

Medical Student Selection: The Key to a Lasting Model of Cultural Competency

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With the United States rapidly becoming a truly multicultural society, the ability to provide comprehensive health care to the diverse patient population is increasingly dependent on physicians who achieve and maintain a level of cultural sensitivity. To meet this challenge, an intense movement has been initiated to provide culturally sensitive health care and decrease the barriers to care that are present for ethnic groups. While widespread reforms have been initiated to implement culturally sensitive health care services, more focused changes to medical school curricula have also been created to ensure formal education in cultural competence.¹ Despite the implementation of such standards, reports cite that students continue to lack a familiarity with the core concepts of culture and to struggle with issues raised by diversity.^{2,3}

Although heightened recruitment of minority physicians has been equated with a solution to this issue⁴, the shared race/ethnicity does not inherently provide a physician with the skills necessary to be culturally sensitive to one's patients, nor does it yield an understanding of patients from different ethnic origins.² As a result, despite the increased representation of minority students that is present throughout American medical schools⁵, a strong need still exists to provide a framework for cultural competency education during medical training. The most effective framework will be one which not only provides for formal and ongoing class work in cultural sensitivity, but also helps to promote cultural sensitivity at a much earlier stage through its selection of medical students.

The selection of medical students who have a background in social or behavioral sciences is the most basic way in which cultural sensitivity may be promoted. Such students have already gained an exposure to the introductory concepts of social sciences, including communication skills, ethical concerns, and interpersonal interactions. As a result of this background, the cultural education of these students during medical school may focus on more

complex issues. In contrast, cultural training is much more involved for traditional premedical students who have virtually no background in these disciplines and must undergo basic education with regard to behavioral sciences. Satterfield et al⁶ describe the negative impact of this discrepancy during the implementation of a new undergraduate medical curriculum at UCSF designed to place more emphasis on the social and behavioral sciences.

While a greater emphasis on the social and behavioral sciences is needed in general, the study of foreign language is a specific example of one such discipline that inherently provides an entry point to cultural sensitivity. Language is the framework to the cultural world and the study of foreign language develops communication skills and forces students to begin to think about cultural issues.⁷ These skills and an understanding of language are needed by all physicians as the linguistic needs of minority patients are chronically overlooked.⁸ Based on these benefits, a few programs have promoted the teaching of language skills to the degree that students can work effectively using the Spanish language.^{9,10}

Although the study of foreign language and, more broadly, behavioral sciences would greatly prepare a student for formalized cultural competency training, little value is placed on previous coursework or experience in these disciplines. The requirements for matriculation into medical school universally include biology, general and organic chemistry, and physics. Most institutions also require English credit and some also demand courses in calculus. A strong emphasis on coursework in social sciences is not common and there are no institutions that require the study of a foreign language. While it can be argued that successful completion of an undergraduate degree requires coursework in the humanities, it does not ensure specific coursework in the behavioral and social sciences that will promote cultural sensitivity. In fact, Satterfield et al⁶ report that despite an undergraduate education, a large percentage of students have no background in the social or behavioral sciences. A second concern regarding broader under-

graduate prerequisites may be raised by those who feel that, despite the known benefits to a more broadened undergraduate education, a more classical pre-medical education may better prepare a student for the science coursework of medical school. However, research suggests that a broader preparation will not negatively affect medical school performance.¹¹

The void in emphasis placed on previous study of these disciplines is evident in the analysis of the AAMC statistics of the 2002 matriculants to American medical schools.¹² A reported 58.6% and 12.1% of entering students majored in a biological and physical science respectively. Only a very small percentage of entering students majored in fields within the category of behavioral or social sciences. While it should not be advocated that undergraduate students major in the humanities simply to provide a baseline for cultural sensitivity, initiatives must be made to place greater emphasis on the undergraduate study of these disciplines. These initiatives must require that matriculants have received a prerequisite training in social science class work that will prepare them to address the issues of cultural sensitivity encountered during their medical training.

The ability to create a lasting model of cultural competency begins with the selection of medical students. Prerequisites that give undergraduate students a common background in social and behavioral sciences should be implemented. Further, undergraduate students should be directed to pursue activities within these disciplines that promote an early introduction to concepts of cultural identity. Foreign language education should be encouraged not only to develop bilingual physicians, but also to help students gain common skills of communication and interaction. This directed undergraduate education may then avoid the need to provide introductory instruction to medical students. As a result, cultural competency instruction may focus on the more complex issues and we may better prepare our medical school graduates for the practice of medicine in a multicultural society.

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