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EDUCATION

Surveys of Cultural Competency in Health Professional Education: A literature review

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Abstract

A literature review, in advance of designing a survey of cultural competency in Australian and New Zealand paramedic education courses, provides the focus of this paper. The review sought to explore the extent to which other health professions include cultural competency in their undergraduate curriculum.

The literature review identified specific research papers that used survey methods to determine the status of cultural competency training in other health professions. With no paramedic specific information available to inform paramedic education, these research papers formed a basis for designing a survey that would examine the extent to which paramedic education includes cultural competency in its curricula.

This paper is timely for informing paramedic education about surveys on cultural competency in health professional education. It is particularly timely for the paramedic profession, which is currently in transition from a vocationally based occupation to a professionally based discipline within a university setting; and, at a time when a small number of student paramedics are opting to take advantage of an Honours degree. Similarly, experienced paramedics are undertaking Masters and Doctoral research programs in prehospital and paramedic related issues. Such opportunities enable paramedics to extend their career prospects into academic research, an opportunity that was previously untenable.

The process of reviewing the literature to develop a paramedic specific survey provides useful information for paramedics who may want to undertake similar research projects to examine other aspects of the curriculum. This paper, therefore, contributes to both developing an appreciation of the complex issues which arise from this process, and establishes an evidence base foundation for the paramedic discipline as it emerges within an academic and research orientated environment. The lessons learned in reviewing surveys might be useful for other health professions and emergency service researchers.

Introduction

Educators of health professionals increasingly respond to a need to prepare students to work with a progressively more diverse population. The development and evaluation of cross-

cultural and cultural competency units and courses now proliferate. However, an absence exists of Australian or New Zealand studies reporting on educational programs that prepare paramedics for working in these culturally diverse communities.

The National Health and Medical Research Council[1] (NHMRC), is an Australian peak body that supports health and medical research; develops health advice for the Australian community, health professionals and governments; and, provides advice on ethical behaviour in health care and in the conduct of health and medical research. One of its recent initiatives is a publication entitled *Cultural Competency in Health: A guide for policy, partnerships and participation.*[2,3] This guide promotes the teaching of cultural competency for all health professionals. In addition to this guide, international, national and state conventions underpin paramedic practice[4] and provide the context and rationale for exploring cultural competency in paramedic education.

Currently, no study has been located that explores cultural competency in paramedic education. This paper is the second paper in a series of research papers that explores culturally related issues in paramedic education. It is, to the best of our knowledge, the first to assess literature that reports on surveys/questionnaires focused on cultural competency in health disciplines, and to use this approach as a means to better understand cultural competency in paramedic education. We believe that this contribution is unique, timely and important for an academic discussion about a topic that is becoming increasingly important, particularly with the introduction of NHMRC guidelines on cultural competency training for health care professionals.

The first paper[4] in the series offered a review of international, national, state, and professional initiatives underpinning paramedic practice, education and training. This paper, reports on a review of literature concerning surveys exploring cultural competency in health disciplines, and sets the foundation for a follow-up paper in which we report a survey design for use in reviewing cultural competency in Australian and New Zealand paramedic education. A fourth paper presents the results of the survey of cultural competency training in paramedic undergraduate education and a final paper presents a review and evaluation of innovative approaches developed within the health disciplines for teaching cultural competency in an undergraduate curriculum.

Methods

A literature review identified research on cultural competency training in undergraduate curriculum in other health disciplines. From this literature review, we extracted studies that reported on surveys of cultural competency in education programs. The bibliographies from these papers revealed further relevant papers.

Fourteen papers were identified as relevant to the study. Of these, six were from medicine;[6,8,9,10,12,13] three from health education;[11,14,16] two each from nursing[5,15] and dentistry[17,18] and one from speech pathology.[7] Only one paper came from an Australian or New Zealand context.[5]

This study used iterative qualitative data-analysis techniques which takes a broad view of the data, soliciting ideas and themes and winnowing these options to topics of importance.[26]

The following themes were identified:

- Rationale for a survey on cultural competence
- Definition of cultural competence
- Research objectives

- Teaching methods
- Unit/subject content
- Cultural training as core curriculum
- Time devoted to teaching cultural competence in the course
- Staff training in cultural competence
- Student assessment and feedback
- Findings of reviewed paper
- Recommendations from reviewed papers

The matrix shown in Table 1 provides a snapshot of the core themes represented in each of the papers.

Results

The core themes listed above provide the basis for analysis to report on the surveys and their implications for designing our proposed survey.

Rationale for a survey on cultural competence

All authors demonstrated a concern about caring and serving cultural and linguistically diverse populations.[5-18] Authors cited demographic changes, including voluntary and involuntary migration, as key factors to the pervasiveness of increasingly diverse societies. An important outcome was health disparities occurring in migrant populations,[14,18] which demonstrated how culture impacts on health and therefore demands curricular and training programs to enable health professionals to better serve minority groups. Training programs also needed a consistent and comprehensive approach or a framework[11,16] to alleviate concerns about what to teach.[7,10,12,14] Perhaps the most disconcerting rationale in the reviewed papers, was the need to combat institutional racism.[13]

The implications of each of the rationales presented, helped contextualise our own proposed survey. Australia's population is becoming more culturally and linguistically diverse, as demonstrated in the 2006 Australian Bureau of Statistics Census.[19] Within this context, Australian health care professionals would need to acquire an appreciation of cultural concepts to deliver good health care, yet the research demonstrated a lack of cultural concepts and knowledge to achieve such care. Similarly, authors noted that little was known about 'what' was taught and the lack of explicit and consistent guidelines, which could have profound implications for the effectiveness of programs for those who adopt cultural beliefs and practices different from conventionally held beliefs.

In light of these observations, our decision to conduct a survey about cultural competence in paramedic education was well founded. Such a survey was overdue in comparison to surveys in other health professions. This view is further reinforced by recent research[20] which evaluated twenty years of literature that measured cultural competence training in health professions, but did not include paramedics. Currently, no such evaluation is possible within the paramedic context.

Definitions of cultural competence

Five papers[8-10, 12, 13] provided no definition for cultural competence. The remaining nine papers demonstrated variable definitions and interpretations. The following definitions

demonstrate this variability. One paper provided a simplistic view that 'culture is the lens through which we give the world meaning and which shapes our beliefs and behaviours'.[6] Two papers provided definitions of cultural sensitivity and awareness[11,16] which in essence was being aware of the nuances of one's own and other cultures by being conscious and sensitive about the existence of cultural similarities and differences to which practitioners refuse to assign values such as better or worse, more or less intelligent, right or wrong. These definitions were complemented by the idea that culturally competent care included 'knowing, explaining and interpreting … within the context of the patient's cultural beliefs and practices' which required the complex integration of knowledge, attitudes and skills.[5] Two definitions of cultural competence[11,14] included skill and ability. An old but forward-looking definition saw it as:

> *a set of academic and interpersonal skills that allow individuals to increase understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications, and other support.* [11]

A more contemporary definition combined cultural sensitivity and awareness with skill and defined cultural competence as 'an individual ability to understand and respect different values, attitudes, beliefs, and mores across cultures, and to plan, implement and evaluate health education and promotion program interventions appropriately.'[14]

One paper[17] made reference to what is perhaps regarded as a classic definition which Cross[21p 13] coined in 1988 whereby cultural competence is defined as:

> *a set of congruent behaviours, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.*

This was, however, not a new idea, with authors generating previous definitions that evolved from the early seventies and contributed to Cross and his need to develop a reality-based approach to cross cultural service delivery.[22]

The implication of such variation led us to use the term 'cultural training', which incorporates cultural competency, cultural sensitivity and cultural diversity. More specifically, we base our definition on Doyle's[11] for its community-based relevance to our research and will include the following statement on our survey/questionnaire.

> *Cultural competency*: is 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. Cultural competency demonstates a willingness and ability to draw on community-based values, beliefs, traditions and customs, and to work with knowledgeable people of and from the community to develop focused interventions, communications, and other resources. *Cultural sensitivity*: sensitivity and awareness of the nuances of ones own culture(s) and those of other people, and *cultural diversity* includes the wide range of 'ethnic', 'minority' and 'multicultural' groups that form the Australian population and communities.

Because such variability exists in definition and terminology, this statement will serve to inform research participants enabling greater consistency and reliability of data.

Research Objectives

The research objectives of all papers related to determining the status of cultural competency education and training in their respective discipline. Most papers comprised other research elements such as questions about comparative research,[8] developing an assessment tool[10] or whether multilingual students were encouraged to apply for particular courses.[7] Papers, which explored broader research questions than our own, were included because they shared some commonalities that could contribute to the design of our survey/questionnaire.

The implications of reviewing the research objectives of each paper was that it enabled us to refine and simplify the research question for our proposed survey/questionnaire, i.e. to, 'review the current status of cultural competency training in Australian and New Zealand undergraduate paramedic programs'.

Teaching methods

The reviewed papers revealed different teaching methods and a synopsis is provided in Table 2. Analyzing teaching methods was difficult due to the variability of reporting, for example, clinical clerkships versus internships; case based studies versus culturally specific projects; and self-awareness versus introspection versus reflective journaling. To avoid multiple categories in Table 2, we used:

- 'clinical placements' to include clinical clerkships and internships;
- 'culturally specific/case based projects' to include case based studies and culturally specific projects; and,
- 'personal reflection' to include self-awareness, introspection and reflective journaling.

Combining the categories in this way made no difference to the final numbers as no repetition of the actual events occurred.

Two papers[5,7] reported teaching methods in such a broad manner that we were unable to include these in this part of the analysis. Similarly, we did not include a teaching method if it occurred only once in the reviewed papers.

The most frequently reported methods of teaching cultural competency are listed below in order of reported frequency:

1. Lectures
2. Group discussions
3. Culturally specific/case based projects
4. Clinical placements
5. Guest lecturers, personal reflection and games/role play.
6. Films/videos and cultural simulations
7. Written assignment/exams
8. Objective structured clinical examinations (OSCEs), and history taking/case history

This review enabled us to include the most commonly used teaching methods as part of the survey/questionnaire and promoted us to consider including open questions to identify successful teaching methods and to gain comments on why these teaching methods proved successful. Responses to theses questions will enlighten us about best practice on teaching methods for cultural competency training in paramedic education.

Unit/subject content

The content area on which the authors reported, varied from six[5,7,9,11,15,16] providing no details to one[6] providing extensive details. Seven papers[8,10,12-14,17,18] provided details that gave some insight about what was taught. Consistent with the other areas of analysis included in this paper, there was great variability with the way authors described unit content. We report the extensiveness in this paper to elucidate the diversity of unit content in cultural training that exists in medicine; nursing; dentistry, speech pathology and health education.

The extensive list of topics shown in Table 3 uses the following themes:

- *Aboriginal and First National Health*
- *Access and Disability*
- *Age Sex and Gender*
- *Alcoholism*
- *Attitudes and Behaviour*
- *Complementary and Alternative Medicine*
- *Cross-Cultural Communication*
- *Cultural Issues*
- *Ethnicity*
- *Immigrant Health*
- *Oral Health*
- *Racism*

This review enabled clearer insight of the substantial descriptions used to depict unit content, which also portray a picture of what other health professions are teaching. The descriptions also provide insight into what others see as important content to include in teaching cultural competency. However, the vastness of the categories identified challenged us on how to best structure our questionnaire in order to clarify accurately the content of cultural competency training in paramedic education.

Cultural training as core or elective curriculum

Seven papers[5,7,9,11,13,15,17] did not mention whether cultural training was an elective or a required element of the curriculum, while the remaining seven reported variably. For the purpose of clarification, we interpreted 'required participation',[6] 'formal instruction',[8] 'mandatory instruction'[10] and 'integrated across the curriculum'[14,17,18] as core curriculum. Three papers[8,10,14] reported that some schools provided separate courses devoted entirely to cultural competence training, and three[8,10,12] reported that the topic was an elective.

This aspect of the review prompted us to include questions to determine whether cultural training was a part of core curriculum, an elective subject, an identifiable, stand-alone unit/subject within the course or integrated across the curriculum. Responses to this question

would give us an indication to the status of cultural training in Australian and New Zealand paramedic education.

Time devoted to teaching cultural competence in the course

The amount of time devoted to teaching varies in each paper. Eight papers[5,7,9,11,14-16] provided no details and six provided details. Of these, four gave the number of years in which students study cultural competence and two gave the number of hours devoted to teaching through the entire course, and one gave the amount of time spent on the topic in each year. Of the four authors reporting on the number of years, one reported teaching from 1st-4th year[12] two[10, 13] reported that students received training in 1st, 2nd and 4th year but not 3rd year, and another reported no training in 4th year.[8] Of those authors reporting on the number of hours, these varied from less than five hours[18] to an average of ten hours per year over three years[8] and up to a total of forty hours over the course of study.[6]

The implication of this review is that the time devoted to cultural competency training in paramedic education is likely to report sim ilar variation as the other health professions. To facilitate reporting we will include a question on how many hours are devoted to didactic teaching of cultural training in each year of the paramedic course.

Staff training in cultural competence

Nine papers[5-7,9-13,15] did not report on the provision of staff training in teaching cultural competency. Five papers[8,14,16-18] reported that training was not a requirement, whilst only two[8,18] reported staff expertise and interests as factors influencing the teaching of the topic.
This review identified a low level on reporting the level of expertise required for teaching the cultural aspects of health. However, we hold the view that cultural training, like clinical training, is a specialised area of teaching that requires specific staff training. To facilitate reporting, we will include specific questions on the qualifications and experience in cultural competence of the teaching staff.

Student assessment and feedback

One paper reported a range of assessment methods in cultural training,[11] that included written exams, direct observation, reflective journals oral presentations and OSCEs. Five additional papers[6,8,9,13,18] reported assessment, of which written and oral exams were the most common. The remaining eight papers[5,7,10,12,14-17] provided no information.

Similarly, student feedback was reported in two papers[8,9] while the remaining papers provided no information. This review of student assessment and feedback failed to demonstrate the important principles of curriculum design.[23] Further investigation may be required to identify appropriate methods of assessing student work and capturing student evaluations of cultural competency training.

Findings of reviewed papers

The papers reviewed illustrate the status of cultural competency training in health professional education.

In 1994, higher education institutions were inactive in providing or incorporating cultural sensitivity training and respondents rated their institutions low in terms of making the topic a high priority for inclusion into the curriculum, even though institutions believed it was

important and should be integrated.[16] Advances had been made by 1996 but few were addressing the need for cultural competencies as a part of effective health promotion in a diverse society.[11] In 1999, research into the medical curriculum identified both the need for cultural education and its vertical integration to deflect deteriorating student attitudes in the latter years of medical education.[13] Such needs remained unmet. One-year later, research identified that fewer medical schools taught cultural issues in 2000 compared to 1991, and, that most US and Canadian medical schools did not teach specific cultural issues relating to their largest minority groups. This worsening situation was described as due to the rapid growth in population diversity and mounting evidence about the important effects of culture in clinical care.[12]

In 2001, speech pathologists recognised a need for more information about cultural and linguistic diversity and despite the restriction of units in courses.[7] Medical education saw moderate gains in 2002 for cultural competency training but with gaps persisting in training,[6] and also a marked increase in prevalence of multicultural curricula for family practice residences from 1985-1998,[8] with cultural competency being integrated to varying degrees into curricular.[10]

In one nursing survey, twenty-three of twenty-eight universities conducted general studies in the area of society and culture[5] and another noted inclusion of cultural competence and sensitivity content within the program, with several having extensive curriculum content presented as a program thread – awareness in first semester and sensitivity in second semester.[15]

By 2005, 72% of medical schools in UK and N Ireland reported teaching cultural diversity.[9] Of concern was that most health education professional preparation programs were not offering courses devoted entirely to cultural competence with students being referred to other departments for training, which could have common and uncommon elements, but programs were addressing cultural competency through core-required subjects.[14] Conversely, one paper identified that most US dental schools offered cultural competency training with a rich variety of topics and considerable integration but few offered a stand-alone course devoted to the topic,[17] and another reported similar findings with 80% of American dental schools addressing cross-cultural issues formally in their curricula using multiple educational methods.[18]

This review identified as a common theme, concern about what constitutes cultural competency training and that more valid and appropriate methods and techniques for student assessment and program evaluations need to improve the current fragmented approach. The effect of cultural competency training on students and patient outcomes raised concern, as did developing ways to best operationalise and measure such training. One suggestion included standardising the delivery of cultural competency education. These findings demonstrate the sporadic but incremental increase in cultural training over a thirteen-year period and characterise the status of cultural training in medicine; nursing; dentistry; speech pathology and health education.

Recommendations from reviewed papers

A number of authors[8-11,14,17,18] recommended the need for further research. Suggestions ranged from the provocative, which asked whether the topic is required,[8] to the committed which raised the need for further research to embed teaching of the topic within the medical undergraduate curriculum and to ensure that it is valued by staff and students.[9] Other research

questions included understanding the true extent of cultural diversity training,[6] measuring proof of students' cultural sensitivity and competency levels,[11, 14] exploring strategies for effectively teaching cross-cultural issues[18] and researching student experiences and perspectives about the educational value of these activities.[17]

Finally, in terms of research, one author expressed the desire to move from descriptive studies toward rigorous evaluation of the effects of cross-cultural education on clinician behaviour and patient care outcomes[6] which correlated with what educational activities work best.[14]

A number of relevant curriculum recommendations included reassessing curricula priorities in order to formally incorporate cross-cultural issues,[18] because culture profoundly influences clinical care.[12] Preferably, the topic ought to become a core subject[14] or a semester long or longer course.[12] Such training could provide the opportunity to apply academic and clinical knowledge to a multicultural client base;[7] and greater involvement with diverse groups from outside the university would provide students with the opportunity to gain multicultural experiences[14]. Importantly, one author noted that clinicians and staff need to confront their own values, beliefs and biases, their own cultural perspective, and be prepared to negotiate with clients in order to progress.[7] The benefit of reassessing the curriculum could be greater cultural understanding might help eliminate ethnic disparities in heath and use of health services[12] as might the recruitment of minority students and staff to provide culturally diverse environment to create a workforce that is representative of population.[18]

The implications of these recommendations for further research correspond with our proposed study. This current research on paramedic education is embryonic and is therefore unable to address all suggested recommendations. However, the recommendations are informative for their health context, inspirational for developing ideas and provide direction for further research. Furthermore, they confirm the tardiness and need for this research in paramedic education.

Discussion

The articles reviewed in this paper surveyed cultural competency training in medical, dental, nursing, speech pathology and health education disciplines and informed the design of a proposed survey/questionnaire. Each of the papers presented a background and perspective from which we established a starting point to help us create a survey/questionnaire to review cultural training in paramedic education.

Research methods are often fraught with biases[24,25] and sometimes serve as a self-fulfilling prophesy.[24] We do not hide our belief about the complex ways in which culture impacts on health or that all health events are culturally informed experiences, which heighten in complexity with the involvement of health care professionals, and particularly emergency services. Appreciating this complex nexus is gaining a priority status, as demonstrated in the reviewed papers, in preparing health professionals to work effectively in culturally laden situations. To address this dilemma in Australian and New Zealand paramedic education we reviewed literature reporting on surveys of cultural competency in health education programs to design a survey to explore the status of cultural training within the training programs of the paramedic profession.

A major difficulty was data extraction. Authors expressed data and reported findings in slightly different ways. This resulted in the decision to combine categories that shared

obvious commonalities, as we did with teaching methods, or maintaining categories to demonstrate diversity and as we did with course content.

Conclusion

This paper demonstrates the utility of using published research literature to identify the major constructs of cultural competency in paramedic education programs. However, a range of complex issues arose in analyzing and extracting data in a consistent and systematic manner for developing a rigorously and well-designed questionnaire. Particularly, the different ways that authors described and discussed their research was particularly problematic. A judicious and close analysis of the data provided reasonable and fair interpretations that reflected the integrity of each individual paper. These research papers form a basis for designing a survey to examine the extent to which paramedic education includes cultural competency in its curricula, reported in a subsequent paper in this series. The paper may assist others in the process of developing and designing questionnaires

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Table 1 A snapshot of core themes covered in each paper

AUTHORS AND YEAR OF PUBLICATON														
THEMES COVERED IN EACH PAPER	Redican 1994	Doyle 1996	Loudon	Flores 2000	Cheng 2002	Azad 2002	Culhane –Pera 2002	Dolhun 2003	Martin-Holland 2003	Pinikahana 2003	Dogra 2005	Luquis 2006	Rowland 2006	Saleh 2006
Rationale for survey on cultural competence	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Definitions of cultural competence	✓	✓			✓				✓	✓	✓	✓	✓	✓
Research objectives	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Teaching methods	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓
Unit/subject content			✓	✓		✓	✓	✓				✓	✓	✓
Cultural training as core/elective curriculum	✓		✓	✓		✓	✓	✓				✓	✓	✓
Time devoted to teaching cultural competence in the course			✓	✓		✓	✓	✓						✓
Staff training in cultural competence	✓											✓	✓	✓
Student assessment		✓	✓			✓	✓				✓			✓
Student feedback			✓				✓							
Findings of reviewed papers	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Recommendations from reviewed papers	✓	✓		✓	✓	✓	✓	✓			✓	✓	✓	✓

Table 2 Studies reporting on surveys that review cultural training teaching methods

TEACHING METHODS	1994 Redican	1996 Doyle	Loudon	2000 Flores	2002 Cheng	2002 Azad	2002 Culhane –Pera	2003 Dolhun	2003 Martin-Holland	2003 Pinikahana	2005 Dogra	2006 Luquis	2006 Rowland	2006 Saleh	Total
Lecture		✓	✓	✓		✓	✓	✓	✓		✓	✓	✓	✓	11
Group discussions		✓	✓	✓		✓		✓			✓		✓	✓	8
Culturally specific/case based		✓	✓	✓		✓		✓				✓	✓	✓	8
Community class visits	✓	✓	✓			✓	✓	✓						✓	7
PBL				✓		✓		✓	✓		✓		✓	✓	7
Clinical placements	✓		✓	✓				✓	✓				✓		6
Oral/case presentations		✓	✓			✓							✓	✓	5
Guest lecturers	✓	✓	✓											✓	4
Personal reflection		✓					✓	✓						✓	4
Games/role play		✓	✓										✓	✓	4
Films/videos		✓					✓						✓		3
Cultural simulations			✓			✓			✓						3
Written assignment/exam		✓												✓	2
OSCEs						✓								✓	2
History taking/case history			✓					✓							2
Total	3	10	11	5	0	8	4	9	4	0	3	2	8	11	76

Table 3 Unit/subject content

CONTENT	1994 Redican	1996 Doyle	Loudon	2000 Flores	2002 Cheng	2002 Azad	2002 Culhane –Pera	2005 Dolhun	2003 Martin-Holland	2003 Pinikahana	2005 Dogra	2006 Luquis	2006 Rowland	2006 Saleh
Aboriginal and First National Health														
Aboriginal care & healing						✓								
Aboriginal health						✓								
Aboriginal health & issues						✓								
Aboriginal health & wellness						✓								
Demographics of Native population						✓								
First Nation's health						✓								
Implications for the treatment of native people in both urban & remote settings						✓								
Native health						✓								
Native spiritual & cultural beliefs						✓								
Access and Disability														
Access issues								✓						✓
Access to care													✓	
Disabilities													✓	
Age Sex and Gender														
Gender issues													✓	
Gender roles & sexuality								✓						
Sexual orientation			✓											
Trans-generational acculturation						✓								
Alcoholism														
Alcoholism			✓											
Attitudes and Behaviour														
Attitudes & health beliefs			✓											
Focus on changed attitudes													✓	
Health beliefs & attitudes towards illness & health care system						✓								
Self-awareness							✓							
Self-awareness of diversity & implication for health of community						✓								
Theoretical – anthropological & sociological theories of attitude development			✓											
Complementary and Alternative Medicine														
Alternative healing systems			✓											
Complementary & alternative medicine						✓								
Complementary medicine			✓											
Complementary medicine & biomedicine							✓							
Definitional & concepts of culture														✓

Traditional & alternative health methods						✓								
Traditional & Chinese health						✓								
Cross-Cultural Communication														
Communication & interviewing skills														✓
Cross-cultural communication						✓								
Cross-cultural communication in physician-patient relationships						✓								
Cultural interviews						✓								
Dr-patient interactions								✓						
Interpreters						✓								
Interviews with non-English-speaking patients						✓								
Issues related to Limited English Proficiency														✓
Language								✓						
Language barriers			✓											
Linguistic barriers													✓	
Cultural Issues														
Awareness & respect of culturally different groups														✓
Awareness of cultural differences						✓								
Clinical cultural issues							✓							
Cross-cultural caring						✓								
Cultural & reproductive health						✓								
Cultural awareness						✓								
Cultural background & maintenance of health & development of illness & treatment of illness						✓								
Cultural barriers													✓	
Cultural beliefs & values of different ethnic/racial groups												✓		
Cultural differences						✓								
Cultural differences & their influences on adjustment of different ethnic/native/aboriginal groups to the white urban hospital environment						✓								
Cultural issues & health						✓								
Culture & effect on patient-physical relationships						✓								
Culture & health						✓								
Culture & illness						✓								
Culture & maternal – foetal health						✓								
General cultural issues							✓	✓						
Health related issues in differing cultures						✓								
Impact of culture						✓								
Impact of culture on health						✓								
Multiculturalism						✓								
Relationship between health & culture												✓		
Socio-cultural aspects of medicine						✓								
Specific cultural content								✓						

Epidemiology														
Demographics			✓											
Epidemiology							✓							
Relationship between health & social issues												✓		
Socioeconomic status								✓						
Ethnicity														
Approach to patients from different ethnic backgrounds						✓								
Ethnicity			✓											
Ethnicity & cultural competence														✓
Health beliefs & practices of different ethnic/racial groups												✓		
Health issues & diseases disproportionately affecting ethnic/racial diverse groups & demographic profile of diverse populations												✓		
Health profiles of different ethnic/racial groups												✓		
Hispanic/Latino/Black African/White Caucasian & Native American cultures													✓	
Minority ethnic groups				✓										
Patients from different ethnic backgrounds in PBL cases						✓								
Patients from other ethnic origins in PBL						✓								
Patients of different ethnic backgrounds in problem-based cases						✓								
Immigrant Health														
Immigrant health						✓								
Major acculturation issues & new immigrants						✓								
Oral Health														
Oral health cultural belief models & practices														✓
Oral health disparities														✓
Racism														
Anti-racist education														
Race, ethnicity cultural diversity & health						✓								
Racism						✓		✓						
Racism & prejudice to challenge offensive behaviours			✓											

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