Taking issues of culture and diversity into account in the education of future physicians
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by

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Preface

This paper is presented in the “Student Work in Progress” category. It describes my proposed PhD research. At this point, I have successfully defended my thesis proposal and am preparing to submit for ethical approval to begin data collection.
Introduction

Members of historically marginalized communities in Nova Scotia, Canada, and, beyond, have received inadequate health care for a variety of reasons (Institute of Medicine 2003, NS Department of Health 2003, Health Canada 1999). Increased attention is now being given, in medical and health research, to members of groups who have traditionally not received appropriate health care: women, racially visible persons, first nation persons, immigrants and refugees, and, gay/lesbian /bisexual/transgendered/two-spirited persons. Despite this heightened awareness, there continue to be gaps with regard to the health care system meeting the needs of diverse populations (Health Canada 2001).

Through the education of future physicians, medical schools are in a position to make a contribution to the reduction of health disparities for members of historically marginalized populations (Health Canada 2001). In recognition of this, certain educational initiatives and interventions have been developed in Western medical schools, particularly training for “cultural competence,” (Nunez 2000). Yet, these developments have been, in many cases incidental, often taking the form of “a half day workshop in sexuality” or “Cultural Diversity Day,” for example, rather than being thoughtfully and thoroughly included in medical curricula (Taylor 2003).

Learning in medicine, as in any discipline, occurs in the context of that institution’s culture (Freebody 2003, Taylor 2003). For the purpose of this proposed research, culture is defined as a “lens through which we give the world meaning and which shapes our beliefs and behaviours” (Azad, Power, Dollin and Chery 2002, p. 222). The culture in which learners are educated influences the ways in which they are educated, including pedagogy and curriculum. An investigation of particular educational practices related to issues of culture and diversity in the institution of medicine holds the potential to contribute to the formation and professional development of competent physicians who are then capable of offering accessible and equitable care within the health systems in which they will practice.
Both formal and informal educational activities can reflect, adapt or reconstruct cultural practices. One of the ways in which changes over time, and local, community and social variations can be documented is through an exploration of the accounts by which members of a culture construe the significance and nature of educational practices. (Freebody 2003, p.132)

This proposed research will be conducted through a feminist post-structuralist gaze (Weedon 1997). It will involve a critical review, through discourse analysis, of a set of curriculum documents from a particular medical school; and, semi-structured, in-depth, open-ended interviews with medical educators and medical students from the same institution. Through the documentary review and interviews, I hope to make a contribution to the scholarly knowledge in three broad areas: 1) the current status of issues of culture and diversity in medical education; 2) the perceptions of educators of the importance of issues of culture and diversity in medical education; and, 3) the perceptions of medical students of the importance of these issues in their education and in their future practices. Ultimately, I hope to learn more about how these issues might be effectively integrated into the curriculum.

**Review of the literature**

Exploring the culture of medical education: Problem based learning

In the institution which I propose to study, the first two years of undergraduate medical curriculum is delivered almost exclusively through problem-based learning (PBL). An overview of PBL in medical education is provided in this section.

Problem-based learning (PBL) (Barrows 1980) has been described as the pedagogy of choice in medical schools world wide (Camp 1996). It was developed as a response to calls for medical education reform.
A growing number of medical schools are adopting PBL in response to criticisms of the conventional medical curriculum, which continued to be based on Abraham Flexner’s recommendations to the Carnegie Commission in 1920. A number of calls for curricular reform have surfaced since Flexner’s time, most recently the landmark GPEP [General Professional Education of the Physician] Report, which... recommended curricular revisions that would make medical education more responsive to changes in health care, prepare students to learn throughout their professional careers, and provide for active, independent, and self-directed learning. (Rankin 1992, p. 36)

Problem-based learning (PBL) in medical education was first adopted by the Faculty of Medicine at McMaster University in Canada in the mid 1960's (Camp 1996). It involves student-centered, case/problem-based, small-group learning. Throughout the 1970’s, 1980’s and early 1990’s, PBL experienced a slow, but steady, increase in popularity. “Now, however, we are seeing an explosion in the use of PBL in its various adaptations. Today, most US medical schools and many in almost every country of the world are implementing (or are planning to implement) PBL in their curricula to a greater or lesser extent” (Camp 1996).

Problem-based learning is generally considered an alternative to the first two years of medical education, which are traditionally dedicated to basic sciences (Block 1997). While conventional programs focus on the acquisition of knowledge and memorization of concepts in the basic sciences, PBL makes use of written clinical cases to stimulate problem-solving, which is intended to promote the learning of basic sciences within a clinical context (McGowan 1995).

In the medical education context, a problem-based learning case usually focuses on a biomedical problem, which is “a typical case of a disease chosen to illustrate the area of basic science to be studied” (Donner & Bickley 1993, p. 296). Rather than a conventional lecture to learn about the issue, small-group tutorial meetings act as the center of learning
in a PBL curriculum. Tutorial groups would usually be composed of six to seven students and one or two faculty members (Donner & Bickley 1993).

The content of the PBL cases and the ways in which issues of culture and diversity are represented, or are not represented, is of particular relevance to this research. A 2002 study of PBL cases at another institution revealed that cases featuring males outnumbered those featuring females; information regarding sexual orientation was generally identified only in the context of disease assessment (e.g., HIV infection); and, most cases did not provide racial or ethnic descriptions (Turbes, Krebs and Axtell 2002). An investigation of the content of these curriculum documents will offer insight into the culture of medicine, and the status assigned to issues of culture and diversity.

Medical education and cultural competence:

Medical schools are in a position to contribute to the reduction of health disparities through physician education. Because of this, government initiatives, such as “Social Accountability: A Vision for Canadian Medical Schools” in Canada (Health Canada 2001) and “Healthy People 2010” in the United States (U.S. Department of Health & Human Services 2000), have called for medical education curricula to be developed which educate physicians to be competent in offering culturally appropriate care to members of historically marginalized groups. Yet, Schools and Faculties of Medicine have struggled with attempting to take difference into account in medical education (Beagan 2003). The recommendations and materials available for medical education curriculum development in the area of cultural diversity, including the American Medical Association’s “Enhancing the Cultural Competence of Physicians” (1998) often focus on addressing the needs of diverse populations through notions of “cultural competence” (Sue & Sue 1990). Cultural competence has been defined as “a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups” (U.S. Department of Health & Human Services 1992).
Cultural competence “implies a discrete knowledge set that focuses on the culture of the patient only as something ‘other’ and therefore aberrant from the norm” (Nunez 2000, p. 1072). This approach focuses on the language and customs of particular groups, with an emphasis on their beliefs and behaviours surrounding health, illness, care providers and institutions.

The thinking here is that doctors – mostly white, well educated, and middle-class or higher- don’t know enough about the range of people they will be caring for (be they people of color; people from nondominant racial, ethnic, or religious groups; people who are economically disadvantaged; people who are disabled; people who do not speak English; or people who are not heterosexual).” (Wear 2003, p. 551)

In a cultural competency approach, it is supposed that by learning about, and even memorizing facts about, particular groups of people, physicians will be able to provide appropriate health care because they will no longer hold ignorant or biased beliefs about those groups. The difficulty with this approach is that members of these groups tend to be essentialized, which may serve to reinforce cultural stereotypes (Nunez 2000, Taylor 2003, Wear 2003). As presented in the following example, stereotyping in medicine can be dangerous.

A student presented the case of an 88-year old Latina with longstanding diabetes who was blind from complications of her disease. The complaint of this pleasant woman was that she had nausea. When asked to present the differential of her nausea, the student first presented a psychiatric syndrome that he understood to be an ailment of Latinos... His incomplete learning about panic attack-like syndromes led him to stereotype the patient and miss her actual diagnosis, diabetes-induced gastro paresis. (Nunez 2000, p. 1080)

The cultural competence method, which is intended to encourage acknowledgment and fitting treatment of difference may, in fact, contribute to the perpetuation of “more of less
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rigid stereotypes about what members of a particular culture believe, do, or want and how they should be dealt with” (taylor 2003, p. 555). this approach, therefore, may reinforce the very health disparities which it intended to reduce. as delease wear writes “i contend that what has come to be known in medical education as cultural competency is theoretically truncated and may actually work against what educators hope to achieve” (2003, p.549).

why has the cultural competence approach survived?

one possible response to this question involves the definition of the concept of culture. taylor (2003) suggests a pervasive factor in moving beyond current cultural competence programs in medical education is an often oversimplified understanding of ‘culture.’ guarnaccia & rodriguez (1996 cited in taylor 2003) note that scholars considering cultural competence in health disciplines

have often turned to earlier writings by anthropologists to present a definition of culture. in general, these definitions have reflected a static view of culture as the distinctive set of beliefs, values, morals, customs and institutions which people inherit… [whereas] more recent approaches to culture in anthropology provide a more dynamic perspective….viewing culture as a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships and migrations. (guarnaccia & rodriguez 1996 cited in taylor p.556)

rather than a static, unchanging notion, current theorizing in medical anthropology considers culture as a process which continually evolves as people make use of their cultural resources. culture, then, encompasses language, religion, education, class and many other dimensions of difference which intersect in complex ways in the life experience and identity of any one individual (taylor 2003).

hunt (2001) notes
Culture is neither a blueprint nor an identity; individuals choose between various cultural options...It is not possible to predict the beliefs and behaviours of individuals based on their race, ethnicity, or national origins. Individuals’ group membership cannot be assumed to indicate their culture because those who share a group’s label may variously enact culture.” (cited in Wear 2003, p. 551)

Another possible answer to the question - why has the cultural competence approach survived? - involves the culture of the institution of medicine, itself. In the culture of this institution, medical knowledge has been considered “real” and “true,” not at all cultural. In fact, the institution of medicine has been referred to as “a culture of no culture” – that is “a community defined by the shared cultural conviction that its shared convictions were not in the least cultural, but, rather, timeless truths” (Taylor 2003, p. 556).

What is it about the culture of medicine that convinces its members it is unaffected by, and completely without, a culture of its own? Fadiman (1997) explains “Doctors endure medical school and residency in order to acquire knowledge that their patients do not have. Until the culture of medicine changes, it would be asking a lot of [physicians] to consider, much less adopt, the notion that, as Francesca Farr put it, [their] view of reality is only a view, not reality itself” (p. 276)

The culture of medicine, although invisible to many of its members, is one which encourages student learners to become part of the community by becoming an expert of medical knowledge – knowledge which is often considered true and non-cultural (Taylor 2003). This involves, for example, learning how to translate from the stories patients’ tell, in their own words, to information that gets recorded on charts and relayed to colleagues (Good 1995). Thus the very skills which students need to develop in order to gain entry into the culture of medicine limit the possibility of gathering information that might be necessary to be thoughtful about issues of difference.

Reinforcing this notion, Good (1995) explains
Students [are] encouraged to learn new narrative forms, to create medically meaningful arguments and plots with therapeutic consequences for patients. In this process, they sharpened their biomedical ‘gaze’ and developed their clinical reasoning. Throughout these exercises, the ‘psychosocial’ aspects of most patients’ illnesses, their social histories and emotional states, and their lives outside of the hospitals and clinics were largely irrelevant; these data from daily life were regarded as ‘inadmissible evidence’ in the presentations made during everyday work rounds. (Good, 1995 sited in Taylor 2003, p.557)

It appears that becoming a competent physician may actually require glossing over the patient’s life experiences. Hafferty (1998) describes this depersonalization as part of the “hidden curriculum” of medical education.

This subtle, yet pervasive “hidden curriculum” may undermine efforts to appropriately take difference into account (Hafferty & Franks 1994; Martin 1976). In medical education, the hidden curriculum involves “unintended messages communicated in lectures and other formal teachings; interpersonal interactions between faculty and students…; and the larger culture and structure of the medical establishment” (Turbes, Krebs & Axtell 2002, p. 209).

For many students, formal and informal curricula are often experienced as prescribed forms of learning which do not encourage them to engage at a critical level or take intellectual risks (Macedo & Bartolome 1999). This is particularly relevant during medical education, as students are often encouraged, both explicitly and implicitly, to establish their overall competence by systematically discounting the individual patients’ culture and experience – a “just the facts, please” attitude. This proposed research will investigate the ways in which problem-based learning cases, as described above, may also contribute to the systematic of the individual patients’ culture and experiences.
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Despite well-meaning attempts at “injecting culture into a culture of non-culture” (Taylor 2003) health disparities persist. Simply put, how can a physician appropriately care for patients without considering the social and cultural contexts in which they live? How can health disparities be reduced if the multifaceted relationship of patients’ values and beliefs with regard to health and illness are not taken into account?

Very few academic medical educators would deny the need for students to understand and respect differences among people based on gender, race, ethnicity, social class, physical or intellectual abilities, sexual identity, or religious beliefs. Yet, racial disparities in health have been documented throughout history, and socioeconomic status remains a persistent and pervasive predictor of variations in health outcomes. (Wear 2003, p. 550)

Although health care inequities persist, medical education scholars have not, to date, thoroughly examined the theorizing of issues of cultural difference in other domains and disciplines although cultural, curriculum, feminist, and postcolonial studies have critically and thoroughly examined such issues and offer new possibilities for the study and teaching of cultural difference in medical education (Wear 2003). The majority of attention continues to focus on cultural competence, even though this method has been well criticized for its emphasis on individual attitudes.

Of course, this [cultural competence] approach (like many others) assumes that the locus of normalcy is white, Western culture – that ‘difference’ means non-white, non-Western, non-heterosexual, non-English-speaking, and most recently, non-Christian – how they are different from us. But this difference can not be too great; the proponents of cultural awareness/sensitivity also hope to convince students that we’re all part of the human family and that our differences make our own
democratic culture rich – leading to what Cameron McCarthy calls a ‘Disneyfied’ culture with harmony among all groups (Wear 2003, p. 550).

There are a number of theorists attempting to move beyond the traditional cultural competence model in medical education. Two of these theorists offer possibilities which I find theoretically appealing. These are Ana Nunez’s discussion of cross-cultural efficacy (Nunez, 2000; 1998); and Delese Wear’s discussion of insurgent multiculturalism (Wear 2003)

Cross cultural efficacy

Ana Nunez (2000) writes that reducing health disparities for members of historically marginalized populations requires a shift from “cultural competence to “cross-cultural efficacy” may be preferable. Cross-cultural efficacy implies that the health care provider is effective in relations with individuals of diverse traditions and neither the culture of physician nor patient is favored (Nunez 1993). This approach increases awareness of: physician-patient differences concerning perceptions of illness; knowledge of health, healing, and therapeutic choices; and, comprehension of population-specific disease and health outcomes (Nunez 2000, 1993). Students develop an understanding of the impacts of their own cultures and “gain a broad appreciation of interactions among cultures, rather than just memorizing characteristics of certain broad groups” (Nunez 2000, p. 1072).

Rather than being offered exclusively in the first two years of medical education, as is often the case (Louden et al. 1999), cross-cultural education occurs throughout the duration of the degree program and its delivery is linked to student progress. At pivotal points, students are evaluated for their acquisition of cross-cultural efficacy using assessment measures which match educational objectives (Nunez 2000).

Insurgent multiculturalism
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Delese Wear (2003) maintains that current attempts to consider cultural differences and inequities in medical education, because they tend to focus on individuals, have overlooked a critical factor – the sources of inequality.

Giroux argues that most multicultural studies have kept the focus off structures, institutions, and governmental policies by limiting discussion to individual attitudes. A more insurgent multiculturalism – sometimes called antiracist pedagogy – does not limit itself to ‘communicative competence’ or to the ‘celebration of tolerance’ but shifts the discussion to power and the foundations of inequalities. (Wear 2003, p. 551)

From Wear’s point of view, a medical curriculum immersed in insurgent multiculturalism would not have students memorizing facts about racial, ethnic, and religious differences on which they would be evaluated for ‘cultural competence’ “by matching traits to groups” (2003 p. 551). Rather, as Giroux suggests, attention would be shifted away from highlighting the characteristics of nondominant groups, which, in health care, often tend to highlight deficits (Wear 2003). Instead, students would focus on racism, heterosexism, sexism, and other forms of dominance, as it is produced historically and institutionally in society.

Students would also learn to identify and analyze unequal distributions of power that allow some groups, but not others, to acquire and keep resources which would also include the rituals, policies, attitudes, and protocols of the very institution educating them.. Such a curriculum incorporates a fuller range of factors that contribute to inequities by looking not only on the doctor-patient relationship but also on the social causes of suffering. (Wear 2003, p. 551)

Insurgent multiculturalism might allow students to become reflective practitioners who are competent at identifying unfairness and discrimination within the patient-physician relationship, medical education, and health care.
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Such skills involve scrutinizing oneself, knowing and respecting human variations, and critically focusing on and working against policies, structures, institutions, and governmental protocols that contribute to inequalities in health. Such skills focus on parts and wholes: not only oneself and one’s patients, but also patients’ illnesses and the historical, cultural, and economic conditions that contribute to them. (Wear 2003, p. 552)

The Aim of the Proposed Research in Consideration of the Current Literature

I agree that physicians require

tools not only to address the pathophysiology of an illness itself but also to deal astutely with language and communication, knowledgeably with biases in decision making (their own and their patients’), politically with how services are accessed, ethically with moral ambiguities in medicine, and emphatically with the experience of illness across differences in race, gender and class. (Wear & Castellani 1999)

Although the cultural competence approach to taking difference into account in medical education evolved from, what I consider to be, good intentions, health disparities persist for members of historically marginalized populations (Institute of Medicine 2003, Health Canada 2001). This is, perhaps as Taylor suggests, because

As long as these basic features of the ‘hidden curriculum’ and institutional culture of medical education remain in place, no amount of fine-tuning the theoretical definitions that students are assigned to read on ‘touchy feely Tuesdays’ is likely to unsettle the tendency of medical education to produce and reproduce itself as a ‘culture of no culture’… To change this situation will require challenging the tendency to assume that ‘real’ and ‘cultural’ must be mutually exclusive terms. Physicians’ medical knowledge is no less cultural for being real, just as patients’
lived experiences and perspectives are no less real for being cultural” (2003, p. 558-559)

Thus, the aim of this proposed research is to make a contribution to the scholarly knowledge in the area of culture and diversity in medical education, with the ultimate goal of learning how these issues might best be integrated into the curriculum in order to educate physicians who are capable of offering equitable care to their future patients. I agree with Taylor (2003) who writes “Cultural competence curricula will, perhaps, achieve their greatest success if and when they put themselves out of business – if and when, that is, medical competence itself is transformed to such a degree that it is no longer possible to imagine it as not also being ‘cultural’” (p. 559)

**Methodology and Methods:**

**Methodology:**

My proposed research is placed within a feminist poststructuralist frame for both theory and method (Weedon 1997). This ideology will guide my research process, my interpretation of the data, and the organization of the written account. Feminism, as defined by Weedon, is

… a politics directed at changing existing power relations between men and women in society. These power relations structure all areas of life, the family, education and welfare, the worlds of work and politics, culture and leisure. They determine who does what and for whom, what we are and what we might become (1987, p. 1).

I identify myself as a feminist researcher because of the theoretical, methodological, philosophical and political gaze through which I conduct research.
Feminist researchers see gender as a basic organizing principle that profoundly shapes/mediates the concrete conditions of our lives…feminists have challenged the invisibility and distortion for women’s experiences in the social sciences. Through the questions feminism poses and the absences it locates, feminism argues the centrality of gender in the shaping of our consciousness, skills, and institutions as well as in the distribution of power and privilege. This is not to deny the powerful shaping forces of race, class, and sexual orientation; increasingly, feminist inquiry looks to the interaction of such social forces in the construction of our lives. (Lather 1992, p. 91)

I embrace feminist theory and method because I am interested in power relations both within the broader society as well as within the very specific method that I used to gather my data.

Feminist research acknowledges that the construction of knowledge is social and political and that “the institutionalization of the research process has, in effect, put a monopoly on the creation of certain kinds of knowledge” (Kirby & McKenna 1989, p.27). Because subordinate groups have been obstructed from choosing, distributing and assessing knowledge, traditional research processes may, in fact, perpetuate imbalanced power relations.

Often, members of subordinate groups recognize the complexities of their experiences, however “their concerns are interpreted as a personal problem or failing rather than as a public issue” (Kirby & McKenna 1989, p. 28). In response to this, I intend to pay attention to the link between personal and the political by acknowledging intersubjectivity in the research process and being critically reflective (Kirby & McKenna 1987). Additionally, I intend to “strive to create wherever possible the conditions for dialogue and the practice of speaking with and to, rather than for others” (Alcoff 1991, p.23). It is my position that “the rituals of speaking are politically constituted by power relations of domination, exploitation and subordination” (Alcoff
1991, p.7). These issues will be central to the processes which I will employ to gather, analyze and report on the data.

I am aware that “qualitative researchers…have wrestled over the years with charges that it is too easy for the prejudices and attitudes of the researcher to bias the data, particularly when the data must ‘go through’ the researcher’s mind before they are put on paper” (Bogdan & Biklen 1998, p.33). This tension regarding subjectivity has developed out of a positivist research tradition. Positivism “…claims there is [one best way] and a knowable truth” (Kempner 1992, p.71) and encourages completely objective and value free research. “The investigator and the investigated ‘object’ are assumed to be independent entities, and the investigator to be capable of studying the object without influencing it (Guba & Lincoln 1994, p.110). In addition, the findings of positivist research should be replicable in order to prove that they are “true” (Guba & Lincoln 1994).

The feminist theory which will inform my proposed method, contradicts the positivist research tradition.

Feminist commitments, like anti-racist commitments and gay rights commitments, count within such analyses only as values; hence they cannot be permitted to inspire, govern, or justify the results of research projects. To be a feminist is, in effect, to conduct value-laden research and hence not to be properly objective. Such ideologies sustain the “myth of the neutral man” who is presumed to be able to represent everyone’s interests with detached objectivity, in his universally motivated and applicable projects of inquiry. Women, and other “Others,” by contrast, are represented as producing only subjective, partial, subjectively interested research. (Code 1995, p.17)

“Positivist hegemony” (Lather 1992) is interrogated by feminists for the ethical and political underpinnings of certain power relations due to research participants’ race,
sexuality, class, ability and gender. Methodologically, it is important to ask, if “knowledge is power” then whose knowledge counts?

I acknowledge the inevitable fluid, temporal and partial elements of research. “Personal narratives/stories/descriptions are always selective and partial, constructed in particular spaces at particular times for particular audiences” and “…personal narratives develop as lives do, and personal accounts of experience differ from telling to telling” (Manicom 1992, p. 372-373). I believe that there is not one, unchanging and complete true story to be learned through the research process. Therefore, I have also embraced poststructuralist theory, the discourses of which “are all deconstructive in that they seek to distance us from and make us sceptical about beliefs concerning truth, knowledge, power, the self, and language that are taken for granted within, and serve as legitimation for, contemporary Western culture” (Flax 1990, p. 41).

Feminist theory has been criticized for the tendency to assume a meta-narrative of the lives of women (Flax 1990, Fraser 1992, Gavey 1990, Kristeva 1981, Lather 1988, Nicholson 1990, Weedon 1997). This criticism arises from the viewpoint that the concerns of white, western, middle class, heterosexual women have historically been the primary focus of feminists. Some argue that issues of racism and classism are not sufficiently addressed within some feminist theorizing (Fraser & Nicholson 1990).

According to Fraser and Nicholson (1990)

In recent years, poor and working-class women, women of colour, and lesbians have finally won a wider hearing for their objections to feminist theories which fail to illuminate their lives and address their problems. They have exposed the earlier quasi-metanarratives, with their assumptions of universal female dependence and confinement to the domestic sphere, as false extrapolations from the experience of the white, middle-class, heterosexual women who dominated the beginnings of the second wave (p. 33).
Researching from a combination of feminist and poststructuralist points of view, thus, offers a critical and historically contextualized foundation from which to consider differences and discourage ‘essentialist’ notions of the lives of women and other members of historically marginalized groups (McNay 1992).

I identify myself as a poststructuralist researcher because, through this theoretical gaze, 'grand theories' or ‘grant narratives’ are shifted to a more contextual approach. My feminist and poststructuralist commitments meld well because

Feminists, like postmodernists, have sought to develop new paradigms of social criticism which do not rely on traditional philosophical underpinnings. They have criticized modern foundationalist epistemologies and moral and political theories, exposing the contingent, partial, and historically situated character of what has passed into the mainstream for necessary, universal, and historical truths. They have called into question the dominant philosophical project of seeking objectivity in the guise of a "God's eye view" which transcends any situation or perspective (Fraser & Nicholson 1990, p. 26).

Many late 20th century feminists have customized and adopted poststructuralism, the philosophy of French social philosopher Michel Foucault (1972, 1977, 1978) because taken for granted cultural practices and rituals, particularly those which endangered the theoretical equality suggested by political philosophers, were identified and explored (Dreyfus & Rabinow 1982). Among these, language and discourse were analyzed and identified as central in establishing and maintaining the relations of power, knowledge and subjectivity (Foucault 1972). The work of Foucault was admired by a number of contemporary feminists because his theories challenged the conception of a fixed and unchanging meaning, a unified subjectivity, and central theories of power (Weedon 1999). “These beliefs provided the theoretical foundation for feminists to challenge examine, and deconstruct patriarchal discourse, social institutions, and power
relationships that disadvantage and oppress women in contemporary society” (Arslanian-Engoren 2002, p.513).

The combination of feminist and poststructuralist analyses offers a “means of understanding, exposing and changing hierarchical social networks that use power to silence and marginalize” (Arslanian-Engoren 2002, p.513). Hence, as a poststructuralist feminist, I have the goal of helping to transform the dimensions of inequity and develop innovative ways of understanding differences (Weedon 1997) and exposing patriarchal prejudices within social, political and cultural institutions (Gavey 1997, Weedon 1997, 1999) that lead to the in the domination and subjugation of members of marginalized groups.

Conducting research from a feminist poststructuralist theoretical perspective involves paying particular attention to issues of language, subjectivity and power, as discussed below.

Language. Language has been, and continues to be, the central focus of feminist poststructuralist analysis (Arslanian-Engoren 2002). Scott (1994) identifies language as the way by which meaning is assigned to gendered ideals (i.e. notions of femininity and masculinity) and subsequently normalized by society.

Language, the common factor in the analysis of social organization, social meaning and power and individual consciousness (Weedon 1997), is how one makes sense and meaning of one’s world (Doering 1992). Socially specific meanings are constituted within language, not by the individual who utters the words (Weedon 1997). In poststructuralist theory, words have no fixed meanings, only specific historical and contextual meanings (Scott 1994). (Arslanian-Engoren 2002, p.513)
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The acknowledgment of discourse as legitimate sources of women’s, and other members of historically marginalized groups, ways of knowing is central to a poststructural approach. As Heslop (1997) explains, words can be a means through which insight is gained into everyday realities. In the research process, paying attention to the discourse of documents and participants offers the space in which the voices of those who are not necessarily typical or representative of the dominant discourse might be heard.

Subjectivity: Subjectivity is also a central concept in poststructural theorizing and has been defined as both conscious and unconscious thoughts and emotions that allow one to make sense of her or his self and to understand her or his relationship to the world (Weedon 1997). Mansfield (2000) considers subjectivity as

an abstract or general principle that defies our separation into distinct selves and that encourages us to imagine that, or simply helps us to understand why, our interior lives inevitably seem to involve other people, either as objects of need, desire and interest or as necessary sharers of common experience. (p. 3).

Predominant stereotypes and other social forces manipulate not only an individual’s perception of self and the acquirement of subjectivity, by assigning current meanings and values for behaviours. “Individuals are constructs whose subjectivity is mediated by social discourse and cultural practices, not by individual motivations and intentions (Alcoff 1995)” (Arslanian-Engoren 2002, p.513).

Power. Poststructuralist theory does not equate power to knowledge. Instead, power and knowledge are considered as mutually dependent entities, with power generating knowledge and knowledge initiating power (Arslanian-Engoren 2002).

Because poststructuralist theory rejects the possibility of an absolute truth and objectivity, multiplicity of meaning is embraced. Poststructuralists contend that because knowledge is socially constructed, intrinsically transitory and closely associated with
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power, those individuals who hold power regulate what constitutes the essence of the experience, the era and our subsequent understanding of the event. In contrast, recognition of different meanings disrupt and displace oppressive knowledge and meanings (Gavey 1997).

Method

Conducting research from a feminist poststructuralist perspective, according to Fraser and Nicholson (1990) involves being “comparativist rather than universalist… and attuned to changes (p. 34).” Throughout the process, I will pay particular attention to feminist post-structural concerns of language, subjectivity and the power relations both within the broader society as well as within the very specific method to be used.

Method 1 – Critical Review of Curriculum Documents:

Expanding upon on a study by Turbes, Krebs & Axtell (2002), I will conduct a content analysis of the problem-based learning cases which constitute a substantive portion of undergraduate medical education curriculum in the first two years of study at the medical school which I intend to investigate. I will analyze these cases with the aim of exploring where and how issues of culture and diversity are presently dealt with in the curriculum.

Data Collection

In the institution which I will investigate, students use problem-based learning cases exclusively in their first two years of study. During Year One, study is divided among seven units: Human Body; Metabolism and Function; Pathology, Immunology and Microbiology; Pharmacology; Genetics, Embryology and Reproduction; Patient-Doctor; and, Clinical Epidemiology and Critical Thinking. In Year Two, study is divided among five units: Brain and Behavior; Skin, Glands and Blood; Respiratory and Cardiovascular; Genetourinary, Gastrointestinal and Musculoskeletal; and Population Health, Community
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Service and Critical Thinking. Students spend a number of weeks learning about each unit through the use of problem-based learning cases.

I propose to conduct a critical review the complete set of problem-based learning cases for a recent academic year. This review will focus on: the presence of issues of culture and diversity; and, the situations in which these issues are represented.

As I review the cases, I will ask questions specifically, regarding culture and diversity, such as:

Is the ethnicity, gender, race, religion, sexual orientation, social class of the patient indicated? Is there any information about the ethnicity, gender, race, religion, sexual orientation or social class of the physician? In which units of study are issues of culture and diversity addressed? In which units of study are these issues not included? If these issues are addressed in a particular case, what is the context? Are certain issues of culture and diversity represented more often than others? Is the patients’ personal life/situation described?

I review the cases, I will ask questions specifically, regarding the language of the cases, such as:

What role does discourse play in the case? From whose perspective is the case presented? Is the patients’ voice represented? If so, in what context? Does the case represent an obvious power differential? Who wrote these cases and for what purpose?

As a post-structuralist, I recognize that no list of questions will lead me to the truth about the representation of issues of culture and diversity in medical education – and, in my opinion, that no one truth exists. In light of this, I acknowledge that the questions listed above are by no means exhaustive and will most likely be added to, expanded upon and reproduced as I become immersed in the data collection process.
Data Analysis

Specifically, the content of the problem-based learning cases will be analyzed using discourse analysis, as described by Michel Foucault (1972), through a feminist gaze. Ramazanoglu (1993) defines discourse as “historically variable ways of specifying knowledge and truth - what is possible to speak of at a given moment” (p. 19). Therefore, discourse(s) is/are not simply “groups of signs (signifying elements referring to contents or representations) but [are] practices that systematically form the objects of which they speak” (Foucault 1972, p. 49).

Although some consider that “Foucault is an unlikely resource for feminist praxis given two features of his work: his neglect of the dynamics of gender in his analysis of power and his displacement of the subject as a central agent for social change” (Naples 2003, p. 27) others, including myself, see discourse analysis as a viable method of feminist investigation. This is perhaps because the politics espoused by Foucault “empha[ze] … local resistance and the questioning of discursive categories that surround us – two political projects that have much in common with feminist praxis” (Bell 1993, p.55). According to Foucault “power is not overt domination of one group by another, but the acceptance by all that there exists ‘an ideal, continuous, smooth text that runs beneath the multiplicity of contradictions, and resolves them in the calm unity of coherent thought’” (Foucault 1972, 155).

Within educational institutions, curriculum is a form of educational policy. The Foucauldian method of discourse analysis is particularly valuable for research exploring social policy of institutions because of the focus on issues of governance (Naples 2003). Nancy Campbell (2000) draws on the theoretical framework of Foucault to explain that a traditional approach to “[p]olicy analysis typically misses the cultural assumptions … which then exert unacknowledged effects on the policymaking process and policy outcomes” (p.7). In order to examine how the values of the culture of medicine are pervasively embedded into its curriculum, I will use a feminist approach to discourse
analysis, as described by Naples because “By utilizing discourse analysis within a feminist epistemology, I argue that the dynamics of gender, race and class are brought into the frame more effectively that is possible with a non-feminist Foucauldian approach” (2003, 28-29).

I will use a standard form to review the cases. The form will be further developed and expanded upon as I become more immersed in the documentary review. The cases will be reviewed twice. The initial review will separate the cases which mention issues of culture and diversity from those which do not. The second review will explore the ways in which such issues are presented. For the purposes of this documentary review, issues of culture and diversity include race, gender, sexuality, ethnicity, religion and social class.

Method Two - Interviews:

Following the review of problem-based learning cases, I propose to conduct semi-structured, in-depth, open-ended interviews with medical educators and medical students. These interviews will focus on issues of culture and difference in medical education. Although it is my intention to develop interview protocol based upon the information gained through the discourse analysis of the curriculum documents, I suspect that interviews with medical educators will focus more on curriculum and the culture of the institution of medicine whereas those conducted with medical students will focus on the experience of being immersed in the curriculum and their future practices.

Data Collection

Following my review of the problem-based learning cases, I will conduct semi-structured, in-depth, open-ended interviews with medical educators and medical students to elaborate and expand upon the information I gained through the review. Because the interviews will be developed based upon what I learn through the documentary review, at
this point I cannot predict a precise number of interview participants. However, with the recognition that qualitative research is not about the production of generalizable results (Bogdan & Biklen 1998), I estimate that ten to fifteen participants will be a manageable number of participants and will provide rich, thick data.

I will use both purposeful and snowball sampling techniques (Creswell 2003) to select medical educators to participate in the study. Potential participants will be faculty members in the medical school which I will be exploring. They will be familiar with the problem-based learning curriculum, either from an administrative position or from having tutored in the program. I will send invitations to participate to individual medical educators via e-mail. As a feminist researcher interested in breaking down the power differential in the research process and in recognition of the very busy schedules of these potential participants, interviews will be scheduled according to participants’ wishes regarding dates, times and locations.

Interview protocol will be developed based upon information gained through the review of curriculum documents. However, I propose that interviews will explore three broad areas: learning about the participants; the representation of issues of culture and diversity in the problem-based learning curriculum; and, the participants’ perceptions of issues of culture and diversity.

The medical students will also be selected using purposeful and snowball sampling (Creswell 2003). These will be first and second year students who are currently immersed in the curriculum, or third year medical students who have recently been involved with problem-based learning. Again, because of my familiarity with the context of this particular institution, I have decided to invite students to participate via e-mail. As with the medical educators, medical students are operating on very hectic schedules. Therefore, interviews will be conducted in accordance with the preferences of participants.
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Interviews with medical students will focus in four broad areas: learning about the participants; the representation of culture and diversity in problem based learning; the participants’ perceptions of issues of culture and diversity; and, the impact of these issues on their future practices.

The interviews will be based upon informed consent and will be conversational in nature. As a feminist, I see my role an active listener and a facilitative voice. I favor the view of the research process described by Toma (2000) “The research relationship is a partnership. It is not a series of detached observations about subjects by intentionally uninvolved researchers. Instead, subjective qualitative researchers consciously avoid such barriers between themselves and their subject” (p. 177).

The interviews will be audio-tape recorded and transcribed. The tapes and transcripts will remain in my possession. Additionally, I will conduct informal observation and keep field notes during the interviews. Marshall and Rossman (1995) contend that “observation plays an important role as the researcher notes body language and affect in addition to the person’s words” (p. 80). Through observation, the researcher learns more about the meanings attached to research participants’ discussions and behaviors.

Data Analysis

As the research will be conducted through a feminist poststructural frame, discourse analysis will again be central to the analyses of data. Discourse analysis of interview data is helpful because

First, it can help us understand how people's social identities are fashioned and altered over time. Second, it can help us understand how, under conditions of inequality, social groups in the sense of collective agents are formed and unformed. Third, a theory of discourse can illuminate how the cultural hegemony of dominant groups in society is secured and contested. Fourth, and finally, it can
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shed light on the prospects for emancipatory social change and political practice (Gavey 1990 cited in Fraser & Bartky 1992, p. 178).

Dorothy Smith (1991) views discourse as the means by which a researcher gains insight into the lives of participants, and thus encourages interviews to be analyzed for their textual form and representation of participation in social relations. As a feminist-poststructural researcher who will engage in data analysis, I acknowledge the participant is the active writer of the text and is drawing on her/his experience to construct the text, just as I, as the researcher, am drawing upon my experience and knowledge in reading and interpreting the text.

Recognizing that perceptions of the self are linked to linguistic practices, analyses of participant interviews must pay attention to how participants construct or talk about the self. I also acknowledge and appreciate the presence of my self in the analysis of these data, as well as the intersection of my self with those of the research participants. As Lather (1991) writes

The texts constructed from interviews are not transparent; they are constructions which inherently distort due to the shirt…from words spoken by one person to words shaped into written form by another. Written texts, then, are ‘a point of intersection between two subjectivities’ (p.146) which could easily have produced a different story with different emphases given different interview conditions.” (p. 94).

With regard to process, data analysis will be a multi-step, reflexive (Fine, 1994) process. The interview transcripts will be reviewed line by line, a form of coding referred to as open coding, where concepts are identified in terms of their properties and dimensions and similar concepts are then grouped to form categories (Strauss and Corbin, 1990, p. 65). Creswell (1998) refers to this process as categorical aggregation (p. 154). The categories I create will be reworked and refined as the research process progresses. The
codes derived from each interview transcript will be compared. Glaser and Strauss (1967) refer to this as “the constant comparative method of analysis."

Throughout the ongoing process of analysis, I will engage with the data in a number of ways, including recording insights in the form of memos in a research journal and by constructing matrices which summarize themes. Huberman and Miles (1994) describe the useful interaction between display (for example, in the form of a matrix) and emerging written text

The display helps the writer see patterns; the first text makes sense of the display and suggests new analytic moves in the displayed data; a revised or extended display points to new relationships and explanations, leading to more differentiated and integrated text and so on (p. 433).

In Conclusion

This paper describes my proposed doctoral research which is, at this stage, still very much a work in progress. I am looking forward to beginning the data collection process in order to learn more about taking issues of culture and diversity into account in the education of future physicians. It is my hope that the research will make a significant contribution to the field of medical education and, education more broadly.
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