

# The Important Role that Diverse Students Play in Shaping the Medical School Curriculum

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**AS THE TRAINING GROUND FOR FUTURE PHYSICIANS**, American medical schools are responsible for educating students to serve an increasingly diverse society. Changing population trends and an expanding health-care system have resulted in a greater demand for doctors who will practice in people-oriented specialties in medically underserved areas (Krupa, 2010). Moreover, racial and ethnic disparities in the access to health care persist and sociocultural differences between patient and physician can be problematic (Betancourt, 2003). In 2003, the Institute of Medicine (IOM) recommended training in cross-cultural communication for all medical students as a way to decrease health disparities in society (Smedley, Stith & Nelson, 2003).

Medical educators have responded to this need by increasing the emphasis on cultural competency in their training models in order to teach students, the overwhelming majority of whom are White and upper-class, how to serve patients from diverse backgrounds. While this training has shown positive outcomes for health care (Kutob, Senf & Harris, 2009; Beach, Cooper, Robinson et al, 2004), other studies have shown that medical students struggle with issues of diversity in medical practice (Dogra & Karnik, 2003). Research suggests that medical schools are still learning how to integrate cultural competence training into the standard curriculum in ways that do not lead to stereotyping and categorizing (Betancourt & Green, 2010). Still in its infancy, little is known about the most effective ways to teach about cultural competency in medical school. This case study investigated the extent to which students were exposed to diversity in medical education and the ways in which diverse information, ideas and experiences were reflected in the medical school curriculum.

## LITERATURE REVIEW

Access to healthcare in the United States is problematic. The IOM report highlights the widespread disparity in America in the management of the health care between minority and white patients. The authors report that the healthcare system contributes to the inequity in care provided and evidence suggests bias, stereotyping, and prejudice on the part of practitioners adds dramatically to disparity in the quality of care received by minority patients. Based on their findings and emerging research, the report recommended that medical school curricula include material that focuses on racial and ethnic minorities (Smedley, Stith & Nelson, 2003).

Although there is growing support for the inclusion of diversity education into medical education there have been debates on the most effective method of developing cultural competence in medical students. Scholars emphasize curriculum that trains medical professionals to target certain interventions to populations most likely to be impacted. However, medical students must also learn to treat each patient as an individual who is situated within a particular cultural context (Betancourt & Green, 2010). Dogra and Karnik (2003) propose teaching diversity not as “a set of static facts that can be learned... [but to] view culture as constantly in flux and gain knowledge about culture through careful and thoughtful interactions with patients, colleagues, and by exposure to various media” (p. 1192).

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**Faculty Member**

Evidence indicates that incorporating diversity into the formal curriculum can yield positive benefits. Whittle and colleagues (2003) conducted a survey of medical students in which they were asked about the significance of racial diversity among their peers in their medical education. Students reported interactions with diverse peers enhanced their educational experience and increased their confidence in their ability to establish a positive rapport with patients from diverse racial backgrounds. Green et al. (2002) argued that cross-cultural medical education better prepares medical students, residents, and other health care providers to care for a more diverse patient population. Betancourt and Green (2010) asserted cultural competence increases the ability of health care providers to effectively communicate with and provide quality care to patients from diverse backgrounds. However, little data exist that explore how students perceive this training and the effect it has on them and their peers.

### **METHODOLOGY**

This report is part of a larger mixed methods case study of campus climate that was conducted at two medical schools in the United States which applied the widely cited climate framework of Hurtado, Milem, Clayton-Pedersen and Allen (1998, 1999) and later modified by Milem, Dey and White (2004) and Milem, Chang, and Antonio (2005). The data for this paper were taken from focus groups and interviews with medical students, faculty and administrators conducted in 2011. Both schools are public institutions, although Evergreen University<sup>1</sup> is a more selective institution and admits students from across the country, while Ironwood University's student body is composed primarily of in-state residents. In addition, both medical schools have low levels of compositional diversity within the student body, and admit students from higher income levels than the national average (see Table 1).

In total, there were 24 focus groups and interviews conducted at the two institutions. Members of the research team moderated the focus groups and conducted the individual interviews which were recorded and transcribed verbatim. The research team coded and analyzed the data contained in the transcripts for salient themes. One important theme that emerged was how diversity and cross-cultural knowledge and skills were taught to medical students and the pivotal role that students from diverse racial and ethnic backgrounds played in this process.

### **PRELIMINARY FINDINGS**

In general, students and faculty members acknowledged that there were some efforts to include diversity within the medical school curriculum. However, they were often recognized as minimal efforts at best. Integrating diversity into the basic science curriculum taught during the first two years of medical school was regarded as particularly arduous. For example, one faculty member who taught cardiovascular and respiratory courses found it difficult to talk about race and ethnicity during his lectures: “I would really have to push the limits of rationality to, you know, work a diversity angle into a PowerPoint presentation in that kind of a setting.”

Some medical students were also puzzled by the idea of teaching cultural competency during basic science courses. This is apparent when first and second-year medical students at Ironwood University were questioned about diversity in the curriculum.

I mean, personally I don't - as far as basic science curriculum, which is the majority of what medical school is, I don't see science as being diverse or not. I don't think that modality

1 Evergreen University and Ironwood University are pseudonyms used to replace the names of real institutions.

applies. As far as the more clinical aspects, and the social aspects, the social sciences that we have to deal with, we're certainly, I think, provided with different perspectives in terms of how disease or social stigmas impact different groups. It doesn't come up that often but I'm not sure that that's because there's an under-representation or focus on it, I just think it's because we're in a mostly basic science curriculum. (Ironwood University medical student)

Diversity in the curriculum at Evergreen University often took the form of panels made up of guest speakers. However, some students questioned their effectiveness because they were not considered in calculating student grades.

I guess I feel like that most people don't take it very seriously, I don't think. I feel like the students themselves are just kind of like, "Uh, it's just something we do." But I mean -- like I really enjoyed those talks, but like looking around the classroom, it was kind of disheartening. (Evergreen University medical student)

Students also felt that when cultural issues were discussed, they were done so very subtly, and in the context of individual patient cases they studied as a group. In part, this approach may be taken to try to reduce stigmatization or stereotyping of a particular group. However, this Ironwood University student wondered if it would be more effective if medical students were given explicit reasons for these decisions:

I feel like there are elements of diversity moving into our curriculum without it being emphasized, and so if you really look at it, they do, like in the [case-based instruction] and stuff [...] I just don't feel like it's ever brought to our conscious or to the forefront if that's the point of it being put in there. (Ironwood University medical student)

Perhaps the most influential finding of this study was the perception by faculty, staff and students at both institutions that the ones driving the majority of the diversity discussion on campus are students themselves.

The students that have the momentum are the ones that keep it going. Faculty and staff maybe tend to be of some guidance, but unless the students are the ones pushing it, it's not going to have -- there won't be a change. (Ironwood University staff member)

This is not to say that faculty members were not interested in integrating diversity discussions in their courses, but many believed that bringing diversity into the core curriculum felt forced, and that the level of success was dependent upon the instructor's own comfort and experience with the topic. This was corroborated in student interviews and focus groups, as they reported a lack of training with diversity topics as a source of frustration with the integration of diversity into the curriculum. This often resulted in the students feeling the pressure to take a leadership role in the diversity dialogue within the school.

I just feel like the facilitators themselves aren't even trained. I mean, it's a skill to be able to push people out of their comfort zone. I just don't think that there's enough training of the people leading the groups to even bring students out, and students aren't going to come out on their own. (Evergreen University medical student)

As a result, in both schools students were the most influential group in moving the dialogue on diversity within the schools. This most often took the form of lunch time talks or roundtable discussions among students in which faculty were invited to participate, initiated by student cultural clubs such as the Asian American Medical Student Association, the African American Student Association, or the Latino Student Association.

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**Student**

And oftentimes, when these groups each have, say, lunchtime talks or things, they're actually really widely attended. And with many of these talks -- and I've been to lots of them -- actually the majority of the people in the audience are not members of that particular ethnic racial group. So that there's much more cross-talk and dialogue among students than there is among, say, faculty. And I really doubt there's much among house staff. (Evergreen University faculty member)

Although the students were the group taking the lead in organizing diversity-related talks and events, students indicated that the administration would often try to restrict, or limit, what topics could and could not be discussed on campus. On one campus, all topics had to first be approved before the talks could occur.

I know from a talk that happened last year that they said there was going to be policies drafted by lawyers saying that they were going to have an attorney look at something to determine whether or not some things could be talked about and it has to be cleared first because people were offended by the material of the lunch talk and what the lunch talk was about, so because of that, a complaint that got filed or something to that effect, they wanted, now you need to get approval for what your topics are going to be about at lunchtime.

(Ironwood University medical student)

“I know from a talk that happened last year that they said there was going to be policies drafted by lawyers saying that they were going to have an attorney look at something to determine whether or not some things could be talked about and it has to be cleared first...”

**Student**

Our results indicate that while some efforts to address cultural competencies were included in the curriculum, they were not done so consistently, particularly in the first two years of medical school. As a result of the absence of this information in the formal curriculum, many students believed they had to seek out and create informal learning opportunities in order to gain exposure to diversity. These opportunities usually took the form of optional lectures or roundtable discussions. However, as one student put it, discussion in these forums was often like “preaching to the choir” as those individuals in attendance were usually already active learners of sociocultural issues in medicine. Instead, as a majority of focus group participants expressed, medical educators need to fine-tune their approach to cross-cultural knowledge and skills, not only making them a mandatory part of the formal curriculum but also a competency necessary to master before advancing to the next stage in medical school.

## **SIGNIFICANCE**

Our study has the potential to inform medical educators on how to improve cultural competency in the curriculum to help them achieve the goal of producing doctors who are capable of caring for patients from diverse backgrounds and medically underserved populations. Our findings suggest that medical educators should closely examine the extent to which their pedagogical practices and curricular content promote cross-cultural competency within medical schools. Moreover, our findings also speak to the critical role that medical students from diverse backgrounds play in providing the opportunities for exposure to the diverse content that is currently provided in medical school.

While this paper focuses on medical education, our findings are applicable across multiple disciplines and professions, particularly those which train students to serve the public good such as education, law and social services. As we consider how to discuss cultural differences while honoring the individual experience, we must critically examine how our pedagogy and curricular frameworks serve (or do not serve) our goals.

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## APPENDIX

**Table 1: Institutional Characteristics and Demographics**

	Evergreen University	Ironwood University
Classification	Public	Public
Class Size	170	115
Male	54.0%	43.0%
Female	46.0%	57.0%
African American / Black	3.0%	1.8%
American Indian / Native American / Alaskan Native	1.8%	0.9%
Asian American / Pacific Islander	30.5%	19.3%
Hispanic / Latino	4.3%	11.0%
White / Caucasian	61.0%	74.3%
Other	3.0%	2.8%
Income Level: Less than \$49,999	9.6%	13.1%
Income Level: \$50,000 - \$99,999	21.6%	36.3%
Income Level: \$100,000 - \$174, 999	37.6%	27.2%
Income Level: \$175,000 and over	31.2%	23.2%

## **ABOUT AMERI**

The Arizona Medical Education Research Institute (AMERI) is a collaborative venture between the Colleges of Education and Medicine at The University of Arizona that investigates topics pertaining to medical education, diversity, climate and access to medical school.



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