medical care system. Given that physicians are at the core of medical care delivery, their authority and example must assume much of the liability for the African-American health crisis (Andreopoulos, 1974). There is evidence that physicians are part of an environment that has contributed to some aspects of African-Americans' ill-health.

Price and colleagues, (1988) determined that primary care resident physicians' perceptions of poor patients presumed

they were ethnic, minority members and predominately African-American. Urban-based physicians further perceived African-Americans as more likely to comprise a greater portion of urban poor, because they encountered more poor patients who were African-American (Rodgers and Weiher, 1986). In fact, African-Americans comprise only one quarter of the population below the poverty level compared with whites, but because some physicians tend to equate them ethnically with low economic status, the nature and quality of their health care is affected (Price, et al, 1988). Specifically, primary care resident physicians reported that they considered poor patients to be less motivated to engage in preventive health behavior, poor patients were usually non-compliant, and poor patients cared less about their own health status. In analysis of the Price study, Roter (1988) proposed that "real" physicians are much like the rest of us in their general prejudices and stereotypes of poor and ethnic, minority patients. Because of physicians' misperceptions, African-Americans do, in fact, receive a different, usually lower quality of care than whites.

Klag's (1991) findings on hypertension in African-American males and females suggest that blood pressure elevation from stress of living with racial

discrimination could be equivalent to biological predisposition factors. Murray (1991) concurs that disadvantaged socio-economic status may be indicated as a marker of African-Americans at risk for developing hypertension, particularly those individuals with low self-esteem and those who felt that they had less control over their lives. He notes that African-Americans' genetic predisposition is important, but that environmental factors may still play the pivotal role for the expression of hypertension.

Beliefs and values: Younger (1988), a metropolitan area minority health specialist, noted results of a Health Department Health Risk Survey targeting African-Americans in Central City revealed 66% of the respondents were very concerned about their overall health, 60% were very concerned about getting cancer, 50% expressed a fear of heart attacks, and 47% believe they were vulnerable to serious injury or potentially fatal accident. Overall, half of the African-Americans providing feedback to the Central City Health Risk Survey felt that their health was fair or poor. A subsequent telephone survey of African-American residents in Harris County (a pseudonym), surrounding

Central City, showed that respondents identified themselves at above-average health risk and living a sedentary life-style (Handell, 1988).

In collaboration with the Central City Health Department, the Central City Black Community Forum's proposed efforts to intervene among the African-American population have incorporated teaching specific health skills. Most of the designated skills are correlated with reducing residents' risk for cardiovascular disease, cancer, and accidental injuries, the three highest causes of mortality in African-Americans (Boring, et al., 1992). This strategy was developed to encourage a greater degree of self-care among the African-American population which has shown a tendency to delay seeking medical attention, in particular preventive health information, believing it to be unnecessary in the absence of serious, noticeable health problems.

Jackson (1992) and Hitchcock (1992) have described this value system as "reactive medicine." Both investigators point to the Health Belief Model, notably that individuals' will weigh the costs of seeking health care prior to action, as an explanatory framework for "reactive medicine." Moreover, they contend the posture is consistent across low SES ethnic minorities, not solely African-Americans, because

it is driven by poverty and lack of education (Jackson, 1992; Hitchcock; 1992). Increasing cumulative evidence about the causes of heart disease and cancer, also support the view that cultural and economic factors are more related to African-Americans' inhibitive health beliefs and associated morbidity and mortality, than inherent ethnic or racial characteristics (Boring, et al., 1992).

Practices and behavior: Handell (1987), associate director of a major metropolitan health department, has attempted to raise awareness in the African-American community about specific health hazards which are known to be elevated in this population and known to be preventable. For example, morbidity and mortality from lung, colon, and prostate cancer in black males can be reduced if high-risk individuals are alert for physiological warning signs in their bodies and if they have regular medical check-ups (National Institute of Health Monograph, 86-2785). African-American women over 50 have shown a marked increase in heart disease and breast cancer which can be reduced through minimal lifestyle changes, such as lowering dietary fat and salt intake and eliminating cigarette smoking (National Cancer Institute Report on Cancer in Black

Americans, 1987-88).

In large urban ghettos, Reynolds (1992) argues that most African-American residents would not seek emergency medical treatment unless they were "ten dollars sick." The phrase means that a person has to be sufficiently ill to pay the $10 taxi fare or face several hours of bus travel to a county hospital. As distance increases, African-Americans' use of health services tends to decrease. For low SES African-Americans, avoidance of the health care system is complicated by the economic deprivation, but lack of awareness of the necessity for seeking physician advice on preventive care, prenatal care, and risk reducing measures also affects their potential for self care (Manton, 1989).

The average U.S. physician ratio is 1 to 500, but for African-Americans in urban ghettos it is about 1 to 4,000 (U.S. Department of Health and Human Services, 1987). If an African-American patient is motivated enough to seek out a physician, they will more likely reject that relationship when it reflects the physicians' insensitivity about African-Americans' health concerns (Jackson, 1992; Handell, 1987). Many African-Americans who do not anticipate a racial double standard on the part of non-ethnic physicians may be permanently alienated from the health care system

when the encounter reflects miscommunication, misunderstanding, tension, and stereotyping (Younger, 1989; Kleinman, 1991). African-American patients who encounter evaluative messages from physicians about their health status and health behavior which are not culture-specific will be negatively influenced and likely refuse to adopt health behavior changes suggested therein. Physician health care advice is also less likely to be heeded when economic feasibility is ignored (Dewey, 1984).

There is little surprise that lower SES African-Americans facing Medicaid non-eligibility and poor health care access turn to their own communities and churches for help (Levin, 1984). In cases of African-American health maintenance (i.e., modifying health behavior, learning preventive lifestyle, risk reduction), both men and women often exhibit tendencies toward self-care and a desire to deal with health problems independent of physicians and professionals, including providers with common ethnic heritage (Manton, et al., 1989).

Boyce (1991) advocates more emphasis upon health education programs in African-American communities which teach and motivate high risk individuals to take control of health issues and make changes in their daily lives.

However, health care interventions targeting African-Americans will not be wholly effective until there is a better understanding of the respective cultural identities of patients and care providers. An honest contemplation of behaviors and communication between patient and care provider could end stereotyping and improve rapport, compliance, and mutual responsibility in the community as well as in physicians' offices.

The implications of cultural relativism between physicians and African-Americans and other ethnic groups are significant given the physicians' reported beliefs that ethnic patients cannot be persuaded by anyone to practice preventive health behaviors. Moreover, physicians contend, cross-cultural behavior modification is not a skill they were accountable for in their medical education (Price, 1988). Roter (1988) found minimal evidence that ethnic patients, including African-Americans, are uninterested in their health or that they are less capable of following medical advice than whites or higher socio-economic classes. Poor health outcomes for African-Americans, therefore, may be more causally related to care-providers' negative attitudes in the medical encounter than the African-Americans' own specific health behavior.

In summary, how physicians learn to appreciate and act upon cultural differences may be best understood through examination of their academic and experiential preparation. Although cultural diversity in professional medical practice has been examined (Rabinowitz; 1983; Haynes, et al., 1985), there have been no qualitative studies yet published focusing on the treatment of cultural diversity within a medical school environment and as a component of training medical students. The significance of this study is found within its focus on the cultural patterns of a medical school, the presence or absence of cultural diversity in a representative curriculum, and those factors within the comprehensive academic and social setting which affect cultural diversity.

CHAPTER III

METHODOLOGY

The purpose of this study was to describe the treatment of cultural diversity in the setting of a midwestern medical school as it occurs through interaction and behavior of students and faculty, as well as its presence or absence as manifested in the curriculum, teaching, and administrative functions of the medical school. The students' responses to cultural differences and ethnicity were also assessed among themselves and in two special patient populations.

Research Model

This study was an ethnographic investigation using a qualitative, naturalistic methodology. A survey instrument was also used to describe medical students' attitudes about culture and medicine, ethnicity, and specific ethnic patient populations in Central City. Ethnography is a qualitative research method which acquires descriptive data for interpretation of individual or group behavior, social

settings, and culture-specific interaction. Actions and beliefs of the study population were interpreted in order that a non-observer, non-participant may understand what happens with individuals and groups with regard to cultural diversity and how they respond to its presence or treatment. To initiate the ethnographic report, no hypothesis is proposed for subsequent verification through acquired data. Meaning is ascribed to the study data based on researcher experience in the setting and knowledge of the study population. The accumulation and interpretation of descriptive data are essential qualitative methods which improve our understanding of locales, processes and behavior (Dobbert, 1984; Bogdan and Biklen, 1982).

Ethnographic research permits analysis of cultural patterns (edic data) and cultural meaning (emic data). Qualitative research methodology in medical education was guided by the researcher's questions in this study as follows:

(1) How are concepts of culture in medicine and health care delivery treated with emphasis upon cultural differences of ethnic minority populations?

(2) How is cultural diversity treated in medical education with respect to students, faculty, patients, curriculum, and environment?

Ethnographic research ethics require the researcher to maintain the confidentiality of the setting and participants in all field notes, written and audio-visual records. The name of the institution which is the setting for this study has been kept anonymous in respect of the discretionary interests of the study population and the setting. Generic reference to the institution was University College of Medicine, based in Central City, (pseudonym), located in a central midwestern state.

Participation in this study by individuals from the study setting was completely voluntary and participants were free to withdraw at any time. Participants were assured of complete confidentiality in the use of all field notes, reports and audiotapes. All individuals volunteering to be part of this study were asked to sign an informed consent form (Appendix A). Informed consent forms were designed and provided to study participants in accordance with standards set forth for the study of human subjects by the University Medical Center Institutional Review Board (Appendix B).

This study did not involve administering a treatment to students or faculty of the University College of Medicine. It was understood by participants that the results of their participation, including personal statements or insights, may be published for scientific purposes providing that no identities are revealed. Study participants were not rewarded nor placed at any risk for their participation. A separate research proposal was submitted to the University Medical Center Institutional Review Board for determination and regulation of any treatments of human subjects (Appendix B).

The Researcher

Study was conducted by a Masters-degreed medical educator working in the field of medical education for ten years. For a period of three years, the researcher has worked actively in secondary and higher education, both as a teacher and an advisor to a multi-cultural student body. In conduct of community-agency and health program liaison responsibilities in the Central City area, this researcher has worked with and advocated on behalf of the two significant ethnic minority groups in the city, Appalachians and African-Americans. In addition to living in Central

City for over twenty-five years, the researcher is also a first generation son of Appalachian-born parents.

Given these personal dimensions in the researcher's background and current employment, special attention was given to the avoidance of bias in the collection and analysis of data. Ethnographers are bound to a code of ethical and objective conduct in research as all quantitative and scientific studies are similarly guided. Ethnographers, including this researcher, are obliged to maintain an objective naivete regarding observed phenomena regardless of their perceived relevance to the research study (Spradley and McCurdy, 1982). This obligation was duly acknowledged by the researcher in the present study.

Some participants in the study were identified through engagement with the researcher's routine as a departmental faculty instructor. This formalized status in the setting facilitated broad access and observation of activities such as teaching, advising, supervision of students, and socialization with both students and faculty. Over a nine-month period of partial immersion with the study population, the researcher's acceptance was more intimately established in the setting. The granting of "insider" status by students enabled the researcher greater opportunities for

participant-observation and key informant revelations about activities previously observed but without a complete context for interpretation.

The researcher took the role of participant-observer including taking part in daily activities in the setting, then reconstructing impressions from field notes taken during or shortly after observations. Unstructured observation was also conducted by the researcher as opportunities arose in order to gather data on informal discussions of cultural diversity between students and faculty, among students, and among faculty.

Research Population

Study participants and informants were selected from enrollees in a representative mid-western medical school (UCM) with four academic class years. The medical students interviewed or observed in the study comprised an overall student body of >600 and originated from the Midwest region, predominately from the home state of Central City, which is (Midwestern state). The students in the study setting were predominately white, male, between ages of 22-32, and of middle class socioeconomic status. Students involved in the study as interviewees represented both genders, multiple

ages, and every ethnic group present at UCM. Students who were observed or engaged (participation) by the researcher, were randomly selected. Approximately 24 students from each year volunteered for non-standard interviews, representing about 6 per cent of the class.

Teaching faculty, physician preceptors and staff were also involved in the study, representing both genders, different age groups, ethnic differences, and sociopolitical status as available. Faculty members at UCM numbered about >800, primary care preceptors numbered >450, and staff numbered nearly >300. A total of 7 physician faculty members, 5 non-clinical faculty members, 3 preceptors and 4 staff members were given standardized interviews. Faculty and staff participants interviewed by the researcher included departmental colleagues and other UCM personnel involved in teaching, advising, and curriculum development. Preceptors included private community-based physicians who serve as volunteer instructors to UCM students. Active preceptors work with 3rd-Year and 4th-Year students in their offices or work settings on a monthly or bimonthly schedule. They represent multiple disciplines with primary care components, including Family Medicine, Pediatrics, Internal Medicine, and Emergency Medicine. Faculty and staff members

and were randomly observed in the medical school building, classrooms, and clinical care settings. Preceptors and students were observed informally in community offices with and without patients present, but with specifically pre-arranged permission.

The number of study participants, interviewees and survey respondents in the study was determined by time restraints and practical access of the researcher. Based on the study's designation of the UCM students as the principal population, the researcher spent a greater amount of time with them than other faculty or staff for data gathering purposes. In order to obtain quantifiable response data from the students, a sample of respondents was randomly polled by survey [n = 114], representing >18% of student body at UCM.

Strategic primary groups of students were found within each medical school class and delineated as student clusters, study groups, and organizations for purposes of analysis. Less formal subgroups of students or students with faculty in the setting were identified and described as they were encountered by the researcher. The significance of identified primary groups in relation to cultural diversity in the setting was analyzed against key informant

data and observations of individuals. None of the naturally-occurring subgroups or social clusters was known in advance of the researcher's entree into the field. The researcher developed relationships with student groups and key informants spontaneously once they were identified.

Crucial participants in the study, as in most qualitative research, were the key informants. These individuals were selected according to their knowledge of the setting and the population, their agreement to frequent, unrestricted interaction with the researcher. Key informants tend to be the most insightful and revealing data sources in qualitative studies because of their membership in the study group and involvement with events, patterns, terminology and cultural values exhibited in the setting.

Though researchers often give implicit trust in the legitimacy of key informant information, their key informants' reports and confidences are triangulated against one or more alternate data sources to establish accuracy. This cross-check was implemented in the present study.

Data Collection

The initial phase of data gathering took the form of

standardized interviews (Appendix C) conducted with key medical school administrators and faculty who aided in directing inquiry into cultural diversity and medical education at UCM. The interview questions were designed to explore concepts of culture, cultural diversity at UCM, attitudes and values of UCM students toward ethnicity, and the relevance of cultural sensitivity in treating ethnic minority populations. Concurrent identification of informants occurred through collection of documents from curriculum development and evaluation committees--composed of interdisciplinary faculty at UCM serving by request of the UCM Dean. The standardized interviews were conducted as the faculty and staff members were accessible and followed and identical format and question sequence (Dobbert, 1984).

A second phase of data gathering was devoted to student participants' opinions about culture and medicine and their perceptions of cultural diversity at UCM. Non-standardized interviews were arranged at the convenience of participants and on an impromptu basis as contact was made in the study setting. Participants were asked a broad range of questions limited only by their willingness to reveal personal insights to the researcher. Duration of each interview was contingent upon their reactions, sensitivity, and knowledge

of peers' culture and posture (Dobbert, 1984).

The third phase of data-gathering was direct observation of students and faculty, guided by the researcher's cumulative knowledge of those settings, times, and events most likely to provide experiences of cultural diversity. These settings included classrooms, student-faculty and student-preceptor meetings, student organization events, and other UCM instructional activities. Data-gathering focused on documentation of cultural diversity and the cultures of primary ethnic patient populations, specifically: Appalachians and African-Americans. However, because the nature of qualitative case study analysis is recursive, decisions regarding the research process evolved as the researcher became acquainted with the setting and participants.

Quantitative data collection took the form of a 5-point Likert-scale survey instrument (Appendix D) to ascertain medical students' understanding of cultural diversity and their experiential exposure to ethnic minority populations. The 15-item instrument was administered randomly to 100 members of each of the four classes (total enrollment = >600) at the completion of standardized interviewing.

Statistical sampling via survey of the UCM students was

appropriate in this study for the following reasons: (1) the population had identifiable characteristics and boundaries; (2) generalizability of the population was a salient objective; (3) the population was not composed of discrete subsets and its characteristics were evenly distributed among the members; and (4) the researcher had access to the whole population sampled (Dobbert, 1984; Goetz and LeCompte, 1984). A systematic application of the selection procedures enhanced comparability of the study and provided a partial basis for inferring similarities and differences among subsets of the population. The sampling was also probabilistic in the sense that it extracted a representative subset for the study from a well defined population.

Four primary descriptors were included in the instrument to obtain an accurate demographic profile of the survey sample, including: (a) gender, (b) ethnicity, (c) class year, (d) exposure to ethnic groups other than own. Institutional records from the UCM Registrar (Appendix E/Document 3) were examined for a school-wide demographic profile.

The survey posed questions pertinent to culture, Appalachian and African-American health issues, cultural

barriers, ethnic minority groups' access to health care, and physician-patient cross-cultural communication. Three cohorts of five questions were prepared variably reflecting a positive perception of culture and medicine, a negative perception of culture and medicine, or a neutral perception of culture and medicine. The coded questions were posed in random order on the instrument and evaluated statistically using the Chi Square formula to determine significance and trend of student responses.

As a means to diminish the "favored-response" phenomenon (i.e., respondents' contrived choice of answers deemed most favorable by the researcher), six additional short-answer questions were posed as an addendum to measure students' cognitive knowledge of Appalachian and African-American culture and behavior. Students were advised that these "addendum" questions were optional and that all answers would be kept confidential by the researcher. The survey instrument was intended to supplement the primary sources of qualitative data and to facilitate multiple-source triangulation of the data from interviewing and observation. Specifically, the 15 survey items which dealt with treatment of cultural diversity in the context of medical training were triangulated (Duffy, 1986; Bogdan and Biklen, 1982).

Data Analysis

Data analysis was a continuous process from the time of the first collection of documents and the initial interviewing phase. Analysis of the study data focused on the identification of major elements of cultural diversity in the context of medical education as they exist and are perceived by the study population at UCM. Field notes and audiotapes of standard and non-standard interviews were analyzed for themes and codes of differentiated meaning.

Triangulation of data for accuracy was conducted through multiple-source comparison, evaluation of trustworthiness of informant relationships, and validation of documentation. The extent to which bias can be removed from a study, i.e., confidence, is increased by a cross-check with independent sources of information and various collection techniques utilized by the investigator (observations, participant-observation, interviews, and documents) during the data-gathering phase.

Through a synthesis-analysis approach guided by the study questions and objectives, a unified description of cultural diversity as a phenomenon in medical education was derived. The summation of data components in qualitative research incorporates the experience and beliefs of the study

participants (Parse, Coyne, and Smith, 1983). Conclusions made in this study through analysis of the data components did not necessarily reflect participants' experience or beliefs.

CHAPTER IV

THE UCM CULTURAL EXPERIENCE: NAVIGATING THROUGH PLACE, PEERS, PEDAGOGY, AND PATIENTS

The purpose of the study was to examine the role of cultural diversity in the process of educating medical students. Principal emerging themes about the institution, its students, faculty, and the patient population, and curriculum offer insight into the cultural experience of studying medicine at the University College of Medicine (UCM). This chapter is intended to provide a description the UCM milieu, cultural patterns and phenomena as experienced by the UCM students, the primary study population.

First, an overview of UCM is presented including descriptions of its physical structure and features, mission and goals, administration, and student services. These data are followed by a description of the undergraduate medical students. UCM faculty, support staff, and ethnic minority patients whom students encounter directly in the course of

training will also be profiled. A third component of the chapter reports on the UCM curriculum and teaching with emphasis on courses and content open to discussion of cultural diversity. Finally, social organization and cultural patterns observed at UCM are identified, including students' cross-cultural, inter-ethnic relationships and activities among themselves, with faculty, with UCM staff and with patients.

Treatment of cultural diversity at UCM from the students' perspective can be described by analogy to a map having a starting point in the first year of the predoctoral curriculum. From that origin, the directional course students pursue by random encounters with faculty, staff, and patients, by required coursework and elective choices and by selective socialization with peers, will influence their experience with cultural diversity.

A description of the UCM setting in terms of physical features and institutional policy will permit a recognition of the internal and external influences which drive of repress the treatment of cultural diversity centered upon the UCM students. A profile of the population in the UCM environment, including the students, the faculty and the staff will elucidate which individuals play significant

roles in fostering appreciation of the culture and medicine education relationship. A discussion of the UCM curriculum and medical education in each academic year will illustrate a major aspect of students' culture-oriented learning opportunities. Identification of the students' social organization and cultural patterns in the UCM environment will lend to understanding the impact of their own behavior upon cultural diversity.

Students' encounters with cultural diversity at UCM are a function of their "navigation" through phenomena and people that compose the UCM environment. The culture-specific impact students have upon UCM adds new points of reference to "the map" they follow toward becoming a physician. The totality of their learning and understanding of the connections between culture and medicine will affect their character as practitioners in a multi-cultural world. For the students, the treatment of cultural diversity in medical education at UCM is fundamental and never static. An ethnographic account of their medical education and cultural enlightenment through people, places, events at UCM is at the core of this study.

The Setting: (1) physical features

The multi-story Medical Sciences Building housing UCM, a Health Sciences Library, and >20 clinical and science departments, is noted for its utilitarian architectural style. On surrounding sides are located Central City Children's Hospital, Haynes Private Hospital, and a College of Allied Health Building. Inside the structure, the UCM Dean's Office, Administration, and the clinical departments providing medical education share >8 floors, with remaining space devoted to laboratories and technical support.

The main classroom (A-1) for student lectures and feature presentations is on the Entrance (E-Level) floor of the medical school. The room is arranged with amphitheater style seating, 180 capacity and is immediately adjacent to the student lounge, mailroom, and personal lockers. Directly above (A-1) on each floor are seven smaller classrooms, used daily for teaching, small groups and student meetings. The Entrance Floor of UCM also contains the Dean's Office, Student Services, and Health Sciences Library all in close proximity to the student lounge and recreation area. The layout of these offices is designed to facilitate students' class attendance, academic study, access to support services, organizational meetings, and

recreational pursuits (Appendix E). As a result of the concentration of offices and classrooms within 8000 square feet, student activities and lectures often compete for space, forcing some student organizations and social groups to meet away from the UCM complex.

A 22% reduction in student enrollment in 1989 partially alleviated the need for additional space, though recent remodelling of the Dean's office suite, Classroom (A-1), and the Health Professions building much of the working area for faculty and staff is now highly segmented. Gray-colored, portable office components have made UCM space utilization more efficient than the former arrangement, but staff and student interactions are notably limited by the cramped, physical parameters (See Appendix E).

As the designated student area comprises one hub of activity at UCM, a second intersection of traffic in the setting is the Dean's Office suites. The Office of Student Services is located here, including all administrative staff and resource personnel who provide services to students: a) UCM Dean, b) Dean of Students, c) Assistant Dean for Student Services, d) Medical Registrar and Admissions Director, e) Academic support and Psychological/Social counseling, f) Minority Affairs Office and Mentor network.

The UCM Dean's Office suite consisted of three principal administrative levels upward from the receptionists: a) administrative and technical support staff, who process information and aid interoffice operations, b) Registrar/Admissions Director, who serves multiple functions with student admissions, current academic data, graduate archives, and as the primary mediary for students having tutorial, psychological, or financial intervention from the Dean's Associate staff, c) Associate Deans, who advise students as problems or issues arise in the course of their medical education, d) Dean of Students, who is responsible for all formal academic and disciplinary decisions affecting enrollees, as well as student recruitment. At least three Assistant Deans are known to the researcher, dealing respectively with Student Services, Counseling, and Minority Affairs.

Access to staff working at these three levels is often depends upon their individual working style, and the students quickly learn these differences among members of the Dean's staff. For example, all of the Assistant Deans can be met by appointment, but two maintain an open-door policy for students. One exception is the Assistant Dean for Student Services to whom access by students is difficult

and, consequently, is avoided by them. She is not known as a student advocate, as are the other Assistant Deans noted herein. The Assistant Dean for Minority Affairs does have a reputation for giving all students strong support and every resource available within the UCM system to resolve problems. Her primary responsibility is to African-American and other ethnic minority students. As an ethnic minority member herself, she has reputation among these students' for relating to their perspectives on medical education and the treatment of cultural diversity at UCM.

Alison R. (pseudonym), the UCM Medical Registrar, is a pivotal figure for medical students in the Dean's Office network. She also represents an important landmark on "the map" for students throughout their tenure at UCM due to her uplifting of cultural diversity, both in attitude and curiosity. This individual is a 15-year veteran UCM employee who has had experience in several positions related to medical student services, which has earned significant status and trust from the UCM Dean, Assistant Deans, and especially, the students. Ms. Ray is noted primarily for her sincere concern for the satisfaction and well-being of the medical students. She has often cited concerns for the degree of stress placed on incoming students and has

expressed particular interest in ethnic and foreign students' adjustment to the "intimidating society of medical education." Alison Ray's office door is decorated with postcards from students sent to her from worldwide locations during their international health care preceptorships. She has shown vicarious excitement whenever the returning students held slide presentations of their "cross-cultural medical exploits . . . because, stated Ms. Ray, "this is what being a doctor really means."

The Setting: (2) mission and policy

The site of the investigation was the University College of Medicine, a centrally-located Midwestern city (referred to as Central City, a pseudonym) teaching institution associated with a university hospital. UCM is one of the oldest medical schools in the U.S., founded by a renowned physician and egalitarian educator. UCM was established with a philosophy based on providing top quality medical education and advancing social and humanitarian aid to all members of the society, a unique perspective given the broad biases of the time toward poor and ethnic minority persons (UCM Medical Heritage Center).

Subsequent generations of UCM medical classes have been

guided by these precepts developed when teaching was at the forefront of UCM goals. Increasing emphasis on research and the economic necessity of garnering outside funding since 1980, has influenced the academic departments to devote less time to teaching undergraduate medical students, < 20% of total time (1989-90 Liaison Committee on Medical Education). There is a continuing institutional identity at UCM based on these values, though it is not universally manifested in the curriculum or faculty teaching. The egalitarian philosophy which spawned a course for medical education at UCM is embodied by select members of the faculty, but the researcher has observed that the students do not encounter it in the major part of their didactic and clinical training. UCM students, faculty, and staff are repeatedly informed of the necessity and urgency of the institution to prioritize research advancement (Interview, UCM Department of Emergency Medicine, December, 1991).

In 1990, the University Medical Center stated an obligation through a consensus of its Liaison Committee on Medical Education (LCME) to "achieve excellence in scholarship and knowledge application to the health sciences" while stating that education is a central part of its mission (1989-90 Liaison Committee on Medical Education

Report). The latter aspect of the LCME mission statement, "to recruit and train by the highest possible standards a student body more representative of the people we serve," has been undertaken by UCM through its admissions program and predoctoral curriculum. This self-directed responsibility may be interpreted as recognition that the predominately white, middle class UCM student body is not adequately proportional with the ethnic minority populations of Central City or the region (Interview, UCM Dean of Students, November, 1991).

As of 1991, UCM employed more than 800 teaching faculty for >600 undergraduate medical students. Given the recent mandate of the University Medical Center to become a "Top 20" research center in the coming decade, marked concern has arisen over faculty members' declining availability for teaching medical predoctoral students. Due to increased pressure to generate research and research funding, fewer UCM faculty are committed foremost to teaching. This dichotomy has presented both a problem and challenge to UCM medical education planners attempting to weigh faculty research activity against the fundamental purpose of training medical students.

The University Medical Center Subcommittee on Medical

Students noted in a 1989 report that student education should remain a priority and that future faculty selection should be based on physician educators' understanding of that priority. A tension exists between the perceptions of many faculty that the institutional focus is not on education but toward becoming a recognized research center in several designated clinical fields. The UCM SubCommittee on Medical Students' recommendation to prioritize teaching at UCM today is diluted against an economically-driven urgency for new research (Interview, UCM Curriculum Focus Group Leader, January 1992).

The Population

The participants of the study setting were comprised of undergraduate or "pre-doctoral" medical students, of which 613 were enrolled for the 1991-1994 classes. All medical students are admitted to UCM after graduating from a certified four-year institution and completing the national Medical College Admissions Test (MCAT). In past years, UCM has admitted some students with MCAT scores below the national average (9-10), however students now admitted to UCM must score at least 10-11, above the national average. Minority applicants are evaluated equally with non-ethnic

applicants, although qualitative factors are emphasized more if their scores fall under acceptable levels (Interview, UCM Assistant Dean, October 1991).

Total enrollment was reduced from 192 to 150 in 1989 because as fewer students qualified under UCM's more stringent standards although fewer academically qualified applicants is an increasing statewide trend. The total applicant pool has not match this trend, in fact, increasing from 3500 in 1987 to over 4800 in 1991.

At a time when the school desires a more culturally diverse student body, these factors result in fewer ethnic minority students applying and qualifying for UCM admission. Ethnic minority students who are admitted to UCM arrive at an a early demographic "coordinate" on "the map" when they realized their minority status is heightened by the low percentage enrollment of their cultural peers.

To provide additional perspective on UCM student demographics, the following characteristics over the class years 1988-1991:

Class of 1988

(Gender) >360 men/>200 women

(Age) 18-20yrs = 22% / 21-25yrs = 67%

26-35yrs = 9%

(Race/Ethnic Grp)

Black 7% / Native Amer = 0%

Asian = 7% / Mexican Amer <= 1%

Puerto Rican = 0% / Other Hsp = 1%

Non-U.S. Black <= 1%

White = 85% / Appalachian Orig = Unk

Class of 1991

(Gender) >310 men/>180 women

(Age) 18-20yrs = 19% / 21-25yrs = 66%

26-35yrs = 15%

(Race/Ethnic Grp)

Black 9% / Native Amer <= 1%

Asian = 8% / Mexican Amer <= 1%

Puerto Rican <= 1% / Other Hsp = 1%

Non-U.S. Black = 1%

White = 81% / Appalachian Orig = Unk

Average for Classes 1988-1991

(Gender) >370 men/>240 women

(Age) 18-20yrs = 21% / 21-25yrs = 68%

26-35yrs = 12%

(Race/Ethnic Grp)

Black = 8% / Native Amer <= 1%

Asian = 7% / Mexican Amer <= 1%

Puerto Rican <= 1% / Other Hsp = 1%

Non-U.S. Black <= 1%

White = 83% / Appalachian Orig = Unk

(Reference: American Assn. of Medical Colleges, Enrollment Questionnaire; UCM Registrar, 1988-1991)

In light of recommendations of the LCME in 1989 "to stress and value diversity among the student body" observed by the UCM Admissions Office, the percentage of African-American and ethnic minority students has not increased more than < 2% of total enrollment. This fact may be due to the declining of ethnic minority applicant pool and an 8% rise in fees in the past four years at UCM (Interview, Assistant Dean for Minority Affairs, October, 1991).

African-American students at UCM primarily originate from Central City and other major cities in (Midwestern state) given the lower in-state tuition rate and admissions

preference for (Midwestern state) residents. Since there are more medical schools in (Midwestern state) than in bordering states, qualified in-state African-American applicants are more inclined to choose schools closer to their homes, which also diminishes the applicant pool for UCM. A statistically significant increase in African-American student enrollment will require more long term evaluation before the impact of the Minority Affairs Program and other race-specific recruiting efforts are realized. Native American and Hispanic students admitted at UCM are rare: < 1% total enrollees since 1980. To the knowledge of the researcher, there are no recruiting efforts targeting these particular ethnic groups. The increasing number of Hispanic permanently residing in (Midwestern state), however, is stimulating more awareness about potential qualified applicants and the need for more culture-specific recruitment within this ethnic minority group.

There is no data available accounting for Appalachian-origin students from Central City or other urban centers with Appalachian residents. Despite the recognition of Appalachian-origin persons as a "regional ethnic group" nationally, first and second-generation students from

midwest and southern Appalachian counties are designated as "rural-based" for admissions purposes. The researcher did not determine any recruiting efforts targeting rural ((Midwestern state)) Appalachian students or urban Appalachian students from Central City (Interview, UCM Dean of Students August, 1991).

As of 1991, over 700 full-time teaching faculty were employed at UCM, with an ethnic minority ratio representing < 15% of total teaching faculty. In Central City, the percentage of African-Americans is about 38-40% of total residents and the addition of residents of Appalachian and Asian ethnicity raises the ethnic percentage to over 50% of total residents. Based on these demographics, the imbalance in ethnic student and faculty representation will keep minority recruitment at UCM as a continuing priority.

Medical Education

Pre-clinical courses: Years I and II

In the first year UCM curriculum, students receive didactic science training such as Gross Anatomy, Biochemistry, and Neural Sciences and Physiology. These courses are essentially an exercise in memorization without specific contextual relation to the patient. Discussions of

disease and etiology within the "Basic Science core" are based on definitive biological processes. Students are also required to take Introduction to Clinical Practice (Part I), an orientation to practical exam and diagnosis skills, coordinated by the UCM Dean's Office and taught by the Departments of Family Medicine and Psychiatry.

Below listed are the departments and the percentage of their teaching contribution made over four undergraduate years. The list is presented here to clarify the proportionate number of hours of instruction offered by the UCM basic science disciplines compared with clinical training (noted in weeks) offered by the clinical departments over the four-year curriculum:

Department	Year 1&2	Year 3&4	Total Ave%
	Hours	Weeks	Teaching
Anatomy	25.7	0.2	12.9
Anesthesia	0.0	1.7	0.9
Biochemistry	4.1	0.0	4.0
Dean's Office	5.9	0.0	2.0
Dermatology	0.2	1.6	0.9
ER Medicine	0.0	4.3	2.2
Envir. Med	1.1	0.1	0.6
Family Med	1.7	4.3	3.0
Intern. Med	7.5	30.6	19.0
Microbiology	5.5	0.1	2.8
Neurology	0.7	2.1	1.4
OB-Gyn	0.5	0.8	4.5
Ophthalmology	0.3	0.8	0.5
Orthopedics	0.2	1.1	0.7
Otolaryngology	0.6	1.2	0.9
Pathology	23.1	0.8	11.9
Pediatrics	0.4	14.7	7.5
Pharmacology	6.2	0.0	3.1
Physiology	8.0	0.1	4.1
P.Med.& Rehab	0.0	1.0	0.5
Psychiatry	5.3	8.2	6.8

Radiology	0.1	5.2	2.6
Surgery	0.8	12.8	6.8

With the exception of courses like the ICP series and the Medical Interview, students are not given opportunities to address issues of culture and medicine in the first year. The freshmen are restricted to this formal curriculum early on because medical education at UCM is based fundamentally and traditionally on the scientific model. The heavy basic science emphasis in Year I as noted in the list concurs with this approach. The amount of time basic science faculty spend with spend with students in the first two years means less time with clinical faculty involved with patient care. Medical disciplines which include primary care and are patient-focused (e.g., Family Medicine, Internal Medicine, Psychiatry) offer instruction to students in each predoctoral year, but more in Years III and IV. The researcher observed that teaching from these disciplines is more likely to include cultural differences in patient care compared with basic science instruction.

Introduction to Clinical Medicine / Series

The ICP course series entails a newly-developed component on conducting a medical interview and patient

history. Comprehensive guidance and demonstration was given by faculty, volunteer preceptors and senior medical students. Nuances of patient communication and rapport-building techniques are passed on to the students through immediate instructor feedback. Participating instructors come from department of Family Medicine, Psychiatry, and community medical practices, and select volunteer senior students. Depending on the instructor/student interaction, significant consideration is given to cultural sensitivity toward the patient.

This multi-faceted course series offers many points of reference on "the map" for students enlightenment on cultural diversity. For example, one physician preceptor shared his approach with a student about working with a long-time African-American patient:

> I see Mr. Valentine (pseudonym) two or three times a year, usually when something is bothering him...arthritis or respiratory difficulty. He knows I want him to quit smoking and I think he likes me to encourage his efforts, so I do, but we've agreed it will happen when he is ready ...too much stress living in Central City's (predominantly African-American) West

> End, he says...and I respect that because I took him home one night. Sometimes he just wants to talk about how he feels. That's probably the best therapy I have for him (Interview, January, 1992).

Another UCM family physician related her recent attempt to help a young Appalachian women with a urinary tract infection:

> I knew from the start that she was afraid to see me about the infection because her husband might find out. Normally, I might say she had every right to seek medical help independently, but you have to appreciate how a problem with one member of an Appalachian family affects all of them. Also they tend to be particularly introverted about problems affecting sexual function...but that's OK...I give a lot of time to raise questions (Interview, October, 1991).

The Medical Interview

This substantive aspect of The Medical Interview course depends heavily on the experience and culturally-oriented perspectives of the instructor. The assistance of senior

students in co-teaching skills to the freshmen adds to their (UC I's) receptiveness to learn patient interviewing. In turn, UCM senior student instructors are more apt to emulate those preceptors who demonstrate attentiveness to cultural issues in the delivery of care.

The Medical Interview course is co-directed by the Department of Family Medicine and Department of Psychiatry. A standard twelve-week format includes small group components for instructor demonstration and supervised medical interviews with real patients by the students. Small group discussions and case presentations by students are conducted in the latter portion of the course. Special emphasis is directed to history-taking and its elements which bring the physician and patient closer together, i.e., courtesy, respect, rapport-building. These components of primary care medicine are regularly based upon actual patients encountered during the course, not as abstract models.

Issues of cultural diversity are raised depending on the queries of the students about ethnic, minority patients. Although such issues are addressed by the course instructors, they are viewed more as an "elective set of issues" apart from learning technique. The researcher

observed some instructors from the Department of Family Medicine, along with long-time community preceptors discussing cultural implications in doctor-patient communications.

One faculty member explained his instructional example with regard to Appalachian patients. It illustrates that medical students have more to learn about patients and their culture in home and community settings, not solely in the clinics:

> All of us have to learn more about special interest groups. There's a significant population in Central City. . . . urban Appalachians. They are our patients coming through the door with special needs and rather unique values. . . . religion, health, pain, death, and dying, are all concepts we should learn and teach. The way best way to absorb the culture-specific values is not to read books . . . . we have to go out and "meet" the people where they live. We have to do better for the Appalachian people . . . . my response to the cultural knowledge gap is. . . . "teach us" (Interview, December, 1991).

A community physician participating in the Medical Interview course who had arranged for several students to learn history-taking techniques in his office, commented on the value of role models of cultural sensitivity:

> A positive role-modeling influence early in the curriculum sequence affects attitudes toward underserved and minority patients long after formal instruction ends (Interview, August 1991).

Another faculty ICP-1 (Medical Interview) instructor noted the importance of talking about cultural differences and practicing communication skills with experienced teachers who are also sensitive toward patients' values:

> The introductory courses, like Medical Interviewing, are not considered relevant by many of the first and second year students until they spend time with patients, especially out in the community. But they are useful because students get to see us doing more than just taking the patient's history. I think there should be more opportunities in our present model of medical education to examine differences in patients'

culture and values before a physical exam is given (Interview, December, 1991).

Ethics, Law and Health Policy

Additional components of the ICP-1 course occur later in the academic year. The Winter and Spring ICP-1 quarters focus on Ethics, Law and Health Policy and Human Sexuality, respectively. Herein, students have additional sources to plot on "the map" as they advance in their learning and discern treatment of cultural diversity at UCM.

The Ethics course is coordinated by the Department of Family Medicine and one or more faculty from other disciplines. The course requires participation of > 15 Primary Care preceptors working in tandem with > 15 lay professionals; psychologists, social workers, ethicists, and attorneys. The ethicists are individuals from multidisciplinary backgrounds knowledgeable of the moral intuitions and moral choices that people make, including analysis of choices in medicine. The "Ethics" component examines a variety of patient care cases requiring decisions on culture, medicine and law. For example, one session addresses multi-cultural views on death and bereavement. The instructors affirm for students that a) understanding

death, as it is possible, is an important part of preparation to become a physician, b) in the course of caring for persons of different ethnicity and cultures, physicians are obliged to know how members of that ethnic group view death and cope with bereavement.

In this session, students are introduced to representatives from various cultural and religious groups residing in Central City: Jewish, Hindu, Asian, African-American and urban Appalachian and Native American. Each spokesperson relates their perspectives and customs regarding the reality of death and the manner in which friends and family react to the death of a loved one. The session moves from a lecture format to open dialogue as students pose questions and share their own views about death and dying. In this component of the Ethics course, gives students an unprecedented chance to appreciate the relevance of human nature in medicine with equal priority as human physiology.

A second Ethics session deals with cultural and racial diversity as substantive and affective factors in clinical practice. Students are given points of view from a multi-ethnic panel of physicians regarding their compatible and incompatible approaches to various clinical problems.

The panelists have been comprised of an African-American physician, a Navajo nurse, an Indian physician, a Chinese physician, and an Hispanic physician, each expressing perspectives from their cultural experience and clinical training.

A third session debates ethical dilemmas in primary care medicine including the relevance of religious and cross-cultural values in treating persons "as they are, and where they are." Health beliefs of patients and lifestyle practices which vary from culture to culture were described with debate on how the Western health practitioner may be most effective. Extensive discussions of case scenarios are conducted in student small groups facilitated by multidisciplinary UCM faculty.

The researcher observed fourteen small groups in all, noting that twelve groups raised issues of cultural differences and respect for patients' values. Several discussions center upon how they (students) could learn about different cultural values within the clinical setting and what can be done when treating a patient meant contravening a culture-specific health belief. The small groups are intended to foster debate of issues raised through the Ethics lectures and promote white and ethnic

students' interaction.

The small groups and one-to-one interaction with the Ethics course faculty reflect an extensive consideration of practical and philosophical priorities in patient care. Students indicated to the researcher that discussions with the Ethics faculty and small group facilitators were the only instances that issues of culture were deemed relevant or important in the general context of medicine (Interview, November, 1991).

Human Sexuality

The Human Sexuality (ICP-1) component has been offered for the past five years using a lecture-small group format to a broad range of psychosexual and psychosocial issues. The syllabus lists the course objectives as the "presentation of patient care and sexuality issues where the physician was required to resolve values conflicts." The course is further intended to help medical students enhance their own sensitivity toward patients and families experiencing sexual dysfunction, homosexuality, or sexually transmitted disease.

The course director, a community lay professional associated with Planned Parenthood, takes a "neutral" stance

on human sexuality issues, but advocates for physicians' focus on patients' sexual health and psychological wellness without moral or cultural judgment:

> What is imparted to medical students through this course is not about treating patients for specific problems of sexuality, whether pathological or psychological, as much as relating how to respect their differences. Complications with human sexuality extend over gender, race, age, and culture . . . so it makes sense that physicians should first be accepting. Knowledge of the patients' cultural values is not necessary as long as care is provided in a respectful manner (Interview, April, 1992).

This faculty member's proposal for a neutral intervention with patients varies from the expectations of many students who have previously taken the ICP-1 Ethics component. It represents a different "coordinate" on "the map" for students to consider as they progress through the predoctoral curriculum. In summarizing the course theme, the director states that "cultural neutrality in medicine doesn't signify a judgment about the appropriateness

cross-cultural values." She advises the students to give patients the same care that they would want. The researcher observed that students in the class reflected mixed reactions to the course director's advice, but considered the course speakers to be stimulating.

Case histories discussed in the context of the Human Sexuality course often include indigent persons with HIV infection, homosexuals, drug abusers or female patients who are single, heads of household on welfare. When asked to describe these HIV patients, most students in the class assumed them to be indigent and African-American or Hispanic. The students were advised that this demographic profile (re: HIV patients) is not accurate for the local African-American population, < 38%, compared with other major cities such as Washington, D.C. or Newark, New Jersey with majority African-American populations, > 50%.

The course discussion also deals with common misperceptions reflected by white students that ethnic minority members are most likely to live in poverty and least motivated to take preventive care measures. The researcher observed that African-American students said they didn't know the true ethnic profile of poverty, but felt that whites fit their image of the indigent population most

closely. None of the students were able to comment on the social and health status of urban Appalachians. One (white) student expressed frustration, stating that "she should not be expected to know the socioeconomic realities of ethnic groups (African-American and urban Appalachian) with which she had little contact." Another student remarked that "poor health came with poverty regardless of ethnicity which wasn't a factor in being poor or sick" (Interviews, October 1991).

The Human Sexuality course is annually rated as one of the more popular courses in the required first year UCM curriculum based on the candid nature of the lectures, first-hand patient presentations, and case-oriented small groups. The students are asked to withhold their own values orientation through the quarter while giving deliberate attention to the patients' experiences. The researcher observed that some students found self-restraint from stereotyping and cultural differences in patients difficult, but more students were willing to consider patient care according to a different value system. In one discussion group, (8 white, 1 AA student) debating treatment of a young Hispanic male for prostate problems and an elderly African-American woman for breast cancer, a majority decided

they would be sensitive to these patients even if they didn't understand their cultural views of sexuality.

Human Behavior

The Department of Psychiatry offers an additional required course in the first-year curriculum known as "Human Behavior: An Introduction to Medical Students." The course parallels the format and instruction of the ICP-1 series and is part of the Behavioral Science/Human Development core of instruction. The course director, a UCM Psychiatry professor, raises questions of culture, ethnicity, and behavior as they effect the practice of medicine. For example, students are asked to describe what they would say to a patient who used language or jargon which they heard but could not comprehend for meaning. . . . or an ethnic patient who came for her own care but insisted that her family accompany her during the visit. The researcher observed that most students were intrigued by the scenarios, but had no responses based on experience or knowledge.

The course's premise is stated explicitly by the course director and supported by faculty/guest speakers as follows:

> Disease and its treatment are only in the abstract

> purely biological processes. Such facts as whether a person gets sick at all, what kind of disease he acquires and what kind of treatment he receives largely depend upon social and cultural factors.

The ICP-1 Behavior Science instruction is primarily taught in lecture format, augmented with invited presentations by interdisciplinary UCM faculty and Central City health care providers. The course is based on the bio-psychosocial approach to patient care: (1) social variation is a factor of illness behavior; (2) ideas about the etiology of illness and what to do when people become ill also vary with culture (Kay, 1987). This model provides the physician with the tools to examine aspects of patients' condition beyond a single pathological problem.

Human behavior is reviewed from the perspective of the life cycle, from infancy to late life with the family system at center. The course provides for open debate on questions proposed by the instructor and, in spontaneous fashion, by the students. The most provocative and unresolved issues deal with cross-cultural conflict, continuing on in small group sessions and after-class discussions with the instructor and group moderators.

A group moderator commented that students want to understand how the collective behavior and social life of an ethnic community can be bicultural:

> So many of these students have had limited cross-cultural exposure that we are compelled to give them examples of cultural differences, for example, African-Americans do not behave uniformly as an ethnic population. Each ethnic segment exhibits a variety of standardized behaviors as well as patterns from the mainstream majority culture. Then we try to deal with the phenomena of acculturation without elevating the status of whites over blacks or any other group (Interview, December, 1991).

The ICP-1 Human Behavior course is distinguished as one of three instances in the predoctoral curriculum where health care issues relating to urban Appalachians were formally discussed. A comprehensive overview of Appalachian life and culture as evidenced in Central City is one of the featured lectures by a UCM faculty associate.

A central message about cultural differences which comes through the lecture reiterates the perspective that a group

characterized by ethnicity, whether skin coloration or regional origin, should not be viewed as a monolithic body with uniform experience. Students are told that within a given group, there are class, language, and customs variations which may derive from the members' sense of tradition and ancestry or from their daily participation with peers and role models. The lecture concludes with a caution to students to be careful when making distinctions about the cultural posture of patients of the same race or ethnicity. Finally, they are asked to develop insight to their own attitudes regarding patients' ethnic and cultural backgrounds.

The faculty member giving the presentation heads an Outpatient Psychiatric Clinic serving primarily ethnic, minority residents of Central City. About 40% of the Clinic's clients are of Appalachian origin. The Clinic is an excellent site for student exposure to ethnic, minority patients and families, learning opportunity continued in a Family Medicine 3rd-Year clinical clerkship. This singular lesson on Appalachian culture and health behavior is not augmented further in the classroom for 1st and 2nd-Year medical students.

The cumulative teaching in the Introduction to Clinical

Practice (ICP-1) series which pertains to urban Appalachian and African-American culture is minimal, but attention to generalized issues of cultural diversity is more expansive. For the 1st Year students, who are restricted to the formal didactic curriculum, these courses contain the only consideration of cultural diversity issues. Individual course directors and invited community lecturers determine the emphasis on culture and clinical care delivery.

Two summer experiences are available to post-1st year students looking for potential cross-cultural contact: The Urban Care Program and the Summer Elective Experience. The Urban Care Program is a student-founded and coordinated public health program focusing on underserved persons in the Central City community. Sixteen possible placements with Central City public assistance and health care agencies offer a chance to work directly with social service clients and the homeless, the majority being urban Appalachian and African-American residents. Students obtain first-hand understanding of the needs of the urban poor and multiple factors which affect their health and well-being.

The Summer Elective Experience is an optional 8-week placement of four to six medical students with community family physicians where they observe patients and care

delivery and participate in limited office procedures under supervision. This experience represents students' initial exposure to patients and primary care delivery in the field. The precepting physicians are volunteers, but selectively chosen depending on their exemplary rapport and cultural sensitivity toward patients.

Both of these summer experiences are challenging early routes for students to take on "the map" because they entail direct and substantive contact with underserved patients in Central City. The students do not work exclusively among ethnic patients, but virtually all are of low SES and living in mixed ethnic enclaves. The value of these two placements is linked with students' realization of the nature of sensitive care delivery whether for cultural or socioeconomic reasons.

In evaluating the Urban Care Program and the Family Medicine Summer Elective Experience, one student expressed his amazement in having the chance to assist with health care in a homeless shelter:

> In my first year of medical school, I think I have learned more than I could have imagined about the lives of these people. There's no way for me to become a

physician and not come back here.

Pre-Clinical courses: Year II

In the second year of UCM predoctoral curriculum there is a continuation of the Introduction to Clinical Practice series (Physical Diagnosis, Problem-Based Learning) in addition to a greater variety of elective choices available to the students. The required ICP-2 sessions feature physical examination skills with group instruction (4-6 students per physician) leading to supervised exams with actual patients, selected randomly from a volunteer pool. Problem-based Learning sessions are led by multi-disciplinary faculty work individually with rotating sub-divided small groups (12-14 per faculty facilitator).

An important aspect of the Problem-based Learning experience is its student-generated discussion and analysis. Faculty facilitators are involved in presenting several clinical cases, beginning with basic facts added in eight progressive meetings. The students determine among themselves which variables are relevant and which questions must be answered in order to diagnose and treat the patient. Case issues are researched independently and findings reported as the groups reconvened. A collective decision on

the patients' care is developed in the end.

Issues of culture arise in the case analysis when the hypothetical patient happens to be an ethnic minority member, but the researcher observed that this was done in a utilitarian manner, unless an African-American student was present in the group, there was they expressed reluctance to speculate about the patient's culture-specific point of view. The groups' consensus found it was easier to prescribe a treatment without identifying possible values conflicts. This was a new plot on "the map" for many students who saw that issues of cultural diversity and health care could be avoided if others were in agreement with that stance.

The UCM curriculum offers few Year II electives opportunities to observe and analyze the relationship of culture and health care. Two of the most direct exposures occur through the UCM Family Medicine departments' placement of students in one-to-one situations with underserved patients: Family Care Elective and Homeless Health Care Elective. The Family Care program, designed for 15-20 students, matches participants with individual pregnant women who require prenatal care, delivery, and postnatal care.

The year-long experience enables students and patients to develop personal interaction in the course of providing obstetrical care and psychological support. As described by the course supervisor, Family Care gives inexperienced medical students a chance to see patient advocacy and to follow the example set for them. For some, its a turning point in their education:

> Family and Prenatal care is an area where the patients' culture and physician sensitivity are crucial factors in the outcome. This course renders clinical care and a flexible student-patient interaction which leads to the optimism and empowerment of both" (UCM Family Medicine Department Curriculum Summary, 1991).

The majority of the patient volunteers working with Family Care students are lower income African-American women. Students do not know initially whether participating white women are from the Central City urban Appalachian community, unless they are advised by the course director or told directly by the patient. In due course, the students stay with the patient through their pregnancy and birth. They are also required to work with the mother and family

members at home as appropriate to render post-natal care (Interview, August, 1991).

The Homeless Health Care clerkship is a two-month rotation oriented to Family Medicine and health care problems of the homeless. Students are provided with the opportunity to interact with residents of a Central City shelter for displaced families and a Mobile Health Van attending to homeless persons. Under close supervision of a family physician, students learn and apply clinical skills, while jointly analyzing psychosocial and societal factors impacting the homeless. The researcher observed discussion of patient care issues including ethnic and racial prejudice, cultural differences, and physician cultural insensitivity.

The course director revealed his thoughts about working with inexperienced medical students in a setting of homeless persons and families:

> My contribution to these students' clinical training is not as important in the long term as what they learn about the ethnicity, values and health status of the homeless. It is useful for them to see that these folks are not all black or poor or ignorant. It is

> also important for students to learn how they can best help. (Interview, January, 1992)

The Homeless Health Care course director often challenges students to place themselves in situations of socioeconomic deprivation and as an minority person seeking respect and survival. In the exercise, students are asked their recommendations for obtaining health care without Medicaid and without access to a physician; relating to culturally diverse health care providers; taking preventive steps to reduce personal and family health risks while unemployed. Students are also required to research various issues on the homeless relating their findings to patients seen at the Central City shelter.

The "mapping opportunities" represented by these advanced Year II electives are substantive and challenging to the students' prior knowledge of cultural norms. Given increased chances to explore their own limitations about working with ethnic minority patients, UCM students gain in confidence and the desire to place humanism at the forefront of medical practice. Students' encounters with ethnic minority families, single mothers and children, and the responsibility for their care provides a foundation to deal

with their biases and naivete.

The Year II curriculum completes UCM students' basic science and physiology instruction. Those few students who are selected for the Family Care or Homeless Health Care electives gain additional experience in their second predoctoral year than their peers. Those students desiring to learn more about the role of culture in medicine begin to look for specific course tracts in the curriculum. As they learn more in the primary care disciplines they engage in Year III, another route on "the map" becomes apparent and they follow it.

Clinical Rotations: Year III

The UCM 3rd-Year class is required to spend the entire academic period in training rotations with the major clinical departments: Internal Medicine, Surgery, Neurology, Pediatrics, Family Medicine, Obstetrics-Gynecology, Psychiatry, Radiology, and Dermatology, Orthopedics, Emergency Medicine, and Physical/Rehabilitation Medicine. Within this grouping of disciplines, excepting Surgery and clinical rotations, others are chosen depending on students' individual scheduling. For the majority of the UCM students who have

not chosen a career specialty, primary care experiences available through Departments of Family Medicine, Internal Medicine, and Pediatrics, are give high priority. A UCM Curriculum Task Force member noted the predilection of medical students to the primary care specialties in the later years of medical training:

> I think Family Medicine, Internal Medicine and Pediatrics hold a special attraction for them because of their focus on patient and family issues. The third year students sense that these specialties address more than clinical matters, like racial and socioeconomic barriers to health (Interview, January, 1992).

In 1990, the Primary Care Clerkship in the Department of Family Medicine was opted by over 66% of the 3rd-Year students. One reason for the popularity is due to the large number of community-based preceptors with whom the students may apprentice; meaning certain assignment to "hands-on" patient care. This rotation included possible placement in rural or urban sites as part of UCM students' required AHEC experience. Prior to placement with precepting family physicians in the Central City area, students often

expressed their preference for a particular locale and were advised on the unique nature of the practice and patient population. During the one-month clerkship, students participated in the office routine and various procedures under preceptor supervision. One day each week, students returned to UCM for sessions on clinical decision-making, common health problems, "the complex patient," Bioethics, preventive medicine, and small group experiences with Geriatrics, Alcoholism Clinic, or Physician-Patient Communication.

Issues of cultural diversity were interjected in discussions on bioethics and the complex patient as students analyzed actual case encounters from the community setting. For example, one student presented a case which entailed management complexities, ethical decisions, and cultural dilemmas:

> A 17 year-old urban Appalachian teen (white) was brought to the family physician's office in early stage pregnancy. She had refused prenatal care in an attempt to disguise her condition from her mother, who advocates birthing the child and taking it into the family. The daughter wants no involvement with the

pregnancy and is considering an abortion. Both mother and daughter ask the physician (African-American) to sway the decision.

In each presentation, treatment choices recommended by students were reviewed before Family Medicine faculty including physicians and behavioral science instructors. The implications of the treatment choices were debated by all present toward eventual consensus, including health beliefs of the patients and physician's posture and attitude.

Students were not advised of "right versus wrong" positions to assume with regard to cross-cultural patient encounters, but were encouraged to acknowledge tendency toward bias and stereotyping in communications between with ethnic minority patients. This debate of ethical choices with cross-cultural variables represents a "map" course which emphasizes the encouragement of culturally sensitive faculty. The faculty instructor's admission of stereotyping does not condone the practice, but suggests to students that they should attempt to control the tendency.

In the course of six separate observations of clerkship students, four cases were presented on African-American

patients and two white patients identified as "coming from a (Central City) Appalachian neighborhood." Neither the presenting students nor other clerkship participants noted that cultural differences existed or that physicians should be aware of ethnically-oriented health beliefs of his patients. As these issues were raised by the UCM faculty, all of the students responded favorably (noted in post-course evaluations) and indicated that no other UCM faculty made such emphases in their first two years of instruction.

The Primary Care Clerkships in Internal Medicine and Pediatrics placed students with community preceptors with the charge to "demonstrate suitable respect to all patients." Thereafter students' insight into matters of cultural diversity came solely from the Central City precepting physicians. At the completion of their rotations under these departments, the students are tested for didactic knowledge, without further attention to psychosocial dimensions of the patients or families (Interview, September, 1991).

The Year III curriculum comprises a 12-month period of clinical training, including required rotations of Surgery, Obstetrics-Gynecology, and a Primary Care Clerkship from

Internal Medicine, Pediatrics or Family Medicine. Some choice-based rotations, such as Cardiology, Emergency Medicine, and Physical Medicine and Psychiatry are also available. The Family Medicine Clerkship represents a clear opportunity for students to broaden their experience with cultural diversity because it is more strongly emphasized by the Family Medicine faculty and community preceptors (Interview, August, 1991). A course on "the map" toward the primary care disciplines is now charted by many of the students who benefitted from the special electives in Year II and the summer experiences at the end of Year I.

Senior Electives: Year IV

The UCM Senior Year curriculum is a ten-month period of elective choices with Departments of Family Medicine, Internal Medicine and Pediatrics, offering the best opportunities in primary care training which incorporate cultural diversity exposure. UCM 4th-Year students were required to fulfill their last AHEC rotation in unlimited local, national, and international sites. All AHEC placements by pre-established criteria involved primary care delivery to an underserved patient population.

Based on socioeconomic demographics, in Central City and nationwide, the greatest portion of underserved patients are ethnic minority persons (Central City Health Department Commission Report, 1988; Haynes, et al., U.S. Dept. of Health and Human Services, 1985). The predominantly white, middle class UCM seniors expected to encounter a cross-cultural patient population during their AHEC rotation. Primary care placements made through the Department of Family Medicine emphasized cross-cultural contact and required preparatory faculty consultation for most national sites (e.g., Indian Health Service, Appalachian Preceptorship) and all international sites (e.g., Latin America, Africa, Haiti, India, Nepal, and Malaysia). Key issues which are covered in the students' orientation for a placement in the developing countries include a) the meaning of cross-cultural sensitivity, b) culture as a concept, c) recognizing one's ethnocentrism, d) economics and health, e) social setting and health, f) religion and health, g) health perceptions, and h) cross-cultural communications.

Senior students who choose specific sites for this senior elective have in most cases investigated the geographic and demographic features of their requested sites. Each student

is required to submit a written profile of the site, the nature of the practice, and the patient population prior to their departure. In applying for especially sensitive multicultural sites, students are asked to demonstrate some understanding of the ethnic groups they intend to work with and a rationale for overcoming cross-cultural barriers they will encounter.

A designated Family Medicine faculty member coordinates the senior AHEC placements and maintains extensive files on the training sites, including aspects of community and national culture, language, health beliefs, and traditional medical practices. Upon completion of the rotation (1-2 months in the field), students are asked to return for exit interviews in Family Medicine department to assess cultural differences and barriers and to make recommendations for providing holistic (re: inclusive of psychosocial aspects) medical care.

Each year, five or more students who serve successfully in cross-cultural settings present their experiences publicly to classmates anticipating international placements, along with interested UCM faculty and staff. In terms of ethnic composition of students completing international rotations, white, African-American, and Asian

students present their field experiences proportionate to their representation in the class.

Specialty Senior Clerkships in Primary Care are available in the Departments of Family Medicine, Pediatrics and Internal Medicine to a selected number of students seeking advanced patient care training. Students are required to assess and follow patients for a 4-8 week period, perform required inpatient clinical duties, participate in clinics, patient rounds and daily tutorials with faculty members. Depending upon the supervising faculty physician, these students are often assigned primary care responsibility for a patient. Most patients (67%) assigned from the outpatient services at the University Medical Center were African-American or urban Appalachian residents of Central city and vicinity (University Medical Ctr. Medical Records Report, 1989-90). In the case of those students taking the Primary Care clerkship via the Department of Family Medicine, the Senior Clerkship Director places special emphasis on cross-cultural patient encounters, particularly when family issues were involved. This is evidenced through the Clerkship Director's efforts to collaborate with physician-preceptors serving largely ethnic patient populations in the Central City underserved areas.

Minority member preceptors are sought as Clerkship preceptors not only for their ability to teach primary care skills, but also to impress students with the relevance of ethnic patients' lifestyle, values, and culture-specific health behavior. The Clerkship Director gives his own perspectives to student on culturally-sensitive care among African-American and urban Appalachian patients, such as reinforcing their self-concept and validating each member of their families, but the field experience has the greatest impact on their attitudes (Interview, Senior Clerkship Director, November, 1991).

Clerkship students are asked to research additional culture-specific issues (often on African-Americans or urban Appalachian patients) as care delivery progresses in the clerkship. Because of the opportunity for daily one-to-one interaction with this Clerkship Director who models cultural sensitivity regularly in his practice, this rotation is considered a pivotal experience for students selecting Family Medicine careers. (Interview, November 1991).

The Year IV curriculum is a year of choices for UCM students during which they sharply focus their training and specialty interests. For most UCM students, the end of the senior year brings them to their final destination with

respect for new cultural experiences and fuller understanding of the treatment of cultural diversity in medical education.

Social Organization and Cultural Patterns

As UCM students focus their learning path on "the map" through curriculum advancement and elective training, their understanding of the treatment of cultural diversity is also manifested by involvement with social organizations and responses to behavioral patterns of their peers at UCM. This component of "the map" presents them with potential choices and experiences among fellow students pursuing social activities, special interest functions, and non-randomized ethnic gatherings. As the students reject or gravitate toward any of these "coordinates" on "the map," their choices symbolize their curiosity as much as cultural values. Students' blending with customary or unique behavioral patterns at UCM is also a pathway to their acceptance in the setting. The researcher recorded social organization and cultural patterns among the medical students, and between students and faculty by observation and participant-observation. Social organization consisted

of formal and informal groups operated by the students. Some groups have existed over several years, while others are initiated spontaneously in response to a need or interest. Unique activities within each class occur such as music and recreational groups, with concurrent traditional, functions across all the classes, such as the annual Talent Show, Clothing and Food campaigns for Central City's needy residents, and "Ears for Peers" International Health Support Project.

The UCM academic year began in mid-August for the 2nd-Year class, followed a week later by the new 1st Year class who were assisted in orientation by the 2nd-Year class. The 3rd-Year clinical rotations begin in July and continue for twelve months. Senior students may choose June or July as a starting point for their elective series. When the entire UCM student body is engaged in class work and clinical training by September, the medical school is scene of intensive activity. In the course of learning the setting, the researcher observed every student-occupied area in the Medical Science building, emphasizing the UCM Entrance Level area, (Appendix - E). Observations and informant interviews were made over a time span of 19 hours on randomly chosen working days and weekend days, lasting 7 1/2 months overall.

The flow of student, faculty and UCM staff traffic is most notable on the Medical Science building Entrance Level. By 6am on Mondays, 3rd-Year and 4th-Year students begin to arrive for Surgery rounds and patient chart review in the University Hospital. An hour later, other departmental rounds requiring students' attendance begin marked by increasing numbers of students coming from the north doors of the Medical Science building (Map, Appendix D). By 8am, the remaining students, 1st and 2nd-Year classmates arrive and move toward the locker rooms and student lounge in preparation for the day's first lectures. Typically, the students come in groups of 2-4 persons. Some students arrive alone, but are quickly engaged in communication when approaching the lounge area. Students are rarely alone outside of the UCM Library, indicating a strong socialization function within the Entrance Level lobby, student lounge, mailroom, and locker rooms.

In the UCM Library, most students devote themselves to studying medical texts, notes, anatomical models, reviewing audiovisual tapes, and using computers in the Media Center. Solitary students spread out uniformly on the Library's second floor or gravitate to study carrels without social interaction. As a routine, most UCM students study alone or

in study groups and spend 4-6 hours per night in the Health Science Library, interrupting their sessions only for refreshments or dinner. The researcher observed that the study groups tend to remain intact through the semester, occasionally joining with another group just prior to major exams. Only once did an all white-group join an all ethnic group for joint study.

The implication of this pattern suggest that white students chose not to study with African-American students and vice versa. However, this ethnic-group separation is evident only among the freshmen students who have not socialized significantly outside of their own ethnic circles. Mixed ethnic groups of junior and senior students are more apt to be found studying together in the library and other sites in the building.

The Library's ground and lower floors are more active areas in terms of student-student social interaction facilitated by greater open space and lounge-type furnishings. Socializing which does occur in the UCM Library is evident between male-female couples and small study groups of 2-3 students. There is no pronounced division between male and female students studying in pairs or in groups. It was also noted that the black students

remain together in study groups exclusively while in the Library, though other ethnic students (i.e., Hispanic, East Indian, and Asian) intermingle with the white students in study groups.

Researcher observations of student interaction in the UCM Library and primary socializing site at UCM (lounge) are not conclusive of ethnic-group behavior in themselves, but they reflect a pattern of separation which existed between white and African-American students. Observed students of known Appalachian origin and other ethnic backgrounds do not demonstrate distinctive group cultural patterns or behaviors, but individual Appalachian students seem to be fully accepted. Only their random colloquial use of language and "Southern/ Appalachian" accent drew attention (ie, critique) from white majority UCM students.

The UCM student lounge is the focal point of social interaction for students in all the classes (Appendix E). This room is intended to be a multi-purpose area under jurisdiction of the students 24 hours per day. It contains several sofas, stuffed chairs, a coffee and food counter, a piano, a telephone, and two card tables. The 15' x 45' room is conducive to students' interaction adjacent to its large entrance foyer and the nearby piano, yet enough space

remains for "split-off" groups to sit together undisturbed at the opposite end. The lounge is more often populated with members of the 1st and 2nd-Year classes mainly because they are required to attend lectures in nearby room E351. The junior and senior students stop into the lounge at the end of each day (between 4:00-7:00pm) after their rotations as more socializing occurs among all student present.

The researcher observed activity in the student lounge on three separate occasions over six months. Without regard to gender the findings follow: a) Monday 8am, August 1991--Sixteen students present, twelve white, three African-American, one Asian. White students and Asian students clustered at west end in two groups in social dialogue. The black students sat on east end facing away from others. b) Thursday 12:30 pm, October 1991--Eighteen students present, fourteen white (one of Appalachian heritage), two East Indian, two Asian, one African-American. The white, East Indians, and Asians intermixed in 4 small groups on both ends in social dialogue, the African-American student sat alone on sofa in middle reading notes. c) Saturday 2:00pm, January 1992--Seven students present, four African-American students in west corner at table in study session, one African-American student and one Asian student

sitting on same sofa in personal conversation, one white student alone reading newspaper at east end of lounge.

The UCM seven classrooms were observed by the researcher at different times and on different days to determine variation of student-student interaction and student-faculty interaction. A repeated routine was noted in the pre-clinical lecture classes as students seated themselves in small groups, socialized briefly prior to lectures, interacted during the lectures, then exited in small groups. Also noted in each classroom was repeated separate clustering of African-American and white students.

In most of the didactic-format classes, faculty directors did not designate a seating arrangement resulting in students' varied placement from classroom to classroom. The clustering is most noticeable in the 1st Year class and diminishes among the 2nd-Year students, possibly due to their increased independence after surviving the first year's exams and familiarity with setting. This pattern is not evident with UCM students alone, as ethnic group clustering among the faculty and Dean's Office staff was observed in the hospital cafeteria and in UCM Committee meetings throughout the year.

In the clinical laboratory rooms, students are assigned

specific chairs, microscopes and equipment cabinets. They are also assigned lab partners randomly selected by the course directors. During structured laboratory sessions, there is a breakdown of the clustering previously seen during the lectures. There are no appreciable differences in students' attitudes or functional ability with regard to cross-cultural pairings (i.e., white student working with African-American students or other ethnic classmates). When subject to the influence of departmental procedures or faculty directions, cross-cultural student pairs are cooperative toward one another, though social interaction is more subdued or absent.

A number of UCM student organizations conducive to social and culturally-enriching activity were observed by the investigator. The most notable of these organizations are oriented to public service and experiential development with underserved persons in Central City and other sites, identified as follows: a) International Health Forum, b) Student National Medical Association, c) Christian Medical Society, d) Family Practice Club and e) Doctors Ought To Care.

At the beginning of the academic year, the upper class medical students sponsors an orientation day for the

incoming 1st Year students which included presentations of the organizations' purposes and membership. Significant effort is made in communicating each organizations' altruistic ends and open membership. The appeal of association or belonging (re: group membership) within the medical school milieu is noticeably strong with the incoming students anxious for acceptance by peers and senior classmates. The 1st Year students are inundated with information about volunteer opportunities in their limited discretionary time making their organizational commitments difficult. Once a commitment is made, many UCM students maintain their interest and loyalty to the group and its purposes.

Since its formation in 1987, the International Health Forum (IHF) has been the largest student organization. IHF was established in response to increasing student interest in exposure to international cultures and the practice of primary care medicine in those sites. Open monthly meetings are held to discuss world health issues and to hear invited presentations from faculty, staff and fellow students on health care experiences in developing countries. At least two IHF sessions during the year are devoted to procedural steps for students intending to serve in a medical care

setting overseas. In each presentation, speakers are asked to discuss cross-cultural barriers, health beliefs and values associated with other (non-Anglo) cultures.

The level of interest in the IHF is proportionately equal between white, African-Americans, and other ethnic students in all four classes. Since the formation of the International Health Forum, all UCM senior preceptorships in international settings have increased by 60% and attract equal numbers of ethnic students and white students.

African-American students at UCM are active participants in their own organization, the Student National Medical Association (SNMA). The group at UCM represents the local chapter of the National Medical Association, an organization for the promotion and support of African-American physicians. With fewer than 35 African-American students enrolled at UCM, the SNMA chapter does not manifest a strong presence among the larger student body, but the student organization is granted proportional financial support through the UCM Medical Students Association.

The SNMA sponsors several outside physician speakers from the Central City medical community to address issues and problems facing African-American physicians. These engagements are attended almost exclusively by the SNMA

members with minimal interest from white majority UCM students. The researcher observed that the SNMA did receive consensus student support in its effort to request more African-American adjunct faculty and preceptors from the Central City medical community. One SNMA member analyzed the issue as a case of subtle, institutional racism:

> When SMNA and Dr. Andrews, (pseudonym), of the Minority Affairs Office, pointed out the dearth of black physicians serving as community preceptors and adjunct faculty, they were told "not enough black physicians qualified to come in here and teach UCM students." What criteria did they use for that determination? Did they ask SMNA to help select physicians? Do they know how few black role models are on the faculty? I cannot help but feel some racially-based exclusiveness in faculty choices was present. We (SNMA members) have to keep up the pressure on this issue because no one else would.

In 1991, SNMA members independently surveyed the African-American physicians working in the Central City area, reviewing specialty practices and board certification

credentials. Results indicated that the proportional percentage of African-American physicians practicing in the community exceeded national physician-patient ratios for African-Americans in urban practices. Moreover, the majority of physicians contacted were board certified in their field. To date, less than seven African-American physicians are listed on the active preceptor roll by the UCM Dean's Office. In the past year, only two African-American physicians have been invited to address the UCM students in lecture on clinical topics (Interview, January, 1992).

The UCM SNMA chapter views its role as one of advocacy for African-American medical students and issues of national scope regarding the crises in African-American health care, morbidity, and mortality. In general, the SNMA chapter functions in isolation with the majority of UCM students as do most of its members during organization activities. The researcher noted that the faculty advisor for SNMA, a black female family physician, is considered to be one of the most popular and respected faculty members at UCM by all students. Much of the integrity of purpose held by the SNMA chapter emanates from the group faculty advisor, an ethnic, culturally sensitive family physician.

The Christian Medical Society (CMS) (not same as Christian Medical and Dental Society, a national organization) has had a small and eclectic membership over many years at UCM. The organization's objectives center on exploring ecumenical issues in the practice of medicine worldwide. Invited speakers from the faculty and community often espouse the incorporation of holistic, Christian principles in health care delivery regardless of cultural and socioeconomic differences. CMS members annually provide services and provide health care projects for needy persons in Central City urban communities. In recent years, CMS members have specifically targeted urban Appalachians and African-Americans through a community shelter and alcohol drop-in center after identifying specific needs among these populations.

A faculty sponsor was designated for CMS during the time of this study who generated specific concerns for the urban Appalachian and African-American children in Central City who were not receiving adequate health care and nutrition. Based upon this guidance, CMS student members raised the issues in writing with the city health department followed by fundraising and awareness efforts aimed toward the UCM student body. The CMS is noted among the UCM students for

its openness to all cultures and personal values (Interview, December, 1991).

The UCM Family Practice Club (FPC) was formed to promote the specialty practice of Family Medicine. The organization has a designated faculty advisor, but the agenda is student-generated and coordinated. Since primary care medicine has less appeal with the incoming students as compared with more experienced, globally-minded medical students, most of the Family Practice Club members are 2nd, 3rd-Year and 4th-Year students. Since most of the 2nd-Year FPC officers have not yet committed to a Family Medicine, there was strong interest in understanding the universal scope of Family Medicine.

Frequent focus on caring for the underserved populations and "commitment to the person over the disease" is made by the FPC guest speakers. Through FPC, students debate holistic philosophies which underscore physicians' concerns for a group of people, or a segment of society in which he or she lives juxtaposed with becoming a clinical specialist. Many students who have looked to their faculty advisors for direction without success, affiliate with the club for a broader perspective about medicine and humanism issues. One club regular noted her frustration as follows:

> I am pretty sure that some field of primary care will be my choice, but Family Medicine offers the most experience with patients who are truly different from people I have known all of my life. It is difficult for someone like me who has had limited cross-cultural contact . . . even with blacks, Asians, or Hispanics, to know if I can work well with them. Most Family Practice Club members feel the same way, so we look for information about poverty health care and the cultural aspects of medicine . . . Dr. Foster, (FPC advisor) shares his experiences in treating the African-American patients who have drug and alcohol problems . . . and that is a good place to start.

As with the other student organizations, the FPC members seek out community contact with their own service projects with a Central City soup kitchen and the Health Department Mobile Health Van, both targeting urban Appalachian and African-American residents. Senior FPC members who had opt for the Family Medicine specialty help exemplify the concept of "the primacy of the person" which considers environment and culture at the core of health care delivery (Interview,

March, 1992).

Doctors Ought To Care (DOC) was founded at UCM in 1986 in response to national concern for youth exposure to tobacco and alcohol advertising. DOC's main objective is to provide in-school and community presentations on tobacco, alcohol, and drug use and sexual responsibility. Led by 2nd-Year students, the organization functions within the ten-month academic year, culminating in May with a public music festival and health fair held in Central City. Although the DOC school presentations do not target urban Appalachian and African-American youth, the majority of students encountered are ethnic minority residents. Each DOC talk is arranged by request of school or community representatives and requires the UCM students visit the neighborhood site and meet with the school pupils personally. The talks are composed didactic information about the health hazards of tobacco and other drugs along with alternative choices available for the kids which bolster their self-esteem, health knowledge and decision-making ability. In cases where teachers or community representatives do not reinforce self-image and positive decision-making with the youth, the DOC students assumes an aura of importance beyond that of normal "authority figure"--, that is, "youth role model."

DOC is considered to be the most activist and effective outreach group in the medical school, because it offers a crucial entre into communities with ethnic and underserved youth surrounding UCM. The direct contact with urban Appalachian and African-American children stimulates many DOC members toward a humanistic, multi-cultural approach to medical practice. In the words of one UCM senior:

> Being part of DOC helped me realize the amount of influence held by physicians in the community. I felt that the kids looked up to me as a model "big brother" they might want to follow, while the adults respected my medical knowledge and objectivity. The fact that I was white did not seem to affect anyone's opinion in a predominately black school. They reacted to my health message, not my color or status (Interview, February, 1992).

The DOC "Smoke Free is Cool" music festival and health fair, held annually, is intended to embody the organization's positive health message across ethnic, racial and socioeconomic lines. Significantly, in the final month of the year, all other UCM student organizations donate

their remaining funds allotted by the Medical Student Association in support of this event. Public attendance at the free event numbered over 2000 making it the largest student-generated community outreach of year. Despite the lack of official administrative and financial support for DOC from the medical school, independent student effort makes the festival and the organization successful.

Each year, the UCM DOC Chapter encounters some degree of institutional resistance for its alleged "radical stance in the public sector," yet a 1991 (Midwestern state) Governors' Citizens Award and respect from the majority of UCM students distinguish the organization's efforts on behalf of at-risk children (Document, August 1991; Interview, August, 1991).

The "map" by which the students find various ways to acquire their medical education is not given to them at the outset of their academic course. It is composed, in part, of values they bring to the UCM setting at the outset and which they must shape through their own motivations and receptivity. Their cumulative UCM experience with place, peers, pedagogy, and patients provides them with clear and subtle messages about cultural diversity. The navigation by "map" leads students along distinctive routes at UCM, permanently changing their perspectives toward culture and

medicine.

CHAPTER V

LEARNING THE HARD WAY: STORIES FROM THE FIELD ON HOW CULTURAL DIVERSITY MAKES A DIFFERENCE IN BECOMING A PHYSICIAN AT UCM

Data reported in this chapter reveal principal themes which emerged from the researcher's observation, participant-observation and non-standardized interviews within the setting. The representative themes are based in part on the personal experiences of five UCM students from different cultural backgrounds, ages, and academic classes served as key informants for investigation of the setting. The themes may also be construed as affective features on "the map" guiding the students' course through medical education. For some students, the ethnicity of peers and faculty has little influence, values differences are virtually ignored, alignment with the medical education process is not a problem, and finding affinity with a teaching mentor never happens. Each student who served as a

key informant, discovered open routes as well as barriers on their "map." All five advanced in the system, but had very different stories to tell.

As key informants, these students contributed personal observations, anecdotes, and interpretations of events to the study data throughout the investigatory phase. The researcher maintained regular contact with the students over a 9-month period in the form of interviewing and participant-observation in classrooms, departmental offices, and the student lounge. In forming an agreement with the students to act as key informants, all were advised of the study's purposes and the assimilation of their views into the data pool.

The researcher made key informant selections based on variables which were germane to the study, including the students': a) maturation and experience prior to entering UCM, b) global views on culture, medicine, and the UCM environment, c) involvement in extracurricular social or volunteer activities at UCM, and d) availability and willingness to share information about themselves and their classmates in a variety of contexts.

The researcher invited the students' free expression of biases with the presumption that all remarks would be

honest. The students agreed to unscheduled non-standardized interviews, observation, participant-observation (in classrooms and clinics, with other students and faculty), and a review of random personal documents relating to UCM.

The themes manifested from this data-gathering include the following: a) the ethnicity factor, affecting students, faculty, and patients as they interact among themselves seeking information, receptivity, or therapy; b) a dichotomy of values, both cultural and ethical, which confront students as they progress in their medical education; c) the survival of dis-synchrony, representing ethnic students' means for enduring inequities in the system which provides their medical education; d) the achievement of synchrony as a goal of ethnic and white students in relation to the cultural postures and ethics of UCM faculty; and e) the meaning of connectedness, instilled in students who understand the value of cultural diversity and sensitivity through faculty mentoring.

UCM students' experiences are unique as well as universal with respect to the themes which emerged from the setting. All of them are affected by standards of conduct, formal/informal rules and expectations, generated from sources throughout the UCM environment. Each student

manifests his or her particular style toward barriers and facilitators in the process of learning medicine.

The Ethnicity Factor

The influence of cultural diversity and traditional ideology in medical education are revelatory in the accounts of the students, faculty and staff of UCM, all participants in the setting. The first theme: the ethnicity factor, is manifested in the encounters of incoming students and experience of long-term staff and patients with ethnic minority persons. Though their responses are varied, there was no overt evidence of skewed conceptual views, for example, that one group is "just like" any other or "we are the same under our skins." African-American students and others of identifiable ethnicity at UCM (e.g., students of Appalachian origin who are classified as "rural recruits") reported that they were advised of their "significance to the student body" during the admissions process (Interview, February, 1992).

African-American students have been at the center of UCM efforts to improve cultural diversity since the middle 1970's. A key member of the UCM Admissions Committee and Strategic Planning Task Force declared that " [everyone]

should recognize just how difficult it is to recruit and retain culturally diverse and disadvantaged people in the medical school . . . this is a well-known national problem. In spite of that dilemma, UCM has a small but strong ethnic representation. When asked to define "cultural diversity" and to describe perceptions held by UCM students about ethnicity and their minority classmates, this faculty member responded, "I have no answer for that" (Interview, January 1992).

Ethnic minority students interviewed by the researcher noted awareness prior to admission that UCM strives for balanced composition in its student body. Most ethnic minority students indicated they were advised their enrollment would help maintain a balance with respect to the white student majority. In a number of ethnic minority applicants' cases, modified criteria are utilized in the admissions process (e.g., GPA below 3.5 and MCAT scores below average) and in the provision of financial aid. The ethnic minority students admitted to UCM and the Admissions Committee acknowledge the application process as appropriate and necessary under legislative and legal guidelines (Interviews, September, 1991; November, 1991).

Ethnic minority applicants are not made aware of the

dwindling pool of academically qualified students and the resulting dilemma in maintaining a comparable level of cultural diversity. In light of the expected future growth in diversity of the UCM student body, including "non-traditional and less academically prepared students," increased concern is being voiced by the UCM faculty over the amount of future recruitment and support to be given by the Admissions Committee. Within the year of this study, a key faculty member of the Curriculum Review Task Force protested that "greater diversity by mandate has lowered UCM standards" (Interview, UCM Associate Professor, 1991).

The 1988-95 University Medical Center Strategic Plan proposes a commitment to attract (1) "the most highly qualified student body in the state system, and (2) "a percentage of minority students more closely reflecting the population at large." Since Strategic Plan was issued, a restructuring of the UCM Admissions process and curriculum toward becoming a "center of excellence for education of minority students" is still deemed a future goal. No specific strategies have been given on extracting the most qualified students from the population at large. No details are yet available for turning UCM into a center of excellence for minority students (Document, Liaison

Committee for Medical Education, 1988).

Reaction to the UCM environment is qualitatively different for white students compared with ethnic minority students experiences. Being a majority culture member as a UCM 1st-Year student provides a sense of affinity with the faculty and staff, which are mostly white. Being a white male UCM student bolsters the affinity with regard to the faculty, which is mostly male. Administrative staff at the lower level (secretaries; clerks) to mid-level (Assistant Deans; Program Coordinators) is predominately white and female. The highest level administrative positions (UCM Dean; Vice President) are held by white males.

Although the researcher did not observe differences in behavior (re: sociability, overt confidence in class) between white male students and white female students (1st-Year), ethnic minority male and female students (1st-Year), are notably more reserved in the first six months. Ethnic minority students do become more confidant as their familiarity in the UCM environment grows, although as a group they are not as extroverted as the white students. Exceptional individuals who emerge from the ethnic groups are broadly accepted by students and faculty alike and many become class leaders.

Advancement through the process of medical education at UCM is considered to be more difficult for most entering ethnic minority students who must adapt to an environment more culturally imbalanced than the overall population, then determine the sociocultural norms which prevail inside UCM (Interview, Assistant Dean, September, 1991). Academically, all students admitted to UCM are presumed qualified for the high level of instruction and its associated pressures. No differentiation of treatment or evaluative standards were observed by the researcher, but > 28% of ethnic minority students require academic assistance within the first year.

Ethnic minority students who find it necessary to work while attending classes, may contribute to their academic difficulty (Interview, Faculty Advisor to SNMA, December, 1991). Their collective experience is described by the researcher in light of these students' expressed values, interactions among white and ethnic minority students, interactions with faculty who constituted role models and mentors, and exposure to ethnic minority patients.

While it is true that African-American students enrolled at UCM have increased in number, one such student, John B. 1st-Year, felt it was premature to announce the beginning of a cultural diversity evolution:

> John B.: There still is not much cultural diversity here . . . at least not to the degree I hoped for when I entered this year. In my Admissions interview, I was asked why UCM was my first choice, to which I responded my intent was to be a physician in Central City, . . . where I could do something about the health crisis facing African-Americans, . . . Central City also happens to be my hometown. I anticipated once I was here that I could be culturally isolated, but I also feel I'm part of the class. We have some mutual interest in helping each other make it through. (Interview, September, 1991).

John, an African-American student, was a National Merit scholar, certain of his qualifications for acceptance at UCM. However, he still acknowledged that being a minority member was noted by the Admissions Committee:

> John B.: Of course it's a factor. It has to be for those of us who have been made acutely aware of "differences" [from white society] since birth. This medical school and others I contacted are obligated to

> certain ethnic enrollments, I understand . . . but cultural issues should be a driving force in medical school admissions policy. What about our changing demographics, . . . one third of the USA population will soon be composed of ethnic minorities. (Interview, September, 1991).

For another student, Alison H. 3rd-Year, being ethnically unique was a way of life whether others [UCM students, faculty, staff] appreciated that or not:

> Alison H.: They [UCM peers, faculty and staff] know I'm not from Central City at least by my "southern" accent . . . but my family has Appalachian origins and they could very well have migrated to this city from the South. The irony is there are some neighborhoods here which are strongly Appalachian with traditional cultural characteristics. Like them, I had to endure the initial stereotyping . . . that we are "poor, in-bred, uneducated hillbillies." I completed a summer research fellowship at Harvard before coming here, but few students or faculty knew about it . . . some of them were pretty surprised (Interview, September,

1991).

Alison commented further about her experience with stereotyping at UCM, but through innate abilities and high self-esteem, it did not deterred her academic progress or satisfaction with the cultural status quo:

> Alison H.: There has been some of that, but it doesn't bother me. I know what I can do. . . . I've earned my place here like the other students. After two and half years, most of them know I have proven myself . . . and that being Appalachian has nothing to do with my abilities. The students and faculty who respect me are mostly associated with the social outreach projects here, like Urban Care Program and the Mobile Health Van. One encounters little prejudice from students who commit themselves to poor and homeless patients in Central City (Interview, September, 1991).

The UCM Dean reported in a 1991 faculty meeting that insufficient concern had been placed on "the types of students we enroll in our program and our 'product'?" He commented further that the "nature" of students admitted to

UCM in the future might be examined more carefully, "possibly with a view to concerns of the public." When asked to respond to this commentary, Don K. 4th-Year and Lisa M. 4th-Year, concurred that students' ethnicity was part of the proposed formula for change in the UCM student body:

> Don K.: I think that has much to do with our cultural background and its influence on where we will go as future physicians. They [UCM Administration] know that some accountability rests with any public institution which produces mostly white graduates to serve a rapidly-changing, culturally diverse society (Interview, September, 1991).

Lisa M., also a senior student and classmate of Don K., agreed with the assessment that the culture and medicine relationship is reflected in the people in need:

> Lisa M.: They have to be thinking about the training we get here and how whether it is conducive to staying in the state and practicing in underserved and rural sites, where the health care need is greatest. I

> expect that most physician-patient contact in these sites will reflect cross-cultural gaps . . . . but most medical school graduates are not prepared for that, including UCM graduates (Interview, September, 1991).

Don K. and Lisa M. were asked to address the prevalence of lower income African-Americans and Appalachians in urban neighborhoods. In responding, both students emphasized that these issues were never raised in their didactic or clinical instruction at UCM, rather from other, unexpected sources:

> Don K.: My faculty advisor knew I came from a rural [Appalachian enclave] town in the state and he urged me to learn more about rural and minority health problems. I had not heard this discussed specifically by other physicians here. My participation in DOC [Doctors Ought To Care] led to teaching several mostly Appalachian elementary classes about smoking and drug abuse . . . . I plan to continue visiting those schools as a resident and future practitioner now that I know those kids are there (Interview, September, 1991).

Lisa M. also looked for opportunities to discuss health

care issues specific to her own culture [African-American], finding such involvement through a student organization, a culturally sensitive faculty advisor and a community preceptorship:

> Lisa M.: I was aware of the ethnic distributions [in this state] through my work with the Family Practice Club projects in [African-American] neighborhoods of Central City. The Family Practice Club advisor volunteers a lot of his time there and even shared his personal experiences with [blended] multi-racial families. This kind of enlightenment never came from lectures or clinic rounds. Also my AHEC rotation was an "eye-opener" for me because I worked with a white physician whose patient population was largely African-American . . . I had to wait four years for an experience like that . . . it was worth it (Interview, September, 1991).

The ethnicity factor at UCM, as perceived by the researcher, is manifested first in consideration of students' ethnic status in the admissions process for valid reasons. Thereafter the ethnicity factor is present in the

context of faculty interactions with ethnic patients and student interactions among themselves. Specific faculty focus on African-American and urban Appalachian culture and health profiles in the classroom [1st-Year and 2nd-Year required lectures] is not evident excepting some cases discussed in the Introduction to Clinical Practice series. Random notation and interpretation of ethnicity were observed by the researcher during ICP small groups and the primary care clerkships for 3rd-Year students in case presentations. If a patient's ethnicity has pathological relevance, this fact is raised by the student or a presiding faculty member. In general, the cultural implications of patients' ethnicity are rarely mentioned in case presentations or analyses. Other exposures to ethnicity occur through students' association with UCM-affiliated public service projects. Most of the community contacts with ethnic minority residents of Central City are ultimately positive, despite students' sobering realization of existing poverty and poor access to health care. Opportunities for sharing of these cross-cultural experiences take place through the student organizations, and not as part of formal presentations or the curriculum.

Among the students, ethnicity is consciously

acknowledged, but not in a deleterious manner. Student behavior and reactions to their cross-cultural peers is polite, but not engaging. Overt expressions of racism or stereotyping are not frequently observed among the students, but do occur based on intimations made by all of the key informants. In those instances when racial overtones occur through students' interaction, there is usually a swift rebuke from their peers (Interview, December, 1991).

Andy P., a 2nd-Year student commented that he felt other students in his class "protected" him from the rare occasions when ethnic epithets did surface:

> My cultural origins are Mexican-American, which makes me stand out here among a "mostly white, mid-Western" student body. Last year in my first class, somebody asked my if the "double-standard" criteria under which I was admitted to UCM bothered me . . . I said "No, because I came here with a 4-year academic scholarship which had nothing to do with affirmative action" . . . before I could say anything more, two students I didn't even know ostracized him for the prejudice. My feeling was disappointment, but I appreciated the support which came from other students (Interview,

October, 1991).

Students of common ethnic background [African-American, East Asian, Asian, and Hispanic] tend to form small groups for purposes of socialization and study. Only on particular occasions do these groups combine efforts for a common purpose, e.g., exam preparation. Observed students of Appalachian origin integrate successfully after the first year of school. In most cases, Appalachian-origin students [deemed white] are not identified according to their ethnic background. Cultural differences observed between Appalachian-origin students and white majority students include language use, vocabulary, and accent. Those students who identified their rural Appalachian heritage exhibit few other manifestations of their ethnicity, except tendency toward modesty independence.

A Dichotomy of Values

The UCM students responded to a survey on culture and medicine (Appendix D) distributed by the researcher as a data-gathering tool which revealed several differences in attitude and cognitive knowledge. The results reflected dichotomies of values held by the students about

cross-cultural physician-patient encounters, physician cultural sensitivity, patient ethnicity and behavior in the practice of medicine. The researcher determined that disparate student values were hypothesized by some members of the UCM faculty and staff, but had not been substantiated prior to the study survey. The survey findings which were statistically significant [$p < .05$] were further confirmed via triangulation in interviews and observation.

Over the period, January-February each of the four undergraduate classes at UCM were polled with an equal number of 15-item questionnaires. The questions were composed with a positive, negative, or neutral perception of culture and medicine in three sets of five as follows:

Positive = Q-1, Q-5, Q-9, Q-10, Q-15

Negative = Q-8, Q-11, Q-12, Q-13, Q-14

Neutral = Q-2, Q-3, Q-4, Q-6, Q-7

Students responded according to a 5-point Likert scale with response choices ranging from "strongly agree" to "strongly disagree." The middle response choice indicated "no opinion." The survey's last page contained 6 cognitive-type questions requiring students to write in specific

information about African-American and urban Appalachian culture and behavior. These questions were described as optional, although 32% of the students did respond to them. Approximately 18% of the students polled returned the survey representing the study sample, (n = 114); (Appendix D/Survey Results). The survey analysis was intended to reveal patterned attitudinal positions held by the students overall and variations according to specific class years. A Chi-square measure was used to denote response significance. Nine questions reflected overall response significance as follows:

Q-1/agree; Q-3/agree; Q-6/agree; Q-7/agree;
Q-15/agree
Q-8/disagree; Q-11/disagree; Q-13/disagree
Q-4/neutral

Responses indicated that UCM students agreed at a significant level with only <u>two</u> positive-perception items, although the three remaining positive-perception items did reflect the majority. Students disagreed at a significant level with <u>three</u> negative-perception items and chose the two remaining negative-perception items as a majority. <u>Three</u>

neutral-perception item were selected at a significant level. On all other neutral-perception items, students indicated agreement. For the students overall, there were no significant level responses incongruous with any question perception, whether positive, negative, or neutral. Inter-class differences were indicated, however.

Response analysis by class year intended to show whether or not a consistent relationship existed on any item. The researcher presumed a null hypothesis that the response distribution would be the same for each class. Rejection of the null hypothesis suggested that the question responses showed a relationship by class year. The data were as follows:

Response distribution insignificant =

Q-1, Q-2, Q-3, Q-5, Q-6, Q-7,

Q-11, Q-13, Q-14, Q-15

Response distribution significant =

Q-4, Q-8, Q-9, Q-10, Q-12

Students in the 2nd-Year and 4th-Year classes indicated the strongest responses on the five items which varied

significantly from the norm. Students from these two class years tended to match their response with the item perception, whether positive or negative. These students correlated closely on the positive propositions: (a) "physicians who acknowledge ethnicity, family culture, and religion will be more effective with their African-American and Appalachian patients" and (b) "cultural sensitivity and appreciation of cultural diversity are essential in caring for ethnic minority patients." Respondents also concurred on negative-perception items as well: (a) ethnic minority patients are responsible for their own limited access to health care . . .," and (b) "differences in expression of grief and bereavement among ethnic minority patients are clinically insignificant . . ."

First-Year students aligned most strongly with neutral-perception items, possibly explained by their lack of clinical training and cross-cultural patient contact. The Ist-Year class consensus was as follows: (a) African-American and Appalachian patients may consult traditional or lay health care provider prior to seeing a physician" and (b) "ethnic minority groups assimilate values of the majority culture without relinquishing their own cultural heritage."

Third-Year students' response patterns followed the norm responses for every item and indicated the poorest survey return rate, [< 10%]. Individualized experiences with patients in clinical settings reported by the majority of 3rd-Year students were insufficient to interpret as culturally enlightening. The fact of their concurrent obligations and time restraints in clinical rotations reduced their participation.

Cognitive-knowledge questions were included in the survey as an addendum to the Likert-scale, perception-based questions. The cognitive questions were intended to assess students' knowledge base on Appalachian and African-American culture derived from (1st-Year and 2nd-Year lectures), UCM guest speakers (sponsored by Urban Care Program, Family Practice Club, and Medical Student Association), and SNMA cultural awareness [Martin Luther King commemorative and Black History Month] activities.

On the cognitive-knowledge questions relating to Appalachians, respondents showed a wide range of knowledge on cultural values and characteristics, on regional geography, and the multi-ethnic composition of Appalachians. For example, in identifying personal values attributed to Appalachians, responses included the following: "I have no

idea!"; "They have a lot of family rivalry, like the Hatfields and McCoys"; "Poor, dirty, lots of kids, ... and mostly farmers." On the question, "Where and what is Appalachia?", responses included the following: "East, somewhere?"; "Near New York, but not around the big cities"; "I can only describe it as a concept rather than geography, like 'hollers in Kentucky'." In recognizing white and black Appalachians, students said the following: "I doubt any of them could be African-American, unless they were Cajuns?"; "I don't know because I've never met an Appalachian"; "Not sure, but would assume so."

Regarding styles of communication between African-Americans and whites as patient and physician respectively, students offered few definitive opinions, but were comprehensive in their answers. One student noted that "Blacks are more vocal and outspoken, so white doctors often misunderstand them as patients"; another remarked: "I think the difference in educational background creates communication problems, but this is true with all ethnic patients"; another student was more concise: "We don't speak their jargon"; On black/white differences in public discussion or personal debate, two students offered more specific ideas: "Black people gesticulate more than whites,

more free speaking and honest"; "No apparent differences that I know about given appropriate and inappropriate behavior in both groups"; another student was less sure: "No comment, because I have no experience with this issue.

Finally, on the issue of eye contact and physical touch being offensive to some African-Americans, students responses were greatly mixed: "Probably not, but it may depend on the person and their past experience"; "Blacks do not like intrusion on their space"; "I have heard this is true, but any offense taken is understandable if one looks or touches in a paternalistic manner."; "It all depends on the individuals who interact."

Thirty-seven students from the total 114 respondents, responded to the six cognitive questions. Ten students were able to comment accurately on "values attributed to Appalachians"; sixteen correctly identified the region of Appalachia; four correctly noted that some "Appalachians are black or identify themselves as 'black' Appalachians." Only one student noted that Central City is home to a sizeable Appalachian population who migrated from the region.

On issues of African-American culture and behavior, twenty-one students named "potential language or communication difficulties with a white physician" due to

cultural differences or physician insensitivity. Twenty-five students said there were predictable differences in behavioral styles between blacks and whites. Nineteen students commented in the affirmative that "direct eye contact and physical touch could be offensive to some African-Americans."

Three students (self-identified as African-American (2) and as Appalachian (1)) attached additional sheets of comments and explanation on their respective cultural values. They noted further that physicians have a responsibility to "reach out to patients to avoid cultural insensitivity" and to "provide the best quality care in cases where "patients' cultural values and health beliefs are a factor in treatment."

Four students (all in 1st-Year and 2nd-Year classes) indicated they were offended by the survey questions and accused the researcher of attempting to impose "political correctness" in UCM medical education and toward the UCM students. One student accused the researcher of racism for placing undue attention on African-Americans and urban Appalachians in the survey, while "ignoring other groups such as Eskimos, Scandinavians, and Brazilians."

Overall, the student survey responses indicate a

normative pattern without extremes of opinion. Based on the conservative orientation of curriculum and faculty posture on cultural diversity issues, these responses approached predictability. The students favored cultural sensitivity in physician-patient contact and health care delivery. The students agreed that minimal cultural diversity in medical school environments and absence of cultural sensitivity training through the curriculum does not release physicians from a duty to cross-cultural patients. There was also consensus disagreement that African-Americans and Appalachian [patients'] ethnicity and culture are irrelevant to physicians' clinical assessment.

While the survey responses do not wholly identify UCM students' attitudes or experiences with cultural diversity, the representative sample indicates the following: (a) advocacy of respect of patients' values by physicians in cross-cultural encounters, (b) naive and minimal cultural knowledge of African-Americans and urban Appalachians and, (c) strong, but limited presence of cultural and political attitudes which deviate from the norm of UCM students. UCM students were inclined toward affirming cultural differences on neutral-perception issues such as patient encounters, and physicians' medical training and physicians' duty to ethnic,

minority patients.

All of the study's key informants [students] who completed the survey aligned with the normative responses. In post-survey interviews, the informants were asked to comment more specifically on the questions raised, including fairness. Regarding physicians' responsibility to ethnic minority patients expectations, Alison H. recognized a duty:

> Yes, I feel doctors need to "know" their patients beyond the physical dimensions. I always viewed this approach as logical, but our medical education is not often inclusive of the way a patient feels or where he or she came from. These are things I would want to know as a physician caring for any patient, but especially ethnic minorities. (Interview, February, 1992).

Andy P. concluded that expectations between a white physician and ethnic minority patients were mutual, but problematic:

> Patients have expectations of physicians and physicians

> have their own standards for patients, regardless of ethnicity, age, gender, etc. . . . how they reconcile these polarities is another matter, but they should be sorted out. It depends a great deal on whether this sort of exchange is important for the physician (Interview, February, 1992).

Don K. also agreed that physicians have a duty to observe with ethnic minority patients, but it has limitations:

> It's not realistic to ask physicians to be totally sensitive and culturally informed about every ethnic patient seen in the office. If the office is located in an ethnic community, this places a greater duty to "know" the patients' values and heritage. . . . or perhaps the physician should anticipate that ethnic minority persons will be different . . . . just let those patients explain what they want in their own way before making a judgment about them (Interview, February, 1992).

Fourth-Year UCM student, Lisa M., evaluated the predoctoral curriculum on raising awareness about ethnic minority

patients. Lisa M.'s critique is based on experience in contrast to 1st-Year student, John B., who was optimistic about the curriculum as a means to improving cultural sensitivity in future physicians:

> In my opinion, a lot more needs to be done during predoctoral and residency training. Its not sufficient to mention culture and ethnicity in occasional lectures and assume that students have understood all the implications for health care. The Curriculum Committees could insert more course hours addressing with cultural diversity, but I feel the institution establishes the trend and direction for teaching here (Interview, February, 1992).

John B., who had only a few months of medical school instruction at the time of the interview argued that the critical lessons about cultural diversity come through community contact:

> I don't believe any medical curriculum can pass on the wisdom and experience physicians will need in practice with cross-cultural situations . . . maybe the

> curriculum could be the starting point, but I think it takes direct contact with these patients in their own community (Interview, February, 1992).

The informants showed similar positions on the importance of culture in the medical encounter, but differed on expectations for physicians and medical education. The senior students were more reflective on the necessity of learning enough about patient values and health beliefs, advocating more deliberation in the process. The 1st-Year and 2nd-Year students were more assertive on physicians' obligation to do more for underserved, ethnic patients.

The dichotomy of values stemming from these questions and their responses was not resolvable in responses by the key informants nor the students who participated in the survey. Other concerns were expressed by the key informants over philosophical differences and negative roles demonstrated in some UCM faculty members.

Surviving Dis-synchrony

In the professional development of students at UCM, technical knowledge and skill bases progresses according to an incremental plan. The curriculum is designed to train

students in these areas and progress is measured through written exam, oral presentations, and clinical demonstration. The intangible dimensions of physicians' psychosocial awareness, including sensitivity in patient communication and cross-cultural delivery of care are more problematic to teach and harder to assess with medical students. For some students, the necessity and propriety of developing sensitivity toward ethnic, minority patients is self-evident, suggesting reinforcement during the clinical training.

Those students who work with positive faculty and housestaff role models are advised that "equitable standards of care are due all patients they encounter"; and "as cultural and value differences arise in the delivery of care, physicians must be guided by their ethical sense, not ethno-centricity."

For the UCM students, there are apparent tensions between humanistic interpersonal values and cultural biases shown by peers and authority figures. The researcher observed that interactive influences among students' peers and with faculty are strongly influential in the first two years, the time most students adjust to the social milieu of medical school. The formation of bonds with others who agreed with

their points of view or who professed persuasive opinions about the practice of medicine solidify during the second year. Students place a high priority on acceptance into study groups which evolve into cliques for purposes of socialization. Group membership at this stage for most UCM students represents like-mindedness in values and assimilation of cultural norms shown by the predominant white [student] culture.

Dis-synchrony for UCM students is discernible at two junctures in the UCM medical school experience: (1) as students [both ethnic and white] enter the freshman year with their individuality affirmed through prior experience and background, they immediately exhibit cultural views and behavior distinctive from their ethnic peers and from the student body overall and, (2) as the students formalize their individuality in their third and fourth years, when given more responsibility for patient contact and care. The fact that the majority of patients they encounter on inpatient wards and outpatient clinics are African-American or urban Appalachian means more experience with these culturally-diverse populations.

Through their learned ability to apply ethical principles while assessing the relationship of culture and medical

care, 3rd-Year and 4th-Year students are empowered to make more independent judgments about patients and their needs. The researcher observed that postures reflecting more psychosocial interaction with ethnic patients, reflected many students convictions in the care of ethnic minorities, often in contrast with their instructors. To this extent, they are non-conformist and "dis-synchronous" from their peers.

Second-year student, Don K., was made aware of his philosophical separation from his class by an interaction with a basic science instructor, Dr. Gary Landrum (a pseudonym). As a full-time Anatomy Professor, Dr. Landrum incorporated his personal affinity and knowledge of native American cultures into his lectures for reasons that went beyond attempts to capture students' attention.

Don K. cited Dr. Landrum's influence on him early in his academic tenure at UCM:

> When I heard Dr. Landrum begin his anatomy lecture with an anthropological tour of Indian cultures in Southwest, I was intrigued by the association he made between their beliefs in the sanctity of the "whole" body and our scientific inclination to dissect it. I

> sensed that he was teaching us more than "the body is equal to the sum of its organ parts." Even more striking was the realization that only a few students correctly interpreted the association, and fewer still felt it was meaningful (Interview, January, 1992).

Months after his Gross Anatomy course, Don K. and Dr. Landrum continued to discuss "the cultural connections" in medicine and the physician's assessment of patients outside of the "scientific model." While many students in Don K.'s class considered Dr. Landrum's fascination with native American culture to be eccentric, he was drawn to its wisdom and relevance:

> What Dr. Landrum did for me was to widen my perspective about health and wellness. We all learned to examine a diseased liver, for example, but only a few of us saw the way of life and sociocultural choices made which precipitated the death of the individual. I tried to discuss these concepts with others in my class . . . even friends of mine, but they responded with skepticism or shunned me altogether. Now, I am committed to the [physicians'] need to be sensitized

> to the range of beliefs and behaviors present in ethnic groups they serve (Interview, January, 1992).

Don K.'s survival of dis-synchrony has impacted on other students under his tutelage as a "student preceptor" in the ICP-1 course, The Medical Interview. As Don K. benefitted from his "new-found cultural awareness," in his words, he "saw an opportunity to pass it on. Since his interactions with Dr. Landrum and the label of "idle curiosity," Don K. sought out other faculty members and staff with culture-specific knowledge. The process of discovering health care connections to cultural practices and health beliefs has led him to raise the issue with "any faculty member who can add to his understanding" (Interview, January, 1992).

Dr. Landrum's singular emphasis on culture, lifestyle, and the human body had a impact on another key informant, Andy P., who spent the majority of his life living in one midwestern state:

> I have to admit that my knowledge of native American culture and other ethnic groups has been minimal. I have tended to see all of them in the same terms as my

> own. Somehow, I've omitted factors such as low socioeconomic status, poor educational opportunities, and societal prejudice. I was not raised with the notion that I am "disadvantaged" with my Hispanic heritage. Dr. Landrum taught me to set aside my "cultural neutrality" when looking at the human body . . . to consider individuals' health beliefs and regard for preventive health practices . . . . all based on culture (Interview, January, 1992).

As observed by the researcher, Andy P. took the influence of one faculty member into his approach to learning medicine at UCM and his prospects for future practice. Since his first year, Andy P. has participated in the Urban Care Program, the International Forum, and the Mobile Health Van (summer experience). He indicates his intention to serve his junior and senior AHEC rotations in Appalachian sites, one rural and one local (re: urban Appalachian enclave in Central City).

With heightened sensitivity toward other ethnic groups, Andy P. has become markedly integrated within the white majority culture at UCM, although he was perceived as a philosophical "outsider" in his own class. Andy P. has been

able to diminish his experience of dis-synchrony with his ability to validate his cultural differences with differences inherent in other cultures. Andy P.'s opportunity to do this has come primarily through patients he encountered in clinical training and in the community (Interview, January, 1992).

Andy P.'s status among UCM students has been enhanced as he conveys more eclectic and culturally-sensitive views. Ironically, these views continue to place him apart from most other UCM students who also have experienced minimal cross-cultural contact, but have continued to harbor their ethnocentrism (Interview, January, 1992).

Key informants, Lisa M., Alison H., and John B., have understood and empathized with the dis-synchrony experience at UCM. In a joint interview, they offered their own experiences and convictions regarding issues of culture and medical care. Lisa M. commented first on her views about treating ethnic minority patients:

> In my opinion, its not necessary to agree on all of the health care issues because they are too complex and we see patients under the influence of our own cultural upbringing. That's OK. What has bothered me since

> beginning my clinical training is that we are expected to mimic the behavior of our instructors, that is, the residents or the attending physicians. If all of us are white and we're trying to treat a black patient, our [students'] "personal slant" on what that patient needs or how she feels is not relevant for the moment. Some of the instructors are just closed to student's viewpoints (Interview, January, 1992).

John B. offered a realistic assessment of conforming with a majority view of ethnicity and care of ethnic minority patients:

> It's hard to respond to issues of minority patient care since I have very little contact with actual patients . . . only the Medical Interview course when I was learning basic communication skills. But, I would certainly make a point to my instructor that [we] African-Americans have views on health and the medical system which may vary from a white persons perspective. I sense a lot of the faculty feel students represent a colorless society outside the institution. (Interview, January, 1992).

Alison H. gave additional context to the phenomena of being "different" within a majority white culture, inside a medical school:

> I am considered "distinctive" merely from my accent alone, so often times, faculty members I'm working with assume that I will act in a certain way which fits their concept of a "Southerner" . . . they're usually not interested in my Appalachian origin. This relates to caring for ethnic patients, because I give them the same attention that I would want without worrying about what a colleague or instructor says if I mention something about the patient's cultural values . . .that makes me a "maverick," so I accept the label. Too few students at UCM know enough about these issues and too few faculty care enough to demonstrate the appropriate postures toward ethnic patients (Interview, January, 1992).

The phenomenon of dis-synchrony for these key informants and the UCM student body varies according to their background and the exemplary experiences each student has with faculty and patients. For ethnic students, there are

inner conflicts between the necessity of conformance to mainstream ideologies as conveyed in the first basic science lectures through the clinical rotations. Their own cultural values drive them to resolve these conflicts or modify their self-image.

For many white students there is a tendency to perceive dilemmas of cross-cultural health care as a lower priority in the absence of cues from the faculty. Without a faculty catalyst, the risk of dis-synchrony and attitude modification does not offer enough incentive for them.

For key informants Don K. and Andy P., enlightenment came through the cultural awareness of one faculty instructor. Their belief in the associations he drew between a native [American] culture and natural science separated them from other students who misconstrued the concept or rejected it outright. Lisa M., John B., and Alison H. also encountered conflicts in their values toward ethnic minority patients and "model" physician-patient communication and care. Their survival of dis-synchrony depended on humanistic motivations more than espousing ethnic values or assuming a "culturally-appropriate stance" with ethnic patients. Ultimately, each student was successful in holding their convictions about culture and medicine despite the potential

for peer alienation or faculty disapproval (Interview, February, 1992).

Achieving Synchrony

The researcher observed in many UCM students an attitude of confidence and egotism about their capacity for medical education. In 1st-Year and 2nd-Year class lectures, the researcher observed several (7) student-faculty encounters (i.e., debates) of health care issues which made references to "patients" as abstractions. As instructors use abstract terms routinely without humanistic inference, students refer to "patients" in the same manner.

Less emphasis is placed on patients' values or cultural personae outside of the ICP small groups. Exclusive concern is given to diagnosis and treatment protocols of ill individuals over social and cultural issues relevant to their care. Observations and interviews with faculty members and students support the impression that the "biggest message about culture presented in medical education at UCM is the non-message" (Interview, August, 1991).

UCM students' desire to conform with the mainstream ideology put forth in the Ist-Year and 2nd-Year curriculum

is apparent in their reluctance to challenge concepts differing from their own viewpoints. As observed repeatedly by the researcher, students resort to classification of instructors according to their knowledge of subject matter, ability as a lecturer, academic rigors, and subjective impressions of professionalism. Amiability and receptivity are also factors many students expect in faculty, but deem less important than traits they would cultivate as physicians. Virtually every UCM student screens the faculty for credible, desirable role models. Those students who identify faculty role models avoid much disillusionment with medical education and "attain synchrony" in the UCM system.

Some students express disappointment as key expectations of the medical school experience at UCM are not realized. In particular the following points were described to the researcher:

> (1) the notion that physicians are humanists and motivated by benevolence--(students felt justified in this idealistic view of the medical profession and its practitioners, and expressed surprise when hearing that "patient care has limits as do physicians who provide the care." The students' conceptualized "model

physician" also presumed sensitivity to the values of patients, but neglected awareness of ethnicity and culture).

(2) utilization of patients in the interests of the teaching program rather than prioritizing their existence and needs--(the students' were forced to acknowledge their naivete about the realities of clinical teaching, but many became cynical as a result).

(3) patients are receptive, cooperative, and respectful toward physicians--(this perspective of patients was admittedly idealistic on the students' part, but many assumed they would be taught techniques for fostering these characteristics in the process of care delivery). (Interviews, October, 1991, January, 1992, February, 1992)

As UCM students discover increasing contradiction between their expectations of the medical school experience, they tend to gravitate toward elective learning opportunities and faculty members who are capable of providing inspiration.

This phenomenon can be described as the "search for synchrony."

On entering medical school many students are motivated by the desire to contact patients. As the UCM curriculum provides little contact with patients in the first two years, the abstract references to patients become the normative way of analyzing them and their illnesses. With few exceptions, students who enter UCM with narrow-minded views toward others' [patients] age, gender, and ethnicity and values are not influenced toward more universal and ethical perspectives (Interview, December, 1991).

A faculty physician who counseled minority students in the UCM Dean's Office expressed concern over incoming students' ignorance of cultural diversity and the devaluation of ethnicity by faculty:

> My feeling is that most of the students who are considered "ethnic" by their peers have high personal values on ethnicity. However, I also feel that most "majority" [white] students probably do not. Why? . . . one reason is that students' values are imprinted in their home life and upbringing. When they get here there's a chance to affirm or revise concepts of

> cultural differences. Some of them will progress and accept the differences, others will cling to their skewed values because no one teaches them otherwise (Interview, January, 1992).

The onset of the third year of medical education at UCM brings opportunities to contact patients. Although most students view patients as "different" from themselves, they seek an eclectic knowledge of patients' health behavior and lifestyles. The researcher determined that students' interest in patients is both clinical and objective. The "differences" they recognize in patients are rarely based on an understanding of sociocultural dimensions which affect patients' lives and health.

Without exemplary models for cultural sensitivity, students are hesitant to explore the concept independently. Consequently, most UCM students look to the consensus of their classmates before making a philosophical commitment. In the opinion of one clinical faculty member, the students simply have not been shown another way of "knowing" patients of ethnic minority status or lower socioeconomic background:

> More than any other means, one leads medical students

> by example. They should discover that we are products of our heritage and environments. Physicians who have attained their knowledge and position through fortunate circumstances are no less vulnerable than their patients. Poor or minority patients may have qualities each of us needs to have, but it's not enough in the eyes of some students. As a teacher of future physicians, I have to show them the evidence . . . . and they have to see the other side of the issue (Interview, February, 1992).

New elective choices in the third year are significant in students' efforts to achieve synchrony. Through clinical rotations and departmental electives, students are able to seek out influential instructors and develop relationships with the potential for critical learning and attitudinal change. The researcher observed that the student-faculty interaction at this level of training affects students' perceptions more by indirect example than direct instruction.

Learning by observation is the norm in the 3rd-Year clinical rotations. As faculty physicians treated patients, confer among their colleagues and relate to other students,

patterns of professional and ethical behavior for physicians are memorized and replicated by student trainees. Few independent actions or inquiries from the students with respect to patients' cultural differences are evident unless first modeled by a faculty member. Students are inclined to follow the guidance of their instructor in order to "synchronize" themselves with the teaching styles and learning objectives.

As described by a primary care resident supervising 3rd-Year students in techniques of the clinical examination, association with a faculty role model is a "turning point" in becoming a "physician of conscience":

> The students are confronted with more values-based issues in their clinical training. The real influence occurs during one-to-one interactions that go beyond casual discussion on cultural diversity, or advice about communication approaches to Asian, black, or white patients. This period in my medical education was an introduction to cultural perspectives of patients which I had not considered before. I would like to return the favor with my own students. These issues are part of medical education and the best way

> to teach them, that is, through modeling desirable techniques and attitude (Interview, December, 1991).

The senior year at UCM offers further elective choices to students and continuation of relationships with influential faculty models. Preceptorships in low-SES and rural-based settings provide the most in-depth exposure to cross-cultural health care delivery. Students are permitted to choose placement in medical practices serving ethnic, underserved patient populations on a daily basis. Those students who are already committed to overcoming health care barriers insist on additional cross-cultural exposure. Community placements supervised by inspired preceptors offer unlimited opportunity for direct observation and replication of physician-patient communication skills.

Preceptors who are ethnic minority members themselves are especially valued by [white] students seeking synchrony through cultural sensitivity and by [African-American] students seeking synchrony through an ethnic role model. Although no preceptors are specifically known to be Appalachian, several preceptorship sites are located in the Appalachian enclaves of Central City. Students who choose these settings are informed about cultural values of the

community and the patients.

The researcher determined that some of the ethnic [African-American, Hispanic, East Indian] preceptors prefer student trainees of the same ethnicity, but all have indicated their willingness to work with any student who is open-minded about cross-cultural patient contact (Interview, Central City AHEC preceptor, January, 1992).

One physician preceptor [African-American] commented on his precepting style with white students in his Central City office.

> Aside from clinical skills that I passed on to these young students, I helped them appreciate how important patient's values are in their overall care. I started by defining cultural diversity in a context they would understand . . . "the presence and acceptance of people with different belief systems and ethnic-cultural identities as well as tolerance and support for communication about different cultural problems." My practice includes blacks, whites, urban Appalachians, even some Vietnamese. They all get the same quality of care and I'm sure the students notice that (Interview, Central City AHEC Preceptor, December, 1991).

The study's key informants, John B., Andy P., Alison H., Lisa M., and Don K., described their search and achievement of synchrony at UCM in similar contexts as the faculty members who became their role models. Each student discovered his or her readiness to view ethnic minority patients beyond physical parameters, with "culturally sensitive eyes."

John B. 1st-Year student, remarked that he would be successful when he acknowledged his ethnocentrism. He was looking forward to cross-cultural contact with patients from Central City, especially urban Appalachians, "because I know so little about them . . .their traditional ways, with pride and family first."

Andy P. 2nd-Year, was already comfortable with his openness to other cultures before coming to medical school, yet he admitted his own naivete about inequities in the health care system toward minority patients, and planned to inform himself better.

Alison H. 3rd-Year, also claimed a commitment to cultural diversity which was generally devalued by the UCM administration and curriculum . . . she contended that "targeting racial distributions in the student body" did not constitute adequate support or sensitivity toward ethnic

minority members. "It was something I had to nurture in myself and look for in my [UCM faculty] instructors."

Lisa M. and Don K., 4th-Year students, found early synchrony through culturally-oriented instructors and benefitted from cross-cultural experiences in their preceptorship training. Both students were ready to integrate their sense of "respect for all" with medical education. Their extra-curricular volunteer work with the African-American and urban Appalachian patients (UCM Mobile Health Van and the Urban Care Program) was "the most valuable lesson in cultural diversity possible" (Interviews, January, 1992).

For the students who determined that there was more to physician-patient communication than rote dialogue, diagnosis, and treatment, a greater effort was required to find the answers and to chart directions on their "map." Choosing a route through the maze of medical education which honored cultural differences, compelled all of these students to look beyond narrow, science-based pre-clinical lectures and beyond superficial faculty relationships. These were individuals who discovered mentors in the culmination of their of medical education; these were individuals who found "connectedness."

The Meaning of Connectedness

Connectedness is a higher learning objective attainable by students who survive dis-synchrony or who achieve synchrony in medical education at UCM. Connectedness for UCM medical students is a rare state of mind for students as it pertains to physician behavior and attitude toward culture and medicine. It represents the highest degree of affinity any student can reach through exposure to all elements of cultural diversity inside and outside of the medical school. Being connected in the UCM environment entails substantive medical knowledge, intuitive understanding of cultural differences and complete sensitivity toward ethnic minority persons and patients. During research in the study setting, the researcher documented only one student [Don K.] who understood and described the meaning of connectedness as manifested in medical care.

In an educational institution which mandates ethnic balance, but struggles to develop cultural diversity within its curriculum, a burden is placed upon students desiring more intimate knowledge of culture and medicine. For most of them, the realization that mentoring is the most direct course to cultural sensitivity does not come easily or

expediently. The culture-specific experience of students like Don K. was such that he was not satisfied with contemplating the care of ethnic minority patients. He sought out faculty members who could give a rationale for cultural sensitivity in medicine and teach him how it is accomplished.

For those UCM students who hope to discover connections between culture and medicine, faculty role models, both physicians and non-clinical professionals provide a crucial element for learning more than practical skills. Faculty role models facilitate the students' deeper understanding and appreciation of cultural diversity among themselves. Faculty role models influence students through demonstration and behavior; students learn from the role models through observation and replication of behavior. The mentoring experience adds a further element to the teaching of medicine, the mentor's "sharing of self" through trust and friendship. It is this extra component of mentoring which takes the student-teacher relationship to a higher level, in the case of Don K., to a state of connectedness as a future physician.

(Interviews, September, 1991; October, 1991; February, 1992).

Don K. described his relationship with UCM faculty which evolved from role modeling to mentoring:

> I was one of lucky ones in my class who figured out what Dr. Landrum was saying about the links between culture, the body and the mind back in my Anatomy lectures. He was an early role model for me. From that time, I began to think about cultural differences and how they affect people's views of health, medicine, and physicians. . . . I usually raised these points in small groups to everyone's disdain because they didn't see the relevance at all.

Don K.'s path toward connectedness was incremental, but not convoluted or aimless. Insight about which physicians and faculty could introduce him to ethnic minority patients in unique teaching sites, enabled him to seek out these exemplary instructors:

> When I began working with Dr. Fraley (pseudonym) in the Homeless Health Care elective in my second year, and then in his alcohol treatment clinic during the Family Medicine Primary Care Clerkship, I realized he had a

> different professional manner with ethnic patients . . . I learned from his behavior in the clinics and from the insights he shared with me about cultural differences. This year, as a senior, I a Family Medicine Clerkship with Dr. Fraley, working together on the wards with mostly African-American and Appalachian patients. My time with Dr. Fraley and our joint efforts with ethnic patients in the city helped me "connect" four years of training (Interview, February, 1992).

Having become a culturally sensitive individual with much empathy for ethnic minority health, Don K. attained connectedness through mentoring with one physician who served as a teacher and a friend. This relationship with a UCM faculty member motivated Don K. to place the physician's role in the context of a culturally diverse world which began in the ethnic neighborhoods of Central City.

For UCM students, mentoring is a unique and intensive student-teacher relationship. As a quality learning experience, it surpasses learning through behavioral role modeling. It is available to any student motivated to pursue it, with a "map" in hand. The ultimate success of

the mentoring is a factor of the student's receptiveness to new ideas and the mentor's willingness to impart his or her knowledge.

Mentoring offers an ideal means of teaching UCM students [like Don K.] the meaning of connectedness. This synthesis of medical education, cultural sensitivity, and appreciation of cultural diversity, ultimately serves the health and dignity of ethnic minority persons (Interviews, August, 1991, December, 1991, February, 1992).

CHAPTER VI

SUMMARY AND RECOMMENDATIONS

In this case study the phenomenon of cultural diversity in medical education was qualitatively examined in the setting of a medical school. This chapter will integrate study findings, discuss implications of cultural diversity in the medical school environment and present recommendations for a culturally-relevant medical school curriculum. The study questions were:

(1) What are the key concepts of culture in medicine and health care delivery with emphasis upon the needs of ethnic minority patient populations?

(2) How is cultural diversity cultivated or constrained in medical education with respect to students, faculty, patients, curriculum, and environment?

The study's initial guidance and focus were facilitated by historical, sociological, and philosophical precepts from the literature. Several themes emerged from the analysis of the students' individual and collective experiences in a midwestern medical school, University College of Medicine (UCM). Themes derived from the study were supported by patterned behavior of the study population [medical students] and other groups and individuals interacting with them. The data-based themes may be categorized into the following areas which reflect the didactic and experiential preparation of physicians at UCM:

a) Culture and medicine: Ethnic minority values as a cornerstone and catalyst

b) Cultural diversity in medical education: Interpreting curricula as a cultural awareness tool

c) Impact of faculty role models and mentors: The art of teaching medicine beyond the didactic

d) Urban Appalachians and African-Americans: The importance of two special populations encountered at

Culture and Medicine

As other researchers of medical education and medical student development have pointed out, culture is a prime variable used in explaining human behavior (Kleinman, 1978; Harwood, 1981). The impact of culture on behavior has significance beyond solely anthropological parameters. For example, cultural differences associated with disease among ethnic groups have epidemiologic significance, and psychological interpretations of response to pain or illness may vary widely according to cultural affiliation (Kleinman, 1978; Brodsky, 1983; Clark, 1983).

The social and genetic linkage each individual has with an ethnic group will characterize much of his or her behavior and attitude in society. Other variants contributing to individuals' cultural identity include race, age, gender, family, and religion, vocation, and disability. Distinctive cultural identity systems are represented by psychosocial structures through which group behavior may be described (e.g, professional culture, youth culture, homosexual culture). As the variants change for individuals, so does their identification and group

reference.

For physicians, understanding the cultural identity of individual patients and the personal meanings that patients attach to health and health care is essential. Accurate cultural assessment of patients has implications for clinical diagnosis and treatment and the quality of the relationship between physician and patient. Physicians who attend to an eclectic patient population may not provide optimal care without knowing these individuals as members of characteristic sociocultural groups. A number of authors have concurred that members of an ethnic group have common cultural, history, traditions, values, and health beliefs which affect their response to health care as well as the physician's understanding of their problems (Engel, 1980; Haynes, et al., 1985; Palinkas, 1985).

The development of physician-patient relationships according to observed or self-described ethnicity cannot be limited to awareness of color, physical features, and language usage. Physicians are advised to expand their concept of ethnicity to include aspects of ethnic loyalty, ethnic pride, place of birth, and regional-tribal affiliation, all of which may contribute to cultural identity systems (Byrd, 1990; Hill, et al., 1990).

Physicians prone to ethnocentrism may not be aware of the extent to which ethnic differences affect physiological assessment and treatment.

Differences in disease and illness rates associated with ethnicity which should be known to all physicians. Disease incidence and variance among ethnic groups residing in America have been confirmed in epidemiologic studies, including a positive association of hypertension with African-Americans ethnicity, digestive problems with Hispanic ethnicity, nervous and affective disorders with Asians, and alcoholism with American Indians (Haynes, et al, 1985; Palinkas, 1985).

Physicians' realization that culture and medicine are integral to one another and that efficacy of care is linked with communication skills, depends on their sensitivity to cultural differences. This professional and ethical quality can be facilitated through formal medical education, clinical training, and direct cross-cultural patient care, if prioritized by faculty opinion leaders and deans.

Setting aside tendencies of ethnocentrism is a first step toward recognizing and appreciating cultural diversity for the predominant white male element in most American medical schools. Majority culture medical students may nurture an

egalitarian perspective in medicine through culture-oriented curricula and more exposure to ethnic populations. These students can be open to cultural sensitivity by avoiding the belief that their mode of living, values, and patterns of adaptation are superior to ethnic minority groups (Marcus and Marcus, 1988).

The valuation of ethnicity in patients and an awareness of ethnic minority patients should be a cornerstone of medical education. The sensitization of medical students in a milieu of rapidly changing demographics and cultural confrontation is a logical course for future medical education. As societal groups and ethnic populations have increased encounters, the cultural knowledge base and interpretative capacity of educators has become more sophisticated. Overall, the benefits of expanded cultural knowledge have been integrated into social science education and not into medical school curricula. It is time for the role of culture in clinical medicine to be reflected in medical education with improved cultural diversity among the students and faculty.

A revelation with regard to culture and the medical encounter can be taught and modeled to all medical students from their entry into training. It is that in every meeting

of physicians and patients, there is also interaction of their respective cultural identity systems. The communication between physician and patient is affected by each one's connection to a given group and perception of other groups. Responses of stereotyping, rapport, satisfaction, compliance, and responsibility are manifested in the context of this communication. In the event that cultural identity system conflict occurs, one or both participants expect a particular behavior from the other. Based on their respective cultural understanding, the physician and patient move toward rapport or alienation. If their is sensitivity in the encounter, the physician and patient achieve a cultural connection or mutual affinity. In this way, culture and medicine combine to serve the interests of each participant.

The dimensions of culture and identification of ethnic group traits applied by physicians are often inclusive of patients' socioeconomic status. Quantitative studies of physician-patient medical encounters have documented that professional health providers are inclined to treat patients differently according to perceptions of socioeconomic status. Poor and disadvantaged patients tend to be blamed by the physicians for their impaired health and their

dependence on the welfare system.

Price (1988) and Roter (1988) state that physician perceptions of "poor patients" indicate a consensus that these individuals are typically ethnic minorities, i.e., African-Americans and Hispanics living in urban slums. The result of biased or culturally ignorant physician behavior toward ethnic minority patients is that they receive less information, less positive talk, and ultimately, less quality of care, both technical and interpersonal. In this study, many UCM students perceived (survey) that urban Appalachian patients were mostly poor and non-compliant.

The documented tendency of physicians to misunderstand or devalue the cultural identity of patients must be countered by first acknowledging medicine's failure, manifested through medical education and medical school curricula, to place more emphasis on the issues of culture. The introduction of cultural sensitivity into the practice of medicine should be addressed as challenge, not a problem. There is a need for administrative and faculty support for the inclusion of culture in all didactic instruction and clinical teaching in medical schools.

Teaching medicine from a global, multicultural perspective can enhance the capacity of future physicians to

extend themselves across values and language barriers. If this approach to culture and medicine is integrated into U.S. medical school curricula, cross-cultural encounters can be more than a series of impersonal assumptions and skewed expectations. The traditional biomedical model of medicine, which analyzes the human body in terms of parts and not as a holistic system with qualitative differences, must be reconsidered and modified as the core perspective in health care.

Cultural Diversity in Medical Education

The UCM curriculum in Years I and 2 offers standard teaching in the basic sciences augmented by less than 6% of course hours in the Introduction to Clinical Practice sponsored through the Dean's Office, two primary care departments, and the Dept. of Psychiatry. A principal objective of the didactic training in medical school is to prepare students for mandatory passage of Parts I and II of the National Medical Board Examination. The auxiliary training students receive in the ICP series attempts to provide a foundation in medical problem-solving skills, ethics, legal policy, and behavioral science. The instructional approach in all of the preclinical medical

education is by classroom lecture and laboratory investigation.

The ICP courses offer an extra dimension of teaching--small groups--which are preferred by the students at this stage. Small group sessions are often viewed as an alternative to the usual didactic regimen of the classroom. In these sessions, students are asked for opinions on problematic and controversial issues on health and health care, ethical and psychological dilemmas, and even patient ethnicity. The small groups also allow students to observe one another for philosophical leadership on issues rising out of the discussions. Conformity with the majority in behavior and opinions is strong among 1st Year students, except on rare occasions when an instructor encouraged more independent thinking than in lecture sessions.

The advent of problem-based learning in the ICP courses was an experiment intended to modify the preclinical curriculum and student participation in the education process. Initial trials of problem-based learning were successful. Both faculty and students expressed interest in this new teaching strategy with less structure and more opportunity to apply sociocultural issues to clinical cases. At the time of this study, only limited use of problem-based

learning instruction was planned for the next academic year.

In similar respects, the ICP courses have earned higher ratings from the students. Although the academic demands of the ICP courses and evaluation criteria are equivalent to those of the basic science courses, the students have responded with marked enthusiasm to the flexible, open-ended quality of this instruction. In the first two years at UCM, except for the ICP courses and two basic science sessions (Anatomy and Pathology) whose instructors incorporate issues of cultural diversity, there is no other curriculum focus on culture and medicine.

The 3rd and 4th-Year curriculum offerings hold more opportunity for UCM students to explore issues of culture and medicine and, most importantly, to acquire direct exposure to ethnic minority patients. The 3rd-Year clinical rotations provide all students with intensive patient contact and responsibility, with the highest degree of patient contact occurring in the primary care rotations: Family Medicine, Internal Medicine, and Pediatrics.

Limited rotation choices are available to the students in this phase of their medical education, but those individuals who are attracted by experiences in cultural diversity may arrange for additional opportunities. By expressing

specific interests in cross-cultural contact with patients to the appropriate departmental course directors, some students can be accommodated pending instructor/preceptor availability. There is sufficient flexibility in the clinical phase of the UCM curriculum to promote cultural awareness when students and faculty and departmental staff collaborated toward that common goal. However, as observed in the study, such collaboration is rare due to students' limited cultural awareness and faculty apathy regarding cultural awareness.

Cross cultural exposure in health care delivery begins in earnest with students' placement in community settings with physician preceptors. 3rd-Year AHEC and clerkship placements are mostly random with regard to urban or rural medical practices and the designated physician preceptors. If students are matched with a culturally sensitive preceptor, the four-week interaction which follows may have significant impact on students' appreciation for cross-cultural health care delivery. The ideal preceptor-student match is a "role-modeling relationship" with a likelihood of continuance in a 4th-Year placement. In some cases, preceptors may represent poor role models, devoid of cultural sensitivity toward ethnic minority

patients. With primary emphasis given students' compatibility and departmental course coordinators concern with negative role modeling, such preceptors are removed from the active list.

In the 4th-Year, when UCM students have elective choices, cross-cultural exposure is attainable in most instructional situations. Successful preceptor-student community placements from the previous year can be continued with the potential of a mentoring relationship. New role models may be discovered in the senior year in the context of more one-to-one and small group courses with selected faculty members. Students who have become more knowledgeable of individual faculty members are able to cultivate relationships and thereby seek cultural awareness at their discretion.

A requirement for each 4th-Year student is the second AHEC rotation, which is geographically unlimited. Students can choose their preceptor and primary care training in the Central City area, elsewhere within the state, or in other national or international sites. Apprentice placements with primary care physicians on native American reservations, in African-American homeless shelters, and in many international hospitals worldwide, profoundly affect UCM

seniors through cross-cultural exposure.

As noted in Chapter 4, increasing student interest in international clinical training has resulted from the influence of internationally experienced faculty members and the International Health Forum. The Department of Family Medicine, in particular, has taken the lead in developing international health care opportunities for senior students through an information resource center, international health journal club, and an international health care elective based in Honduras.

The International Health Care elective has significance as a model forum to introduce and teach issues of cultural diversity, cultural sensitivity and appreciation of cross-cultural contact. The expertise of an interdisciplinary faculty in the elective presents students with numerous points of view about cross-cultural health care, concurrent with their clinical instruction. Both faculty and students rate the course as "a unique jewel in a classically conservative curriculum."

Another unique opportunity is available to senior students with interest in providing care in Appalachian communities: the Appalachian Primary Care Clerkship. Also sponsored through the Family Medicine Department, this

clerkship may be fulfilled in a variety of sites developed by a faculty member with specific interest in the Appalachian culture. Placements are arranged with Appalachian health centers in rural midwestern states within the Appalachian region. Before and after placement, Clerkship students discuss the cultural history, values, and health beliefs of the Appalachian origin people with the faculty member.

The varied, culture-specific placements represent culminating experiences in cultural diversity unavailable in the earlier curriculum years. The combination of innovative ICP teaching in the first two years and culture-specific clerkship/preceptorship offerings in the latter two years is the best integration of clinical instruction and cultural awareness at UCM. While these offerings are commendable educational components at UCM, more opportunities for cultural awareness are needed in the pre-clinical years, when students' cultural identity systems and perceptions of other ethnic groups can be enlightened.

Impact of Role Models and Mentors

The cumulative observations of students' exposure to cultural diversity and acquisition of cultural awareness

indicate that the strongest influence on students comes from individual faculty members who served as role models or became mentors. An ongoing tension exists between students entering UCM with limited cross-cultural experience and faculty with high regard for cross-cultural values. Through supportive student-faculty relationships, clinical teaching, and one-to-one dialogue with students, humanistic and psychosocially-oriented approaches to ethnic minority patients can be modeled and learned.

Role Models

The phenomenon of role modeling occurs not only in students' relationships with their instructors, but also in some peer interactions. Student role models are usually older, more experienced individuals in the upper classes. Leadership qualities and more global perspectives often determine which students become role models at UCM. First and second-year UCM students are particularly impressionable and, in general, seek out authoritative peers to demonstrate appropriate survival skills in medical school.

Most of the UCM students indicate a desire to "synchronize" themselves with normative behavior of their classmates for academic success and socialization. This

positioning signifies a psychological adjustment to both the substantive and engaging atmosphere of their courses. As issues of culture arise in didactic instruction, students may be compelled to break away from the traditional majority and advocate different perspectives with social or ethical implications. Students' individualistic attitudes about culture and health care of ethnic minorities may move them toward dis-synchrony with their peers, but closer to an informed view of medical practice.

Students struggling to understand the relevance of culture to medicine attempt to validate their views during the process of medical education, that is, in lectures on the biomedical model, in clinical training, or in counsel with faculty. Discovering a faculty member who voices respect for cultural diversity and models cultural sensitivity with patients is a threshold experience for students, but uncommon. The perpetuation of learning from faculty role models depends on the students' receptiveness to new concepts and experiences and on the diligence of the instructor in changing student attitudes. Strong faculty role modeling is conducive to instilling positive interventional skills and concepts in students, but only a few such relationships progress to mentoring.

Faculty physicians may also model negative behavior toward students, peers, and patients, providing students with a standard of conduct to avoid. Certain physicians with reputations as negative role models, known to the students and others within the UCM milieu, are useful for demonstrating behavioral extremes including cultural insensitivity. Students' observation of these faculty members therefore have marked educational value and should not be discounted in the medical school experience. A consequential problem exists at UCM due to a larger number of negative physician role models and too few positive role models with respect to cultural knowledge and sensitivity.

Mentors

The mentoring experience is the most effective and significant aspect of medical education possible for students at UCM. The affirmation of cultural diversity for students who are fortunate enough to find physician mentors can be profound. The experience is limited only by the knowledge of the physician and the willingness of both participants to exchange ideas and cultivate cross-cultural patient contact. The physician and students who find themselves in a mentoring relationship are often unaware of

their unique association until they move on to other relationships.

The mentoring experience seems to be arbitrary because the UCM curriculum does not specifically facilitate such one-to-one teaching. There are logistical and manpower limits to this type of teaching, and it is not uniformly appropriate or effective for all students. Although some mentoring experiences do not cultivate appreciation for cultural diversity or enhance cultural sensitivity, as observed by the researcher, most faculty mentors at UCM show consummate respect for their ethnic minority patients. Some positive role models show such respect in cross-cultural encounters, but do not often stress this behavioral trait to students after the encounter.

Faculty members who become mentors for students offer more of their skills and wisdom to students than is learned in simple role modeling situations. The personal interaction in mentoring relationships, known to some students as "sharing the physician's psyche," yields lasting, mutual benefit to the faculty member and student.

Faculty mentors at UCM include both physicians and non-clinicians with expertise in behavioral science, bioethics, international health, health psychology, and

other disciplines. Competence and wisdom passed on to students are not exclusively in the clinical realm, but the mentoring focus was consistently relevant to health and health care. More often than not, the mentoring examines physician-patient communication and cultural differences affecting and communication and treatment. In most cases, the student/mentorees are self-selected as areas of common interest related to the specialty of the mentor became apparent.

UCM faculty members are obligated by contract to teach medical students as part of their overall responsibilities. Beyond that uniform commitment, time spent with students is discretionary and subject to demands upon faculty to conduct research and generate income. Those faculty members who become mentors devote a major portion of their energy and time to students to form bonds that transcend academics. The faculty mentors observed in this study were motivated by higher purposes than promulgating the precepts of the biomedical model. The mentors' commitment is to engender the most effective and ethical standards for medical care for all patients regardless of ethnic or values differences. Mentors are able to personify for students the notion that the respect and acknowledgement shown to them is also

deserved by patients, particularly across cultural and socioeconomic lines.

As UCM students complete their journey through medical education, their experiential "map" has brought them to a destination that for some represent new cultural enlightenment. For others who ignore the presence of learning coordinates and educational features along the way, awareness of cultural differences and appreciation of cultural diversity will elude them. The fortunate few who were ultimately guided by a culturally sensitive faculty mentor represent the best hope for enhanced health care of ethnic minority persons.

Urban Appalachian and African-Americans

The setting of University College of Medicine, Central City, is recognized as a home for two special populations, urban Appalachians and African-Americans. Members of these ethnic groups comprise the largest percentage of outpatients seen at the University Medical Center, which is affiliated with UCM. Medical students at UCM, who are required to learn techniques of the medical interview, history-taking, physical examination, are exposed to this same patient population over their four year tenure. Most of the

students are white, and members of the middle-upper socioeconomic class who have had minimal cross-cultural contacts and who manifest poor cultural awareness of urban Appalachians and African-Americans.

The dearth of cultural orientation for students regarding urban Appalachians and African-American results in cultural insensitivity shown in most patient encounters where students are involved. If, as Marcus and Marcus (1988) contend, most medical students are encouraged to perceive themselves as eventual "gatekeepers of health care," an obligation to respect cultural differences in patients must accompany that mandate wherever as students become physicians. UCM students who hear this characterization of their future in medicine, must first look to urban Appalachians and African-Americans where they are . . . . in Central City.

The reality of urban Appalachians and African-Americans in Central City--suffering higher health risks, poor access to health care, and lower per capita income relative to majority culture white residents--is lost to most 1st-Year and 2nd-Year students at UCM. Many patient encounters in the 3rd-Year and 4th-Year clinical training bring cultural and socioeconomic disparities to the forefront, yet the

majority of students continue to show inadequate cultural awareness of urban Appalachians or African-Americans.

The exceptions to this situation come through the influence of culturally informed faculty members who raise the issues of health care of urban Appalachians and African-Americans. Specific focus on these two ethnic populations in 1st-Year and 2nd-Year basic science lectures is virtually absent, except for the epidemiological references, e.g. that African-Americans are at higher risk for hypertension and certain types of cancer or that rural Appalachians experience more mental health problems than non-Appalachians. Two forty-minute Behavioral Science lectures on ethnicity and health care address cross-cultural medical encounters with urban Appalachians and African-Americans, respectively.

Some case presentations utilized in the Introduction to Clinical Practice feature African-American patients for purposes of clinical assessment. Therein, no reference to the cultural values or health beliefs of the ethnic minority patients is made for the students' information.

In the 3rd and 4th-Year clinical rotations, students make mandatory in-patient rounds with attending faculty and residents of specialty departments. Students'

acknowledgement of blatant ethnic and racial stereotypes from faculty instructors indicate that anti-cultural messages are prevalent in the context of clinical training at UCM. Key faculty members verify that a double-standard exists between physicians' professional duty to objectivity and biased behavior toward ethnic minority patients in University Hospital clinical settings (Interview, January, 1992). Negative role modeling in combination with the "non-message" (apathy and ignorance toward ethnic groups) about cultural diversity work against preparing culturally sensitive physicians at UCM.

A rich but subtle variety of culture-affirming resources in the UCM milieu counters the negativism and cultural apathy toward urban Appalachian and African-Americans. The students' own organizations, offering opportunities for public service projects in Central City ethnic neighborhoods, acknowledge cultural differences from a social context. The student-founded Urban Care Program places post-1st Year student in summer volunteer slots with a variety of social and health care agencies in the city which focus on the needs of urban Appalachians, African-Americans and other underserved persons. Doctors Ought To Care, a student public education activist group, delivers

over one hundred talks on tobacco, alcohol, and drug abuse prevention in Central City schools with predominantly African-American and urban Appalachian enrollment.

The Family Practice Club, Christian Medical Student Association, and Student National Medical Association all sponsor public service projects during the academic year, often targeting both African-American and urban Appalachians in the depressed city enclaves. Each of these groups represent and advocate humanistic values and cultural diversity in medicine to all UCM students.

Finally, a small number of ethnic members of the faculty offer personal revelations and insight to students about their own cultural values and history, though not in aggressive fashion. Both African-American and white students often have to seek out ethnic faculty members to elicit their views on culture and medicine associations. Ironically, most African-American physicians on the faculty and serving as community preceptors are conservative about the relevance of ethnicity in their practices and in medical education. The limits of the present study did not allow for further investigation into this particular posture in African-American physicians within the institution.

In the course of the study, none of the UCM faculty

openly identified themselves as Appalachian or having ties to the Appalachian region. Several staff members interviewed by the researcher were, in fact, urban Appalachians, but did not feel that their ethnic roots were recognized or valued by the students or others at UCM. Students of Appalachian origin were acknowledged informally by the UCM Dean's Office and the Admissions Committee, but routinely labeled as "rural residents" for admissions records.

Due attention to the ethnic diversity of Central City residents comprised of urban Appalachians and African-Americans is lacking in the curriculum and in the teaching and clinical example set by UCM faculty physicians. The Dean's Task Force on Educational Diversity has reached a similar conclusion based solely on course content at UCM. Whether or not UCM graduates will attend to the health care needs of urban Appalachians or African-Americans is not the singular justification for examining these ethnic groups more closely. It will represent an important precedent for broader cultural considerations in all clinical teaching at UCM and move its physician graduates toward egalitarian standards in medical practice.

Contributions to Research

The findings of this study contribute to a better understanding of the impact of cultural diversity in medical education at a representative institution. Greater insight into the sources of cultural diversity and medical students' acquisition of cultural knowledge and sensitivity has been provided through the ethnographic methods used herein. The results of this study highlight the importance of incorporating cultural issues into didactic instruction and clinical training at every opportunity possible through medical school curricula and by faculty conduct. The study affirms the influence of cultural values brought into the medical school setting related to students' families and home environment.

The longitudinal design of this study permitted the researcher multiple opportunities to observe student's response to cultural questions and issues. The evolution of UCM students' attitudes on ethnic minority health and health care, particularly concerning urban Appalachian and African-American patients in Central City, have not been examined prior to this research. The study confirms that philosophical and ethical adjustment of perspectives toward ethnic minorities (i.e., patients) is a galvanizing

experience for medical students over four years of schooling.

The study also shows the critical influence of peer and faculty role models in demonstrating cultural sensitivity to students who are apathetic or ignorant about cultural differences. The study's confirmation of mentoring as the consummate method for instilling appreciation of cultural diversity in the context of medical practice is the finding with most potential to enhance future medical education.

Recommendations for Future Directions

It is hoped that this case study raises significant questions for future research into the role of cultural diversity in medical education at other institutions, including as follows:

(1) Is exposure to cross-cultural health care delivery and cultural diversity effective in medical education?

(2) Does attention to indigenous ethnic groups which comprise major patient populations enable physicians to provide a higher quality of care?

(3) What are the best ways to present concepts of culture and ethnicity to medical students?

In the national debate of educators regarding curriculum reform, there is a pressing need for a multicultural perspective in higher education institutions, including medical schools, and the University College of Medicine. A balance between more liberal education and professional training is in order in light of the challenges coming from the larger society. The degree of multiculturalism to include in medical education curricula must be enlarged to provide future physicians with clearer understandings of other cultures and values. A closer examination of their own culture and values is also appropriate to gain context toward optimal cross-cultural patient care. The curriculum at UCM should be subjected to constant scrutiny to maintain adequate focus on cultural diversity issues from both practical and philosophical perspectives. In sum, predoctoral curricula at UCM (and all medical schools) must reflect the increasing diversity that will characterize future student, national and world demographics.

The following recommendations are made in the interests of improving the presence and understanding of cultural

diversity in medical education. The recommendations are based on the findings of the study of UCM students' cultural knowledge and experience with ethnic minority peers, faculty, and patients. The recommendations are intended to emphasize social and philosophical aspects of medical education, notwithstanding anticipated administrative and political barriers:

(1) Prepare medical students as practitioners according to basic precepts of culture and medicine:

a) pursue understanding of illness expressed in context of culture,
b) determine what kinds of treatment are appropriate for individual patients with regard to their cultural framework and health beliefs
c) learn the impact of cultural differences in patients' response to illness and health care providers

d) develop and preserve sensitivity to cultural issues in behavior
e) avoid stereotyping and attribution of health impairment to patients' socioeconomic circumstances.

(2) Implement a mandatory four-year curriculum series of courses, workshops, and small group sessions focusing on cultural diversity and cross-cultural health care. In the first year, a special component of the Introduction to Clinical Practice (ICP) might be devoted cultural differences, socioeconomic disparities, and ethnicity--conceivably entitled "Introduction to Cultures" This course would continue to use the present lecture-small group format, but students would be encourage to pursue more independent research and develop presentations on specific issues of culture and society.

In the second year, a more intensive exploration of the connections between culture and medicine would involve students in special projects and interaction with the ethnic communities of Central City. This academic and experiential course would build upon the precedent set by the Urban Care Program, facilitating placement of students with public service and community health care agencies in the city. Students would be provided opportunities for daily or weekly involvement with disadvantaged and ethnic minority clients through Central City agencies and sponsored programs. Techniques of qualitative assessment might be taught to the students concurrent with their exposure to cross-cultural

situations as a complement to future clinical skills. At course conclusion, students would be asked submit evaluative journals of their experiences for consideration of classmates and faculty.

In the 3rd-Year, all students would be required to enroll in the Primary Care Clerkship sponsored by the Department of Family Medicine, restructured to emphasize cultural values in health care along with acquisition of primary care experience. Student-preceptor placements would feature cross-cultural patient populations as much as possible in Central City and regional rural sites. Ethnic preceptors and culturally sensitive non-ethnic preceptors would be given special recognition before the students and involved as regular UCM lecturers and consultants on cultural issues in medicine. One day each week during the clerkship, students would attend departmental presentations on common health problems, small groups (eg., Physician-patient communication, Alcoholism, Geriatrics) addressing patient care issues with added emphasis on cultural awareness.

In the UCM senior year, all students would be required to serve at least one rotation month in a cross-cultural setting or clinical site devoted to socioeconomic and disadvantaged persons. The UCM AHEC requirement could be

satisfied separately from the added rotation if it did not feature a cross-cultural patient population. Priority placement would be given to those individuals who had distinguished themselves through the Urban Care Program, Homeless Health Care/Family Care electives, Doctors Ought To Care, Family Practice Club, International Health Forum, Student National Medical Association, and any independent effort on behalf of ethnic minority persons.

At the conclusion of the academic year, all senior students at UCM would be encouraged to organize and present to the entire staff, faculty and student body, a "Symposium on Culture Values in Health Care." The agenda would be based on priorities set by the students with input from select faculty members seen as culture-sensitive role models. This event could be combined with prior, localized efforts by ethnic students which have failed to gain interest of the students or support from the Dean's Office--aside from the Office of Minority Affairs. Special honor might be granted to exemplary students and faculty for upholding principles of culture of the individual, the community, and in health care.

(3) Implement a university-wide forum on Culture and Medicine through the UCM Dean's Office, in conjunction with the Student Affairs Office, the Office of Minority Affairs, and a Faculty Committee for Cultural and Educational Diversity. The forum would convene ethnically-diverse, interdisciplinary speakers and a roundtable panel of faculty and students and community residents for debate on the following issues:

a) definition of culture and ethnicity,
b) cultural differences among patients in health, access to care, and use of health services,
c) the formation of prejudice and other social attitudes in both physicians and patients,
d) the perspectives of allied disciplines (ie., anthropology, medical sociology, educational foundations) concerning cultural aspects of medicine.

The symposium would conclude with a joint statement and adjunct publication of recommendations for more equitable and effective cross-cultural health care.

(4) Future research on cultural diversity in medical education might be focused on students' comparative

experiences over time in the process of becoming a physician. Individuals from varied ethnic backgrounds and cultural value bases might be observed separately and concurrently at the same medical school or at different institutions to assess cultural forces and barriers.

Given our present knowledge of the influence of socialization and conformity among white majority students, additional research might be conducted on the perceptions of intra-ethnic students and minority groups in this environment. The phenomena of individual leadership and role modeling among medical students could be better understood through long-term qualitative participant-observation, even immersion in the field (i.e., medical school).

Longitudinal ethnographic investigations of faculty and student interactions would reveal more specific information about how cultural sensitivity and ethnic biases are transmitted in academic and clinical settings of medical school. The same type of investigation could be conducted by a qualitative research team directed toward the institution's Dean, Assistant Deans, key staff directors, committee chairpersons, and faculty opinion leaders. Research focus should be directed to the effects of

political and bureaucratic behavior on cultural diversity in a medical school.

(5) Research the phenomena of conservatism and cultural passivity as demonstrated by some African-American medical faculty at UCM. Comparative qualitative investigation of ethnic faculty members who do espouse cultural sensitivity as a component of medical care should be a complement study. Useful insights into the consistency of behavioral anomalies by African-American physicians and faculty would be gained by observing a randomized sample of this professional population at other medical schools. Study subjects should be interviewed with standardized and non-standardized question formats in academic and informal settings to neutralize external influences from their departments and institutions.

Any study of this population should attempt to determine whether their behavior and attitude are derived from insensitivity to cultural aspects of medicine or socio-political pressures to conform with a majority white faculty. This study would hold significance for medical school hiring policies whether driven by Affirmative Action regulations or by desire for a culturally diverse teaching

staff.

As in the recommendations for studying cultural diversity in an institutional environment noted above, the more comprehensive and intimate the investigation can be made, resulting quality of data will reflect this methodology. Investigator immersion in medical schools holds the best potential to fully understand students' culture and their acquisition of cultural awareness and refutation of ethnic and racial bias in health care. The commitment required to conduct such a study is considerable, but the potential applications of new data could lead to more humanistic physician corps, knowledgeable and sensitive toward all cultures and patients.

Notes

1. The researcher is obligated to follow guidelines for confidentiality which protect all individuals and sources of information reported in this document. The setting of this study and references to the same: (University College of Medicine); (UCM); (Central City); (midwestern state) are intended to be completely anonymous. Every name and place cited in this report is a pseudonym. Descriptive data regarding the study setting, students, faculty, staff, and patients are real and factual. If readers of this study desire to know more about certain names, dates, documents, organizations, or events cited herein, they may contact the researcher through the affiliated institution.

2. The following author/resource/interview citations are pseudonyms, but may identified by request to the researcher: Boyer, Handell, Younger, Oppenheimer, Landrum, Fraley, Valentine, Alison Ray, Lewiston.

3. The following document citations are fictitious, but may be identified by request to the researcher:

Central City Health Department Reports, 1987, 1988, 1989; Minority Health Care Intervention Report, 1987; Central City Appalachian Council Task Force Study, 1990; AAMC Monograph, 1986; LCME Report to the Dean, 1989; University Medical Center Strategic Plan, 1988-95; Lewiston Neighborhood Council Task Force Report, 1990.

4. The following organizations cited in the study are fictitious, but may be identified by request to the researcher:
UCM Task Force on Cultural Diversity, 1989; UCM Liaison Committee on Medical Education, 1989; UCM SubCommittee on Medical Students; UCM Faculty Forum; Council for Appalachian Advocacy; Urban Care Program; Central City Black Community Forum.

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APPENDIX - A

Informed Consent Form

University Medical Center/College of Medicine
Consent to Participate in a Research Study

Before agreeing to participate in this study, it is important that I read and understand the following explanation. It describes the purpose, procedures, benefits, and risks of the study and the precautions that will be taken. It also describes the alternatives available and the right to withdraw from the study at any time. It is important to understand that no guarantee or assurance can be made as to the results of the study. It is also understood that refusal to participate will not jeopardize employee rights or student status, opportunities or benefits.

OBJECTIVES OF THE STUDY

*I,*_____*, of* _____
Faculty/Student/Staff member *Street Address*
_____, _____, _____, *voluntarily*
City *State* *Zip*

consent to participate in a research study, the purpose of which is to describe the presence and effect of cultural diversity in a medical school environment with focus upon the students throughout their academic tenure. This description may contribute to the better understanding of how medical education and cultural diversity are or can be integrated toward preparing physicians to work with ethnic minority persons.

PROCEDURES

In order to prepare a thorough description of cultural diversity and medical education at UCM, the investigator will, observe and interact with people who provide professional training and health care. To ensure accuracy of the information, written field notes, audio recordings, will be made to supplement observations. The sole purpose for making field notes and recordings is to provide reference material for the investigator so that a clear and representative picture of cultural diversity and medical education will be possible. I understand that information I offer in individual or group interviews with the investigator and through questionnaires eliciting information about cultural diversity and medical education may be use in the written research report.

BENEFITS

Since the primary goal of this study is to provide additional social science

knowledge, I understand that I will not expect any direct benefits. I may benefit from increased knowledge I gain by association with this study.

RISKS AND PRECAUTIONS

The risks of participation in this study are minimal. I may encounter some inconvenience in arranging my daily work routine or academic responsibilities to meet with the investigator.

CONFIDENTIALITY

I understand that any information collected via field observation notes, audio recordings or from questionnaires I may complete will be kept confidential. I also understand that the results of my participation, including personal statements or insights, may be published for scientific purposes providing that my identity is not revealed.

THE RIGHT TO WITHDRAW

I understand that my participation in the study is voluntary and that I am free to refuse participation or to withdraw at any time. Should I wish to withdraw, I have been assured that I do so without loss or jeopardy to opportunities, rights or benefits due me as an employee or student associated with the University Medical Center/College of Medicine.

WITNESSING AND SIGNATURES

Before giving my consent by signing this form, I have been sufficiently informed of the purposes of this study, possible benefits, risks and inconvenience which might result from my participation. I have read and fully understand the information specified above and I willingly give my consent to participate in this study.

_____ _____

Participant *Date*

_____ _____

Investigator *Date*

_____ _____

Witness *Date*

APPENDIX - B

University College of Medicine
Review Board Document

College of Medicine

Institutional Review Board

MEMORANDUM

TO: Edwin Barnes
Undergraduate Instructor
Senior Preceptorship Director
Department of Family Medicine

FROM:

Institutional Review Board

DATE: July 2, 1991

This letter is in response to yours of June 25, 1991. I have reviewed your "Proposal for a Case Study of Cultural Diversity in Medical Education". Since involvement in this study presents no threat whatsoever to faculty and students involved, the study is exempt from IRB review and surveillance.

I wish you the best in this endeavor.

APPENDIX - C

Standard Interview Form for UCM faculty and staff

STANDARD -- *INTERVIEW QUESTIONS*

1. *What is the environment of this medical school?*

2. *What is the composition of the student population here? Gender, age, ethnicity, experience?*

3. *Do the students of this institution constitute a culture?*

4. *Who are members of the faculty? The non-clinical staff?*

5. *Does the faculty of this medical school constitute a culture?*

6. *What personal values do you perceive are held by students about ethnicity? Minorities?*

7. *What are the origins of the students' values?*

8. *Do students' values change minimally or significantly while in medical school?*

9. *What role do faculty and staff members play in fixing or altering students' values or perceptions of ethnic minority persons?*

10. *Define cultural diversity.*

11. *Are there contradictory or ambiguous messages students receive about culture and medicine?*

12. *Are there any issues associated with differential diagnosis or treatment of ethnic minority clients/patients?*

13. *Are there distinctive considerations physicians and clinical staff might give to UAs or AAs as patients or with regard to their family members? (Approx. 68% patient population at this hospital are comprised of UA or AA).*

14. *Should culture-specific values of ethnic minority populations be recognized or discussed by physicians who will treat them on a regular basis?*

15. *If issues of cultural diversity are relevant or important in medical practice and community health care, how can medical students be taught about these issues?*

APPENDIX - D

Medical Student Survey
and
Survey Results by Item and Class

Medical Student Survey

Please respond to the following statements by indicating AGREEMENT, DISAGREEMENT, or NEUTRAL by 5-Point Likert Scale. (5-1; Strongly Agree - Strongly Disagree). The first four questions are optional, but your responses would be informative to this study and appreciated by the researcher. All data provided in this survey will be kept completely confidential.

A. *Gender:* *Female* _____ *Male* _____

B. *Ethnicity:* *African-American* _____ *Caucasian* _____

Asian-American _____ *Hispanic* _____

Native American _____ *Other* _____

C. *Class Yr.:* *UC I* ____ *UC II* ____ *UC III* ____ *UC IV* ____

D. *Exposure to ethnic groups other than own prior to enrolling in medical school, including community and school environments.*

Frequent ____ *Periodic* ____ *Infrequent Contact* ____

1. *Culturally uninformed physicians often make clinical decisions contradictory to their ethnic minority patients' perceptions of illness.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

2. *All ethnic minority groups must learn to assimilate values of the larger culture without relinquishing their own cultural heritage.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

3. *Delivery of primary care and preventive health services to ethnic minority patients is hindered because of mutually held stereotypes between physicians and patients.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

4. *African-American and Appalachian patients may consult with a traditional or lay health care provider prior to seeing a formally trained physician.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

5. *For physicians, it is unacceptable ethically and morally for a majority of ethnic minority persons to be medically uninsured or underinsured.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

6. *Socioeconomic and lifestyle factors, not ethnic heritage, account for higher incidence of chronic health problems among African-Americans and Appalachians.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

7. *When delivering health care, physicians should not attempt to separate ethnic minority patients from their cultural and health beliefs.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

8. *Ethnic minority populations experiencing limited access to health care are responsible for this dilemma because they adopt a passive stance toward the mainstream health care system and rarely question their physician or seek further information.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

9. *Physicians who acknowledge demographic factors of ethnicity, age, gender, family culture, and religion will be more effective in treating African-American and Appalachian patients.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

10. *Cultural sensitivity leads to appreciation of cultural diversity which is essential to quality health care for ethnic minority persons.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

11. *Physicians cannot be expected to appreciate or act upon unique values or behaviors of culturally different patient groups because these issues are not part of standard medical school curricula.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

12. *Physicians are trained to treat, teach, and show concern for patients, but cultural sensitivity is not imparted as a requisite for professional competence.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

13. *Differences in expression of grief and bereavement among ethnic minority patients are clinically insignificant with regard to medical treatment or management.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

14. *Physicians' assessment of African-Americans and Appalachian patients is best undertaken apart from consideration of ethnicity and cultural values.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

15. *Comprehension of the social and cultural milieu of African-American and Appalachian patients is essential for development of an effective treatment plan.*

5	4	3	2	1
Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree

Addendum Questions

1. *List two or more personal values or characteristics attributed to persons of Appalachian heritage.*

2. *Where and what is Appalachia?*

3. *Are there any Appalachians who are black or who identify themselves as non-white?*

4. *Name two or more language/communication difficulties which can occur between African American patients and white MDs.*

5. *In a public discussion or personal debate, describe modes of behavior which blacks consider appropriate in comparison with modes of behavior which whites consider appropriate.*

6. *Is direct eye contact or physical touch offensive to members of the African American community? Explain your answer.*

Medical Student Survey Results
by percentage
n=114

Question	STRONGLY AGREE %	AGREE %	NEUTRAL %	DISAGREE %	STRONGLY DISAGREE %
1. (+)	17	55	18	8	2
2. (o)	12	41	24	22	11
3. (o)	15	51	21	9	4
4. (o)	8	36	51	4	1
5. (+)	24	41	26	6	3
6. (o)	26	55	13	4	3
7. (o)	13	51	19	15	3
8. (-)	0	4	26	49	21
9. (+)	41	43	10	5	1
10. (+)	38	48	9	5	3
11. (-)	4	10	14	53	20
12. (-)	9	21	18	38	15
13. (-)	4	5	14	63	21
14. (-)	0	15	29	46	10
15. (+)	23	55	15	6	1

(*) Indicates premise of question with regard to culture and medicine; (o) = neutral.

Medical Student Survey
Responses

Q-1 (+)

	SA	A	N	D	SD
UC 1	5	24	10	5	
UC 2	6	10	2		
UC 3	6	11	5		
UC 4	8	13	6		

H_o not rejected

Q-2 (o)

	SA	A	N	D	SD
UC 1	6	15	10	7	4
UC 2	2	10	3	3	
UC 3	3	6	4	3	2
UC 4	5	12	8	2	2

H not rejected

Q-3 (o)

	SA	A	N	D	SD
UC 1	6	23	12	3	
UC 2	2	10	7		
UC 3	5	13	3	1	
UC 4	8	18	3		

H_o not rejected

Q-4 (o)

	SA	A	N	D	SD
UC 1	3	14	21	4	
UC 2	7	9	3		
UC 3	4	10	7	1	
UC 4	8	14	6		

H_o rejected
UC 1 diff. sig.

Q-5 (+)

	SA	A	N	D	SD
UC 1	11	19	8	3	
UC 2	6	8	3	2	
UC 3	4	11	5	1	
UC 4	8	12	6		

H_o not rejected

Q-6 (o)

	SA	A	N	D	SD
UC 1	11	30	3		
UC 2	5	10	3	1	1
UC 3	6	10	4	2	
UC 4	14	9	6		

H_o not rejected
UC 4 diff. not sig.

Q-7 (o)

	SA	A	N	D	SD
UC 1	5	25	7	6	
UC 2	4	9	3	3	
UC 3	7	12	2	1	
UC 4	4	18	7		

H_o not rejected

Q-8 (-)

	SA	A	N	D	SD
UC 1		1	10	27	6
UC 2		1	5	10	3
UC 3		1	4	15	2
UC 4		1	5	8	15

H_o rejected
UC 4 diff. sig.

Q-9 (+)

	SA	A	N	D	SD
UC 1	18	20	5	1	
UC 2	10	6	3		
UC 3	6	14	2		
UC 4	18	9			

H_o rejected
UC 2 & 4 diff. sig.

Q-10 (+)

	SA	A	N	D	SD
UC 1	14	25	3	2	
UC 2	13	6			
UC 3	4	14	3	1	
UC 4	18	9			

H_o rejected
UC 2 & 4 diff. sig.

Q-11 (-)

	SA	A	N	D	SD
UC 1	1	3	5	26	9
UC 2	2	3	2	9	3
UC 3	1	2	4	12	3
UC 4	1	2	3	14	8

H_o not rejected

Q-12 (-)

	SA	A	N	D	SD
UC 1	1	8	6	24	5
UC 2	2	3	3	7	4
UC 3	1	9	6	5	1
UC 4	3	14	8	2	2

H_o rejected
UC 4 diff. sig.

Q-13 (-)

	SA	A	N	D	SD
UC 1	1	2	10	18	13
UC 2	3	2	2	10	2
UC 3	1	1	5	12	3
UC 4	1	4	3	18	3

H_o not rejected

Q-14 (-)

	SA	A	N	D	SD
UC 1		7	10	24	2
UC 2		3	2	12	2
UC 3			6	12	4
UC 4				18	9

H_o not rejected

Q-15 (+)

	SA	A	N	D	SD
UC 1	12	22	8	2	
UC 2	3	14	1	1	
UC 3	3	16	1	2	
UC 4	9	17	2	1	

*Other respondent demographics:

56% male
44% female
86% white
9% Afr.Amer.
5% Asian Amer.
39% UC 1
17% UC 2
19% UC 3
25% UC 4
56% Freq con w/ other ethnic gr
35% Per.con w/ other ethnic gr.
9% InFreq. w/ other ethnic gr

Open-ended Cognitive Responses:

All UCM Survey Respondents

1. List two or more personal values or characteristics attributed to persons of Appalachian heritage.

Strong family ties, undereducated, and low income.

I have no idea!

Poor and a lot are farmers.

I am not from this area and only know it is a very depressed region with little access to health care.

Family and land are important.

Poor, old-fashioned and unclean.

Low SES and intelligence.

I would not be able to identify an Appalachian if my life depended on it.

Many children. Dirty. Inbreeding.

They have a lot of family rivalries, like the Hatfields and the McCoys. Also, they drink a lot.

Suspicious of outsiders and always keep to themselves.

I am not familiar with this culture.

Strong kinship and appreciation for Nature.

2. Where and what is Appalachia?

An area within parts of Appalachia Mtns. in Pa. and W. Virginia. It is generally secluded from larger cities.

Western USA?

East. Near Appalachian Mtns.

Kentucky?

I don't know?

An area I associate only with "poor whites" in Ky. and Tenn. who lives in the "hollows".

A poor region in Virginia?

Part of Southern Ohio?

A mountain range in Eastern U.S.

A region somewhere in Northeast. Mostly Pa and W. Va.

3. Are there any Appalachians who are black or who identify themselves as non-white?

I would assume so.

I think some identify themselves as non-white.

Probably, but not sure?

I don't know.

I doubt this is true.

Yes, the Cajuns.

I have no clue...not part of my experience.

I believe that this is probably not true. Almost all Appalachians are white.

I cannot answer this question. I have never met an Appalachian.

I would imagine some Appalachians could be black?

4. Name two or more language/communication difficulties which can occur between African-American patients and white MDs.

African American slang and accents

Blacks may be more vocal and outspoken.

White doctors misunderstanding of African-Americans' lingo.

Black pts. not relating to white MD vocabulary and technical terms.

Poor compliance in following MD verbalized orders.

I don't know?

Hard to understand their "street dialect", but such knowledge may be important when discussing bodily functions.

Different colloquialisms, pronunciation schemes.

Neither can understand dialect of opposite culture.

"Black lingo".

When a white MD speaks above the range of the patient, it can cause the (black) patient to feel intimidated, angry, or aggressive toward the MD.

Different educational backgrounds and vocabularies creates a communication problem.

Black slang changes so frequently its very hard to keep up. When the two cultural communication styles meet, there is the perception of inferiority and superiority which results.

We don't speak their "jargon". African American patients may have a predetermined hatred of all white people. But I would say not in all or most cases, however.

When any physician uses medical or unfamiliar terms, most people (white or black) would be confused.

Difficulties can occur when the black patient attempts to describe "how the pain feels".

5. In a public discussion or personal debate, describe modes of behavior which blacks consider appropriate in comparison with modes of behavior which whites consider appropriate.

Yes, especially males.

Any other black is a "brother" or "sister". Also they tend to raise more volume, (in argument or grief, for example)

I can't comment on this issue because I have no experience with it.

Blacks show more gesticulation. Whites are more subdued.

Blacks are more freely speaking and dramatic than whites.

Whites like to be closer in proximity to each other.

I have been told that African Americans are willing to use words with less regard to the impact on listeners, since "they're just words".

I am a rather alternative white male who enjoys many types of behavior based on situations. I don't deem behavior appropriate or inappropriate. Nor would I as a physician.

No apparent differences that I can see. Many white families have similar styles to black families.

Behaviors are much the same assuming relatively equal educational backgrounds. Informally, female African Americans talk with much greater volume (loudness) and use more body language. Whites that I know consider this inappropriate behavior.

With blacks, there are often open displays of emotion and feeling.

6. Is direct eye contact or physical touch offensive to members of the African-American community? Explain answer.

We have been taught in our Behavioral Science course that AAs tend to be uncomfortable with both of the above attempts to communicate. But I have never had the opportunity to experience it first hand.

I cannot answer this question or the others because I have no experience with these people.

It depends on the person and their past experiences.

I have heard direct eye contact and touching may be considered offensive to African Americans, particularly young males.

This may be the case with some young black people, but it also may be seen as a gesture of caring or support to the individual patient.

Maybe with some males because this sub-culture tends to be chauvinistic. Physical touch between male MD and male black patient would not be appropriate unless medically necessary. Same with direct eye contact...very confrontational and condescending.

Possibly. Some may not want their personal space invaded by a physician.

In many cases, yes. Black males are particularly sensitive to physical contact. Eye contact can often result in a feeling of inadequacy as if to say..."I don't meet your standards".

I have heard this is true, but I don't believe. People aren't that different.

I didn't know about this issue until so informed by a black psychologist in our UC I Behavioral Science lecture.

Maybe, but I think it is important to use our judgment about such encounters when they occur, relying on our empathy and compassion first with patients regardless of cultural differences.

I have been told about this by a professor, but there is the possibility it could be a myth or stereotype.

It depends on whether the eye contact is used as a means of comforting or if it conveys a paternalistic posture.

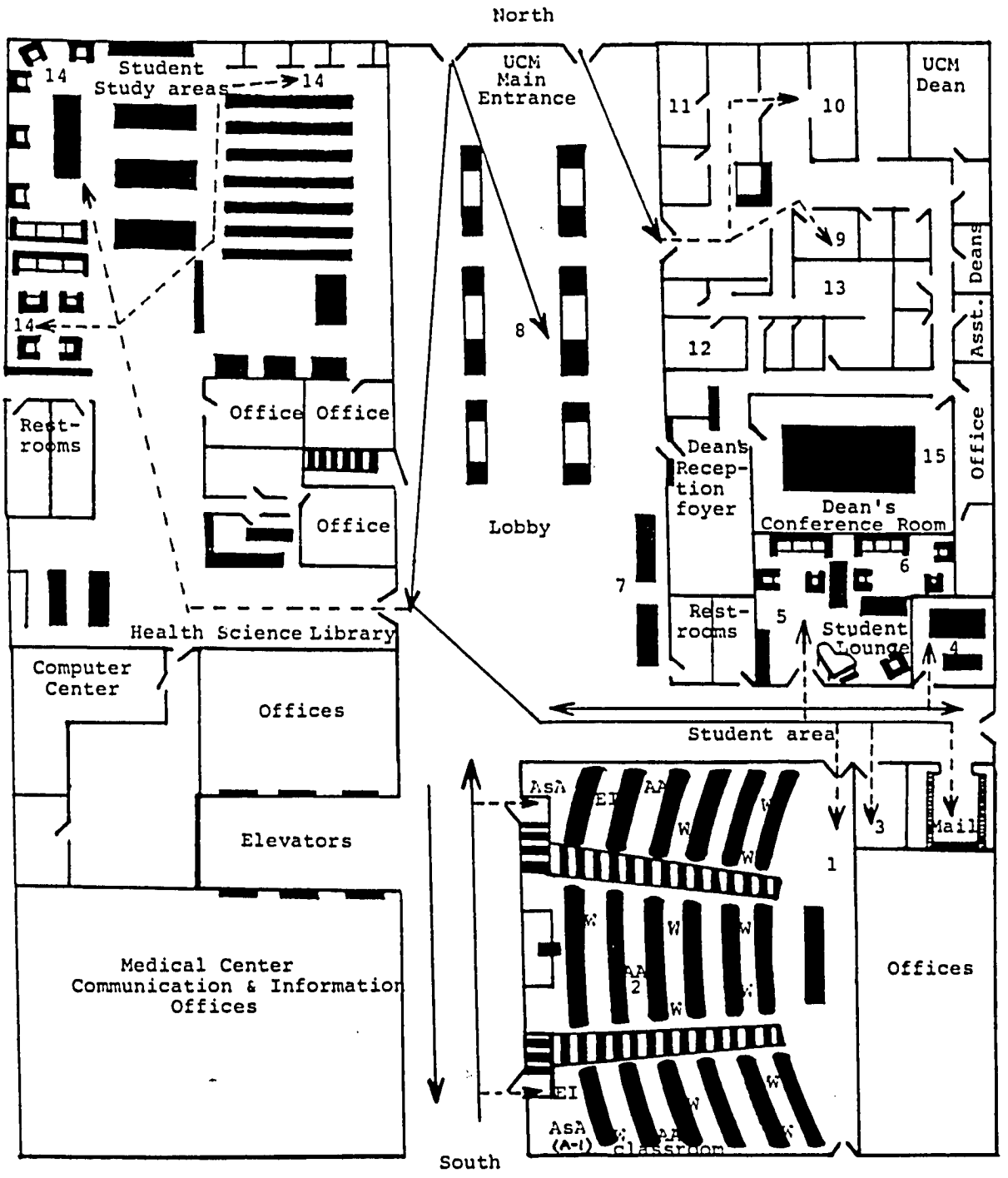
APPENDIX - E

Map of Study Setting (Component)
University College of Medicine

Entrance Level:
Primary areas of medical student activity and interaction

***

Map Coordinate Reference



University College of Medicine
Entrance Level - Medical Science Building
Primary areas of medical student activity and congregation

Map References

1. Main UCM classroom and lecture auditorium. Location for most basic science and ICP lectures and for student organizational meetings depending on need for larger space. This room has become more of a multipurpose center as student activities and groups have increased.

2. Denotes areas of student clustering during class lectures and other events when attendance is mandatory. African-American students (AA) were observed to consistently sit together in rear of (A-1) and usually within the same rows. East Indian (EI) and Asian American (AsA) students also tended to sit in rear of (A-1) and in corners. Those students known to be of Appalachian origin (self-identified) did not show a pattern of clustering, although they rarely sat in front center of the classroom. The majority white students (W) consistently occupied the front rows and center seats.

3. Medical Student Association office and room of frequent activity by other student groups and student leaders. The mail room adjacent to the MSA office, was also an area of daily random congregating by students. The entire hallway designated a the "student area" was a site of intensive student interaction between classes, most often extending into the student lounge.

4. Student Recreation Room. Occupied hourly throughout the day and night by students taking study breaks or leisure periods at end of the day. A ping-pong table was the point of action and socialization for all students spending time in the room. Each month a competitive tournament was held involving dozens of students, both white and ethnic.

5. Student Lounge. This area was the primary congregation and socialization site for all UCM students. The room was always open and rarely unoccupied. Primary point of action was the piano and card games. The lounge was another meeting place for student organizations and occasional study groups during after class hours. Dean's Office and Student Affairs staff were rarely seen in the lounge, unless joining the students in special events by invitation. Certain faculty members who had "friendship-relationships" with students met with them in the lounge after class hours.

6. African-American students' grouping site. The student lounge held significance in the study as a site of observed ethnic grouping, particularly for the African-American students. With the exception of lunchtime when the room was quite crowded and all students intermingled closely, the African American students consistently gathered in the northeast corner of the lounge. Their interactions were disturbed only when other students used the

telephone located in the same corner. The Student National Medical Association (SNMA) members met in this area regularly and did not often interact with white students when meeting.

7. Student Organization Multipurpose tables. These portable tables were always set up in the lobby for variable use by student club members for bagel sales, T-shirt concession, charity food and clothing collection, organization recruitment, blood drive registrations, and International Health Program stethoscope donations. This small site was another regular point of congregation by students separated by group affiliation and often by ethnicity.

8. Main Lobby seating area. These sofas were centrally located in the UCM lobby for maximum usage by faculty, staff, students, and visitors. Despite their unorthodox design, the sofas have become a popular gathering point for small clusters of students at all times of the day, but usually to and from classes. The ethnic clustering which occurred in (A-1) was often replicated in this lobby area.

9. Office of Assistant Dean/Director of (Student) Minority Affairs. This staff member is well known to the students as a rare activist voice for minority assistance and student empowerment. As an African-American, a social worker, and student advisor, she applies considerable influence on behalf of ethnic minority students and among fellow non-minority staff and faculty who shape UCM policy and curriculum. This staff member's office is frequented most often by ethnic students, but she is known as ally to all students.

10. Office of Medical Registrar. A staff member who holds influence in the Deans' Office and with students without the sanctioned authority of faculty or executive staff. This individual is also known as a friend to students, particularly those entering as freshmen still unadjusted to rules and routines. The Medical Registrar is responsible for all student records, including the required statistics on minority admissions. She is routinely memorizes names and backgrounds of students, points of origin, and socioeconomic status of all students. Students who perceive her fund of knowledge, open rapport, and unbiased attitude, confide in her regularly.

11. Office of Dean of Students. This individual is considered by students to be an important advocate in the Dean's Office complex, although he has a reputation of being unavailable. This dean is knowledgeable in issues of minority rights and equity in higher education circles (ie., medical schools) and has been known as a "troubleshooter" when problems of racial balance or minority financial aid arise. Entering UCM students soon learn that access to the Dean of Students is better than access to the UCM Dean, but even that much is inadequate.

12. Office of Dean of Students Services. This dean is a long-term staff member and is deeply embedded in the political processes of the Dean's Office and UCM. She is known for her rigid adherence to administrative rules and conservative curriculum development. She is the least popular and least approached staff member in the Dean's Office. Access to this dean is exceptionally difficult. Her perspectives toward ethnic minority students were not ascertainable in the study.

13. Office of Assistant Dean for Instructional Development and Evaluation. This dean is respected by most students and is approached independently for academic and teaching guidance. She is known to be committed to all students' academic success, but maintains more professional distance from them than other members of the Dean's Office staff.

14. Library study areas. First floor library study areas are routinely used by student study groups as observed in the study. These areas are among the most popular in that more talking, hence socialization, is permitted in this area. As noted earlier, the study groups tended to be ethnically-based and did not intermingle except on rare occasions in preparation for National Medical Board Examinations.

15. Dean's Conference Room. Site of quarterly meetings of social service student program, Urban Care Program (UCP). Also location of UHP open interactive debates with invited lecturers, David Lundberg, M.D., Editor, Journal of American Medical Association, David Hilfiker, M.D., Founder-City of Hope Project for the Homeless, Washington, D.C., and Marilyn Gaston, M.D., Asst. U.S. Surgeon General and Advisor to National Medical Association. Each UCP session addressed needs of special populations based on ethnicity and SES. Guest lecturers consulted UCP participants and faculty advisors on applying culture-specific health care strategies to African-American and urban Appalachians in Central City. Cultural barriers inherent in training physicians were also emphasized, including communication/language gaps, insensitivity to patient values, attitudinal bias, cultural ignorance.

APPENDIX - F

Key Documents from the Setting

Document Cover Sheet

Document Number: 1

Name of Document: Attachment to Task Force of Medical School Curriculum Report-1989 "ON BECOMING A PHYSICIAN-PERSONAL ASSESSMENT

Length: 10 pages +Attachment from UCM Subcommittee on Medical Students- Draft comments on student body profile, future recruitment and curriculum modification

Obtained from: Task Force Member/Physician instructor

Date: 4/18/89

Description: Attachment document to Curriculum Report undertaken in 1989 by Dean-Appointed task force. Entitled, "On becoming a physician-A personal assessment" it details desired qualities in a physician under categories of "coping skills, responsibility, resourcefulness, and tolerance". Specifically notes that a physician is one who should appreciate and gain from individual differences, develops a sensitivity to needs of others, is aware of biases, and who works with persons of different backgrounds in community clinics, inner city health projects, and rural areas.

Attachment: Question 2-C

ON BECOMING A PHYSICIAN - A PERSONAL ASSESSMENT

DESIRED QUALITIES IN A PHYSICIAN	ACADEMIC DEVELOPMENT	PERSONAL DEVELOPMENT
TOLERANCE		
Develops personal maturity Aware of personal values, attitudes and biases Develops a caring attitude for others Gains an appreciation of individual differences Learns to listen to others Develops a sensitivity to the needs of others	Undertakes coursework which challenges one's understanding of different cultures, religions, and ethnic origins Writes papers in areas which demand further exploration of attitudes and values	Works in areas which challenge attitudes and values: Care of the elderly Care of the handicapped Care of the mentally retarded Work with people from different backgrounds in a help related setting - community clinics, inner city health projects, Rural areas, etc.

DRAFT COMMENTS - SUBCOMMITTEE ON MEDICAL STUDENTS - V - (1) Revised

1. Considering the mission of the College of Medicine, its stated objectives, and its constituency, critically review the process of selection of medical students and the results of that process. Suggest improvements which are realistically attainable, citing need for additional resources, changes in policy, organization, administration, etc. Have faculty members observed any recent decline in quality of students enrolled?

COMMENTS

-No statement of mission exists

-the constituency is not clear, some think it is the taxpayers of others the student body and staff

-the # of black applicants and matriculants is low; we are outbid by other institutions for the best; we need to involve the black community particularly MDs and alumni to recruit and encourage at an early age (junior and senior HS) and look at the best students

-JJ - revisit program at worked well; had good student guides; solicited interests

-CM- use alumni and faculty more; new dean an asset

-Expand alumni interviewers

-admissions committee too small for workload

-JJ - admissions moved slowest at

-Accelerate process; expand committee

SUMMARY RESPONSE

The mission of the College concerning education is implicit rather than explicit. There is a long tradition of producing physicians who are excellent practitioners of clinical medicine, and this has not changed, nor seem likely to do so. There is also a long history of trying to obtain the best medical students, academically, but there is also much concern that the student body will have significant numbers of non-traditional students, older students and minorities. The statement adopted at the Curriculum Review in crystallizes this concept. "The College must commit the resources needed to recruit, support, stimulate and retain the best students, whose diversity and range of interests reflect the society in which we live and the environment in which they will practice."

The College has a clear objective as far as research is concerned, to place the College in the top 20 in the nation in terms of research support. The objectives for education and patient care are less clear. In education it is to retain its reputation for producing excellent patient care practitioners, and in service to offer top level primary and tertiary care in many of the important areas of care, and to offer state of the art technology and medicine in areas of rapid development, such as cancer, neurosciences, cardiovascular disease and trauma.

The Constituency of the college is both internal and external. Internally, there are the medical students and the faculty, including those of the other Health Sciences, Nursing and Pharmacy.

program we believe to have much promise, particularly in the University which pioneered the concept

Regardless of other aspects of recruitment, three criteria should continue to apply, criteria of ascending degrees of difficulty. The first is to continue the emphasis on academic excellence that we have had for a long time. The second is to try and ensure that we recruit the kind of student who has a real concern for the humanitarian aspects of medicine. The most difficult in all probability is to recruit life-long learners since the amount of important information is increasing on a curve that approaches the exponential. Self-motivation may cope with this awesome task. Regulation and coercion will fail, though the process will be expensive and uncomfortable for all concerned.

RECOMMENDATIONS

1. Diversity among the student population (as indicated in the GPEP report) is a valued concept which adds value as well as demands to the medical program. The diversity should be continued.

2. Explore imaginative new ways to evaluate attributes of applicants considered to be essential for a career in medicine. Measurement tools of ethical standards, life-long learning potential and other predictors of "success" in medicine should be evaluated for possible use.

3. New approaches to organized recruitment of high quality applicants must be developed. These should include an effective alumni program, increased participation by faculty and students, and employment of a recruiting officer.

4. Introduce flexible pathways in the curriculum to allow for expression of diversity of student interests and accomodation for special needs. Such concepts as co-operative education, combined M.D./Ph.D. or M.D./M.S., thesis for degree with distinction would be attractive to applicants.

5. Explore the possibility and consequences of linking the number of students admitted with the number of quality applicants in the pool.

6. Develop linkage programs between the College of Medicine and regional undergraduate institutions
   where admission would occur after junior year and first year of medicine would be credited to B.S.
   (Award scholarships to promising H.S. students - possibly best done at national level.)

7. Prepare for increasing support service needs especially in areas of psycho/social support, career counselling, financial management, and stress management. Examine cost burden with relation to student share.

8. Increase recruiting effort among minority, rural and inner city potential applicant pools.

28. Student Analysis: To be prepared by knowledgeable student representatives. Indicate how information and opinions were acquired for preparation of the analysis, give names of students involved.

a. Specifically describe student participation in medical school committees.

b. Describe student opinion with regard to the following:

1. Accessibility of Dean(s) and faculty

2. Grading system/academic evaluation

3. Counseling systems (personal, academic, financial aid, career -- comment on availability, confidentialty, utilization, and effectiveness)

4. Facilities (library, laboratories, classrooms, housing, etc.)

5. Student health service

c. Describe your school's strengths/weaknesses regarding:

→ 1. Recruitment and retention of minority and disadvantaged students

2. Evaluation of course content and teaching effectiveness

3. Quality and availability of electives

d. Discuss the curriculum; specifically comment on the workload, content, schedule, strengths and weaknesses. List which courses have been most and which least satisfactory in the basic and clinical sciences; please provide reasons.

e. Briefly describe the structure of student government (if any), its interaction with other (if any) student organizations, nature of support from the school, and effectiveness in representing student opinions and concerns.

Document Cover Sheet

Document Number: 2

Name of Document: Presentation program for Med. Ctr. Faculty Forum addressing Task Force Report on the Medical School Curriculum

Length: 9pgs.

Obtained from: Task Force Member

Date: 4/18/89

Description: Program distributed at Faculty Forum (open meeting of medical school faculty held monthly) featuring the key topic of presentation and debate: Task Force Report on the Medical School Curriculum. This report entailed a series of recommendations to the Dean for curriculum development and changes, including RECOMMENDATION II -- "Commit the resources needed to recruit, support, stimulate and retain the best students, whose diversity and range of interests reflect the society in which we live and the environment in which they will have to practice".

FACULTY FORUM
COLLEGE OF MEDICINE

TUESDAY,
4-5 PM
(Note: Change of date)
ROOM

"Report of Task Force on Medical School Curriculum"

Presentor:

Task Force Members

Document Cover Sheet

Document Number: 3

Name of Document: AAME Medical School Enrollment Questionnaire Part 1 1991
Part 1 1988

Length: 2 pages

Obtained from: College of Medicine Medical Registrar

Date: Oct. 15, 1991

Description: A medical student enrollment questionnaire taken in Fall of each academic year in U.S. medical school. Reports ethnic breakdown of student population at designated facility. Also reports number of foreign nationals enrolled, and totals by gender and class year. This document is submitted annually to American Association of Medical Colleges and the American Medical Assn.

FALL ENROLLMENT QUESTIONNAIRE 1991

PART I — MEDICAL STUDENT ENROLLMENT

PLEASE READ PAGE 2 INSTRUCTIONS BEFORE COMPLETING THIS FORM

Medical School Name: ___ _____ AAMC Code 1 1 2 Public ☒ Private ☐

Academic Year: Starting Date (MONTH/YEAR) 0 _ _ _ Ending Date (MONTH/YEAR) 0 _ _ _

U.S. CITIZENS (Include students holding permanent resident visa)	FIRST YEAR				INTERMEDIATE YEARS				FINAL YEAR		TOTALS			
	NEW ENTRANTS		TOTAL FIRST YEAR		SECOND		THIRD							
	MEN	WOMEN	MEN	WOMEN	MEN	WOMEN	MEN	WOMEN	MEN	WOMEN	ALL MEN	ALL WOMEN	ALL YEARS	
BLACK	4	11	4	12	4	7	4	4	4	5	16	28	44	1
AMERICAN INDIAN OR ALASKAN NATIVE	1		1											2
WHITE	75	39	79	40	78	45	80	47	81	55	318	187	505	3
ASIAN OR PACIFIC ISLANDER	11	7	11	7	10	3	2	5	7	4	30	19	49	4
MEXICAN AMERICAN/ CHICANO						1						1	1	5
PUERTO RICAN (Mainland)						1						1	1	6
PUERTO RICAN (Commonwealth)														7
OTHER HISPANIC		1		1	1	2		1	1		2	4	6	8
FOREIGN (Non-U.S. Citizens holding any visa other than a permanent resident visa)	1		1		1		2		1	1	5	1	6	9
TOTALS BY SEX	92	58	96	60	94	59	88	57	94	65	372	241	[redacted]	10
TOTALS BY YEAR	150		156		153		145		159		[redacted]		613	11
Indicate how many of the students on line 9 are non-U.S. Blacks					1					1	1	1	2	12

INFORMATION PREPARED BY:

NAME/SIGNATURE _____ TITLE Medical Registrar ( ) TELEPHONE

ADMINISTRATIVE OFFICER RESPONSIBLE FOR ACCURACY OF DATE:

NAME/SIGNATURE _____ TITLE Medical Registrar DATE _____

Completed Questionnaires should be received by the AAMC no later than OCTOBER 18, 1991

FALL ENROLLMENT QUESTIONNAIRE
1988
PART I — MEDICAL STUDENT ENROLLMENT

PLEASE READ PAGE 2 INSTRUCTIONS BEFORE COMPLETING THIS FORM

Medical School Name: _____ AAMC Code [ ][ ][ ] Public ☒ Private ☐

Academic Year: Starting Date (MONTH / YEAR) [0][ ][ ][ ] Ending Date (MONTH / YEAR) [0][ ][ ][ ]

	U.S. CITIZENS (Include students holding permanent resident visa)	FIRST YEAR NEW ENTRANTS MEN	FIRST YEAR NEW ENTRANTS WOMEN	FIRST YEAR TOTAL FIRST YEAR MEN	FIRST YEAR TOTAL FIRST YEAR WOMEN	INTERMEDIATE YEARS SECOND MEN	INTERMEDIATE YEARS SECOND WOMEN	INTERMEDIATE YEARS THIRD MEN	INTERMEDIATE YEARS THIRD WOMEN	FINAL YEAR MEN	FINAL YEAR WOMEN	TOTALS ALL MEN	TOTALS ALL WOMEN	TOTALS ALL YEARS	
1	BLACK	5	1	6	4	1	3	2	8	3	5	12	20	32	1
2	AMERICAN INDIAN OR ALASKAN NATIVE	0	0	0	0	0	0	1	0	0	0	1	0	1	2
3	WHITE	83	59	87	61	79	49	97	42	105	54	368	206	574	3
4	ASIAN OR PACIFIC ISLANDER	6	4	6	4	3	4	6	2	7	3	22	13	35	4
5	MEXICAN AMERICAN/ CHICANO	0	0	0	0	2	1	0	0	0	0	2	1	3	5
6	PUERTO RICAN (Mainland)														6
7	PUERTO RICAN (Commonwealth)														7
8	OTHER HISPANIC	1	0	1	0	1	0	1	1	1	0	4	1	5	8
9	FOREIGN (Non-U.S. Citizens holding any visa other than a permanent resident visa)	1	0	2	1	2	0	0	0	0	1	4	2	6	9
10	TOTALS BY SEX	96	64	102	70	88	57	107	53	116	63	413	243	[redacted]	10
11	TOTALS BY YEAR	160		172		145		160		179		[redacted]		656	11
12	Indicate how many of the students on line 9 are non-U.S. Blacks	1	0	1	0	2	0	0	0	0	1	3	1	4	12

INFORMATION PREPARED BY:

NAME/SIGNATURE _____ TITLE Medical Registrar TELEPHONE _____

ADMINISTRATIVE OFFICER RESPONSIBLE FOR ACCURACY OF DATA:

NAME/SIGNATURE _____ TITLE Medical Registrar DATE _____

Completed Questionnaires should be received by the AAMC no later than OCTOBER

Document Cover Sheet

Document Number: 4

Name of Document: "Kujichajulia in Praxis" Inner-Cultural Diversity Among Peoples of African Descent

Length: 3pgs.

Obtained from: Multi-cultural Adolescent Services and Alcoholism Clinic/UC Medical Ctr

Date: 12/20/91

Description: Narrative exposition on a model for analysis of self-determination and self-definition by persons of African descent in America. Includes discussion of concept of "praxis" (application of knowledge or skills) and the Afro-centered self. Four different categorization of interpersonal style of black persons are described. Page 3 is a graphic chart depicting cultural history of Africans in America. This document is used in discussion and counseling group of substance abuse outpatients, students, and health professionals/physicians. The groups are multicultural, with some participants being of Appalachian heritage, but predominantly African-Amer.

Kujichagulia in Praxis;

This model attempts to provide an historic analitical overview of praxis (movement at the level of a group) toward self-determination and self-definition i.e. kujichagulia, on the part of the African and his/her experience in America from ensalvement to the present. The different labels of ethnic identification from negro-to-black,to African American-to- African, also implies an evolutionary path of self rediscovery, by means of "being impacted by the different movements" at four cultural epochs or social junctures, within the context of the "African experience in America" or the common misnomer "The Black Experience".

Inner Cultural Diversity
(among people of African decent)

While this course of praxical redefining moved us to a higher level of cultural self-conciousness, the failure of the total masses of our people to benifit equally (from the movement) either through misconception of the struggle or outright compromise, differing personality types have arisen among the varying social strata within which the African finds him/her self, here in America. These "personality types" can also be viewed as evolutionary, with regard to this notion of Kujichagulia in the context of "practice" (movement at the level if the individual). Finally an analysis of both praxis and practice, with regards to the "Afrocentered-self"suggests that "one's practice be aligned with his/her historic praxis".

(1) THE TRADITIONAL INTERPERSONAL STYLE--The traditional black person is neither accepting nor rejecting of his/her black identity, it is simply a deep part of who this person is. Traditional black people have usually had limited contact outside of the black community. They are the carriers of the essence of the Black American culture. Today. the traditional person is usually older and has his or her roots in the south, even though they may live in other parts of the country. The values, mores artifacts, language, customes, and history of the black experience in America are vested in the traditional black person.

(2) THE ACCULTURATED INTERPERSONAL STYLE-- The acculturated black person has made conscious or subconscious decisions to reject the general attitudes, behaviors, customs. rituals, and stereotypic behaviors associated with being black. He/she has done this in order to assimilate into the mainstream white culture.

(3) THE BI-CULTURAL INTERPERSONAL STYLE--The bi-cultural black person has pride in his/her racial identity, its history and black cultural traditions and yet he/she is comfortable operating in the white world as well. The bi-cultural person tends to seek out racial diversity and is stimulated by it. Bi-cultural persons value integrated living environments and tend to live and work in integrated settings.

(4) THE CULTURALLY-IMMERSED INTERPERSONAL STYLE--This interpersonal style of black attitude and behavior is most often termed "militant" by non-blacks. This client is obviously the most difficult for the white counselor to work with (or for the acculturated black counselor); This person has rejected white values and culture. Although it is said that being "pro-black" is not necessarily "anti-white";

Document Cover Sheet

Document Number: 5

Name of Document: "Hillbillies - Medical Terminology for the Layman"

Length: 1 page

Obtained from: Staff dining area in Medical Building, Medical Center

Date: 10/19/91

Description: Sheet listing terms and phrases which could be deemed stereotypical toward persons on rural American (Appalachian) heritage. Sheet was being distributed privately among staff members of a clinical practice center in the Medical Building and was also left in view of medical students receiving rotational training in this department.

MILLDILLIES

MEDICAL TERMINOLOGY FOR THE LAYMAN

ARTERY----------THE STUDY OF FINE PAINTINGS.
BARIUM----------WHAT YOU DO WHEN C.P.R. FAILS
CESAREAN SECTION--A DISTRICT IN ROME.
COLIC----------A SHEEP DOG.
COMA----------A PUNCTUATION MARK.
CONGENITAL---------FRIENDLY.
DILATE----------TO LIVE LONG.
FESTER----------QUICKER.
G.I. SERIES--------BASEBALL GAMES BETWEEN TEAMS OF SOLDIERS.
GRIPPE----------A SUITCASE.
HANGNAIL----------A COATHOOK.
MEDICAL STAFF------A DOCTOR'S CANE.
MINOR OPERATION---COAL DIGGING.
MORBID----------A HIGHER OFFER.
NITRATE----------LOWER THAN DAY RATE.
NODE----------WAS AWARE OF.
ORGANIC----------CHURCH MUSICIAN.
OUTPATIENT---------A PERSON WHO HAS FAINTED.
POST-OPERATIVE----A LETTER CARRIER.
PROTEIN----------IN FAVOR OF YOUNG PEOPLE.
SECRETION---------HIDING ANYTHING.
SEROLOGY----------STUDY OF ENGLISH KNIGHTHOOD.
TABLET----------A SMALL TABLE.
TUMOR----------AN EXTRA PAIR.
URINE----------OPPOSITE OF YOUR'RE OUT.
VARICOSE VEINS----VEINS WHICH ARE VERY CLOSE TOGETHER.
BENIGN----------WHAT YOU ARE AFTER YOU BE EIGHT.

CHUCKLE FOR PATTI! ☺