

Commentary on a framework for multicultural education

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Today's changing demographics require that multicultural factors be considered in the delivery of quality patient-centred health care in chiropractic. Yet minimal training in cultural competency in chiropractic education leaves graduates ill-equipped to treat a diverse population. This commentary examines cultural competency training in current literature, demonstrates frameworks for curriculum integration, and suggests how cultural competency might be included in a chiropractic college curriculum. A database search yielded little evidence that cultural competency is integrated into curricula of chiropractic schools. Some journal articles note that promoting multicultural education and cultural sensitivity is an important goal. However, they provide no mechanisms as to how this can be achieved within training programs. Thus, although an undeniable need exists for all healthcare practitioners to develop cultural competency in the face of an increasingly diverse population, cultural competency education has not kept pace. Chiropractic schools

Les changements démographiques de nos jours exigent la prise en considération de facteurs multiculturels dans l'administration de soins chiropratiques de qualité axés sur les patients. Pourtant, la formation minimale en compétences culturelles que les diplômés reçoivent pendant leurs études en chiropratique les laisse mal préparés pour soigner une population culturellement diverse. Cet article examine la formation en compétences culturelles dans la documentation spécialisée, indique des structures pour son intégration dans les programmes d'études, et propose les étapes d'intégrer les compétences culturelles dans un cursus de collège de chiropratique. Une recherche des bases de données a révélé peu de preuves indiquant que les compétences culturelles fassent partie du programme des écoles de chiropratique. Certains articles de journaux font remarquer que la promotion d'une éducation multiculturelle et d'une sensibilité culturelle est un objectif important. Cependant, ils ne mentionnent aucun mécanisme pour réaliser cet objectif dans les programmes de formation. Donc, malgré le besoin incontestable de développement de compétences multiculturelles chez les praticiens de soins de santé devant la diversité croissante de la population, la formation en compétences culturelles n'a pas suivi. Les écoles de chiropratique doivent revoir leurs programmes

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must review their curricula to develop the cultural competencies of their graduates and a basic framework is suggested.

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KEY WORDS: cultural competency, cultural diversity, multicultural education, curriculum, multiculturalism, chiropractic

Introduction

The demographics of both healthcare providers and their patients have been affected by the increasingly multicultural nature of North American society. Chiropractic presently enjoys dual status as an acknowledged primary healthcare profession with competence in the area of the spine and locomotor systems, and as an alternative healthcare discipline with holistic connotations incorporating many aspects of general wellness and operating on a biopsychosocial model of health care. Consumers of health care can become patients under one or both of these aforementioned categories, therefore allowing chiropractic professionals to practice according to evidence-based principles and a philosophy of holism. The changing multicultural demographic suggests that factors such as race, ethnicity, culture, language, and religion may modify how patient-centred care is received and how it ought to be delivered. The chiropractic literature is found to contain some articles on the underrepresentation of minorities in the student bodies of North American chiropractic colleges and on the lack of a diverse practitioner workforce. With patient demographic percentages expected to change drastically by 2050 in North America, the profession is ill-equipped to provide culturally competent care.¹ However, the virtual absence of multicultural education as a standalone course in chiropractic colleges suggests that graduates are ill-equipped in cultural competency to treat a diverse population.

The purpose of this commentary is to discuss whether a framework for multicultural education in chiropractic exists in the literature and what research has been done on cultural competency training in chiropractic. It further outlines suggestions on how to integrate it into a chiropractic college curriculum.

d'études afin de développer les compétences culturelles de leurs étudiants. Pour accomplir ceci, un système élémentaire est proposé.

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MOTS CLÉS : compétence culturelle, diversité culturelle, éducation multiculturelle, curriculum, multiculturalisme, chiropratique

Methods

A literature review was conducted using three databases: the Index to Chiropractic Literature (ICL), Medline, and CINAHL. The only limiter was the English language. No limit was put on the date. MeSH terms included cultural competency, cultural diversity, education, curriculum, and multiculturalism. Text words chiroprac*, and ethnic or ethnicity, or cultural or culture* were used to capture any other relevant information. Newspaper and magazine articles were also explored for material relevant to teaching cultural competency in chiropractic, but they offered only comment, not authentic research on the subject.

Results

The search demonstrated that no framework had been proposed in chiropractic education and furthermore, it revealed that health care providers are generally inadequately trained to deal with patients of diverse backgrounds.

The most recent paper addressing diversity issues published in the Journal of Chiropractic Humanities² has a section on “Overcoming Barriers of Diversity: Chiropractic Education”, but provides no specific outline for how that could be accomplished. It offers two suggestions: (1) students, as stakeholders in the curriculum, should be allowed the opportunity for input; and (2) “faculty development should be focused on promoting diversity and cultural sensitivity discourse.” The authors note that the effectiveness should be studied, but provide no mechanism as to how that should be implemented.

Johnson and Green, in their challenge to the chiropractic profession to meet the necessity of the demographics of 2050, suggest that planning must occur in education, research, practice and community, and leadership and policy.¹ Their suggestions are well-intended, but do not

provide a framework for student education at the grassroots level.

Khauv and Alcantara provide a retrospective analysis of the effects of a six-hour cultural competency training course adapted from the University of California, Los Angeles School of Public Health program.³ They conclude that the “program improved chiropractic students’ knowledge in cultural competency”, but they could not confirm that patient care improved. They also found that no standard curriculum for cultural competency exists in chiropractic.

In 2006, Callender determined that there were insufficient number of chiropractic role models amongst minority populations.⁴ She suggested that programs should be created to encourage underrepresented minorities to become students of chiropractic; however, without an appropriate infrastructure to train future role models, a self-perpetuating cycle of lack of a framework will continue the dialogue of need versus implementation.

A number of studies have examined cultural competency training in medical and nursing schools. Lee, Anderson, and Hill concluded from a small pilot study that an education program was an effective cross-cultural knowledge tool among nurses.⁵ Yet Flores, Gee, and Kastner found that “most U.S. and Canadian schools provide inadequate instruction about cultural issues, especially the cultural aspects of large minority groups”.⁶ Other studies found that students of health care, especially Caucasian students, have seldom had to deal with many of the issues faced by their ethnically diverse counterparts. White-Means, Dong, Hufstader, and Brown examined cultural competency among students in medicine, nursing, and pharmacy with the intent of comparing objective and subjective cognitive approaches to detect the possible implications for health inequalities.⁷ Cultural competency scores were higher for Hispanics and non-Hispanic blacks than for non-Hispanic whites among medicine and pharmacy students, and multi-racial nursing students scored significantly higher in cultural competency than non-Hispanic whites.

A further study by Musolino et al. found that Asians, Hispanics, and other non-whites in medicine, nursing, physical therapy, pharmacy, and other health care fields outpaced their Caucasian peers in cultural competency.⁸ Their study indicated that there were several variables including race, degree in health education, contact with

a diverse population, health education setting, and participation in a cultural or diversity educational program that influenced the level of cultural competency among the participants.

A 2006 study by Ruddock and Turner looked at another, more radical way to potentially increase cultural competency using the educational setting. The authors took seven nursing students and immersed them in a culture different from their own with the aim of exploring whether having international learning experience as part of the education program promoted cultural sensitivity in participants.⁹ The findings, illustrating how students began developing cultural sensitivity and experiencing personal growth, suggested that attitudes such as openness, respect, and flexibility enabled participants to better appreciate their own culture, as well as adapt to a new one.

Using both qualitative and quantitative methods, Hilliard, Rathsack, Brannigan, and Sander explored the development of cultural competency among doctoral students of physical therapy during their final weeks of clinical education experiences.¹⁰ The qualitative methods allowed them to reflect upon difficult cultural encounters that challenged their beliefs and assumptions during this period and to understand how they related to people whose attitudes, beliefs, values, and language skills differed from their own. The authors concluded that changes in attitude were the key to effective encounters, as students learn to communicate and connect with those perceived to be different from themselves. Effecting the curricular change necessary to ensure that graduates have the requisite cultural competency and sensitivity presents challenges to chiropractic educators, but strategies found in contemporary educational models can be adapted to encourage students to think critically, communicate appropriately, and meet changing health care needs. The process of acquiring intercultural competence is founded in adult education theory.

A Framework for Multicultural Education

James Banks, a pioneer of multicultural education, defines it as a process that “... seeks to create equal educational opportunities for all students by changing the total school environment so that it will reflect the diverse cultures and groups within a society.” Banks’ intent is to ensure academic achievement for all. He proposes five steps for

the implementation of multicultural education: content integration, knowledge construction, prejudice reduction, equitable pedagogy, and empowerment of school culture.¹¹ Examples and content in teaching concepts drawn from other cultures and groups constitute content integration. The presentation of assumptions that are accepted as understood in other cultures, and examples of situations where these might be questioned or put to a test permits content integration. Students' supervised investigation of the cultural assumptions, biases, and perspectives influencing a discipline of study is a means for constructing knowledge. Helping the student to develop positive attitudes toward other cultures should reduce prejudice. By adjusting their teaching styles to different learning styles, faculty can achieve greater equity in pedagogy and advance the empowerment of students from minority cultures within the school culture.

The Curriculum

In order to enhance students' awareness and appreciation of diversity in any population, such as the school itself or the culture at large, curriculum change must move beyond the lecture. Such change requires a range of methodologies and approaches. Perspectives on a variety of ethnic cultures should be structured in such a way as to maximize critical thinking and productive learning. Since much course learning may otherwise appear disconnected to students, Meacham suggests that multicultural learning should ideally be integrated into as many academic disciplines as possible across all four years of chiropractic education.¹² For example, first year studies should include exposure to the premises of cultural competency and samples of cultural norms, health beliefs, and health practices. Reflection should continue in second year with the examination of language and communication patterns, family relationships, religion, and ethnicities. Small group discussion may be used to encourage engagement and critical thinking. Finally, immersion into another culture, either just before or during clinic internship, would challenge students to examine their own belief system and reflect on their response to that culture and the knowledge acquired. Billings and Halstead confirm that a variety of activity in instructional strategies consolidates experiential knowledge acquisition.¹³

Developing Cultural Competency

Theoretical framework

Nunez, cited in Billings & Halstead, defines cultural competency as "the skill of using multiple cultural lenses and the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviours, and needs presented by consumers in their communities".¹³ Alternatively, in health care, Betancourt in Khauv and Alcantara, defines cultural competence as "...understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system."³

In order to develop a course reflective of this definition, Campinha-Bacote proposes five components of the process of developing cultural competence: cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.¹⁴ The student is expected to progress from a lack of or limited notion of cultural competence to cultural knowledge and awareness and how this will impact the clinical encounter. This process includes progressing from the cognitive to the affective domain with changes in attitude and behaviour. This is of importance for the healthcare professions, including chiropractic. In fact, "one might propose that cultural competence is to quality care what multicultural education is to quality education".¹⁴ This would suggest that it is an added dimension intended to be formative of and integral to the learner as future healthcare provider. Bringing students of chiropractic to this level of care is the mission of faculty and the vision of the teaching institution.

As stated earlier, students come from diverse backgrounds and will practice in ethnically diverse settings. This necessitates sociocultural contextualization. Constructivist learning theory acknowledges that new knowledge is built on students' existing knowledge.¹⁴ The teacher-facilitator's role is to lead students to inquire into their previous experiences, to appreciate multiple perspectives, to become aware of possible differences between learners' and instructors' goals, and to embed their learning in the social context.¹⁵ Educational theories suggest that learning can best be accomplished in small groups and by being self-directed.¹⁶ This philosophical base for the framework is befitting of students from different backgrounds and life experiences.

It is not yet known to what extent cultural competency improves health outcomes in medicine, let alone in chiropractic. But it is acknowledged that a lack of it contributes to health disparities.¹⁷ In order to develop an integrated approach to multicultural education and cultural competency, knowledge, skills and attitude must be co-constructed. This community-based learning will capitalize on Campinha-Bacote's five components to develop cultural competence.¹⁸

Cultural awareness. Students must examine their own culture and life experiences, as some may be bicultural, born of one culture and living in another. They need to explore the implications of their background culture for health care, and be aware of their prejudices and biases towards other cultures.¹⁵ Exposure to other cultures may help them to realize their own ethnocentricity. One project might be participation in an activity in a different culture.

Cultural knowledge. "Cultural knowledge is the attainment of factual information about different cultural groups".¹³ This includes worldviews of different cultures and knowledge regarding specific physical, biological, and physiological variations among ethnic groups. Not only is the student expected to accumulate information, but also to reflect critically on this knowledge according to what has been learned about awareness.

Cultural skills. Students are expected to communicate with individuals of different cultures, conduct a cultural assessment, and learn how to conduct a culturally based physical assessment.¹⁹ Verbal and non-verbal (body) language, eye contact, and silence, for example, may have different meanings in different cultures. Practising with standardized patients in a clinical examination setting would provide that practical experience.

Cultural encounters. "Multiple face-to-face experiential encounters deepen exposure to diversity within cultural groups and prevent stereotyping that may develop when obtaining academic knowledge".¹⁵ By means of multiple encounters, cultural sensitivity is developed. Internship in culturally diverse outpatient clinics would enhance this sensitivity.

Cultural desires. The culmination of all this "is motivation to want to engage in the process of becoming culturally aware, knowledgeable, and skilful and seeking cultural encounters"¹⁹ As constructivist theory suggests, building one component upon another creates multi-di-

mensional knowledge that is more easily transferable to a clinical setting because of its methodology. Activity and experience confirm deeper learning which will enhance the clinical encounter later in practice.

Students trained in the five competencies in four years of a transformed curriculum will be able to be appraised not only for their learning, but also for the success of a multicultural education.

Course outlines should clearly identify the competency to be acquired in each course, based on Campinha-Bacote's five models.¹⁴ Each competency will dictate the type of teaching method to be used. Lectures, small group discussions, and assignments will determine the type of appropriate testing.

Conclusion

This paper has presented an analysis of the need for multicultural education and cultural competency and a critique of the knowledge gap in chiropractic education regarding this need. It has demonstrated the lack of a framework on how best to achieve a learner-centred syllabus in chiropractic education using guidelines grounded in sound education theory. In the current social context in which diverse demographics necessitate an educational response to ensure best practices in patient care, this paper is a preliminary response to the need to address cultural competency education. This review advances the theoretical background to develop the learning process for acquiring cultural competency. It suggests ways to incorporate the stages of learning and activities into a four-year chiropractic curriculum. Research criteria on multicultural education in chiropractic would depend on student outcomes and what areas require further investigation. This article may have future implications that could affect how chiropractic schools develop their curricula and the competencies of the students they graduate.

References

1. Johnson CD, Green BN. Diversity in the chiropractic profession: preparing for 2050. *J Chiropr Educ.* 2012;26(1):1-13.
2. Johnson CD, et al. Multiple views to address diversity issues: an initial dialog to advance the chiropractic profession. *J Chiropr Humanit.* 2012;19(1):1-11.
3. Khauv KB, Alcantara J. A retrospective analysis of the cultural competence of chiropractic students in a public health course. *J Chiropr Educ.* 2012;26(2):169-174.

4. Callender A. Recruiting underrepresented minorities to chiropractic colleges. *J Chiropr Educ.* 2006;20(2):123-127.
5. Lee CA, Anderson MA, Hill PD. Cultural sensitivity education for nurses: a pilot study. *J Cont Educ Nurs.* 2006;37(3):137-141.
6. Flores G, Gee D, Kastner B. The teaching of cultural issues in U.S. and Canadian medical schools. *Acad Med.* 2000;75(5):451-455.
7. White-Means S, Dong Z, Hufstader M, Brown LT. Cultural competency, race and skin tone bias among pharmacy, nursing and medical students: implications for addressing health disparities. *Med Care Res Rev.* 2009;66(4):436-55.
8. Musolino GM, Burkhalter ST, Crookston B, Ward RS, Harris RM, Chase-Cantarini S, Babitz M. Understanding and eliminating disparities in health care: development and assessment of cultural competency for interdisciplinary health professionals at the University of Utah – A 3-Year Investigation. *J Phys Ther Educ.* 2010;24(1):25-36.
9. Ruddock HC, Turner DS. Developing cultural sensitivity: nursing students' experiences of a study abroad programme. *J Adv Nurs.* 2007;59(4):361-369.
10. Hilliard MJ, Rathsack C, Brannigan P, Sander AP. Exploring the cultural adaptability of doctoral entry-level physical therapist students during clinical education experiences. *J Allied Health.* 2008;37(3):199E-220E.
11. Bagniard M, Bryant L, Colin J. Banks multicultural model: a framework for integrating multiculturalism into nursing curricula. *J Prof Nurs.* 2009; 25(4):234-239.
12. Meacham J. Editor's introduction: interdisciplinary and teaching perspectives on multiculturalism and diversity. *Am Behav Sci.* 1996;40(2):112-122.
13. Billings D, Halstead J. *Teaching in nursing: a guide for faculty* (3rd ed.). St. Louis, MI: Saunders; 2009.
14. Munoz C, DoBroka C, Mohammed S. Development of a multidisciplinary course in cultural competence for nursing and human service professions. *J Nurs Educ.* 2009;48(9):495-503.
15. Hunter J. Applying constructivism to nursing education in cultural competence: a course that bears repeating. *J Transcult Nurs.* 2008;19(4):354-362.
16. Wilson A. Activity theory. In: English L. (Ed.) *International Encyclopedia of Adult Education.* New York: Palgrave Macmillan; 2005.
17. Greene-Moton E, Selig S, Tropicano E. Teaching cultural competence to reduce health disparities. *Health Promot Pract.* 2006;7(3):247S-255S.
18. Flannery D, Ward K. Service learning: a vehicle for developing cultural competence in health education. *Am J Health Behav.* 1999;23(5):323-31.
19. Desantis L, Lipson J. Current approaches to integrating elements of cultural competence in nursing education. *J Transcult Nurs.* 2007;18(1):10S-2.