



## Two birds with one stone: Addressing interprofessional education aims and objectives in health profession curricula through interdisciplinary cultural competency training

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## WEB PAPER

# Two birds with one stone: Addressing interprofessional education aims and objectives in health profession curricula through interdisciplinary cultural competency training

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## Abstract

Interprofessional education (IPE) is acknowledged as important in producing health care profession graduates able to work collaboratively with colleagues from other health professions. There are, however, a range of obstacles to development of effective IPE programmes. Differing health professional cultures and socialisation processes have been identified as two potential barriers. This article notes considerable alignment between the broad aims and objectives of IPE and those of cultural competency training. It suggests that in the course of acquiring values, attitudes and skills consistent with a culturally competent practitioner, students may simultaneously develop a capacity to apply these same skills and attributes to their relationships with students (and future colleagues) from other health professions. This article draws on the concept of interprofessional cultural competence (CC; Pecukonis, E., Doyle, O. & Bliss, D.L. (2008). Reducing barriers to interprofessional training: promoting interprofessional cultural competence. *J Interprofessional Care*, 22(4), 417–428), noting that interdisciplinary CC training delivered early in undergraduate years may be an effective vehicle for meeting IPE aims and objectives, and examining an example of this in practice. This article suggests that interdisciplinary programmes developed to jointly meet CC and IPE aims and objectives may provide a platform for fostering interprofessional tolerance, promoting shared values and discouraging the formation of interprofessional barriers as students are socialised into their professional cultures.

## Introduction

According to Barnsteiner, Disch, Hall, Mayer and Moore (2007, p. 149) 'interprofessional learning takes place within a context where differences in culture, beliefs, and prior health care experiences among learners of various professions often exist'. Interprofessional education (IPE) is often defined as a process whereby 'professions learn with, from and about one another to facilitate collaboration in practice' (Faresjo 2006, p. 1). In this article, an interdisciplinary approach to learning refers to one in which students of two or more health professions learn together (Forte & Fowler 2009). Although not always a component, it may also involve cross-discipline collaboration between teachers in the delivery of health profession curricula (e.g. across medicine, nursing, physiotherapy, radiography, nutrition and dietetics and other health sciences). However, Page and Meerabbeu (2004, cited in Barnsteiner et al. 2007) note a paradox between the proposed use of IPE to overcome differences between health professional groups and the difficulties those same differences (e.g. in socialisation) present in realising effective IPE programs. Cooper, Carlisle, Gibbs and Watkins (2001, p.233) point to the importance of starting early with interprofessional learning experiences, as 'by the final year attitudes towards other health professionals [are] entrenched' and can act as barriers to interprofessional

## Practice points

- There is alignment between IPE and CC training aims and objectives in many health profession curricula
- CC training may be a vehicle for introducing IPE in early undergraduate years
- Interdisciplinary CC training has the potential to break down barriers between health profession cultures

teamwork (Barrington et al. 1998 cited in Cooper et al. 2001). They suggest that early exposure to interprofessional learning tends to promote '...practice within an interdisciplinary model following graduation' (Cooper et al. (2001) cited in Pecukonis et al. (2008, p. 423)).

Baker and Shaw (2007) identify a number of challenges for IPE based on differences between health professional cultures. They argue that to be effective IPE needs to change attitudes, reduce prejudices, challenge pre-existing professional socialisation and challenge stereotypes and assumptions. Pecukonis, Doyle and Bliss (2008, p. 420) use the term *profession-centrism* to describe a process by which professionals view the world from the perspective of their own [professional] cultural frames. Like ethnocentrism, *profession-centrism* often leads

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to development of stereotypical views (in this case of other professions) and a narrowed world view. It also involves adoption of competitive rather than collaborative attitudes to other healthcare providers. Although they do not use the same term as Pecukonis et al. and Barnsteiner et al. (2007, p. 144) refer to a similar phenomenon when they talk of health professionals 'undervaluing or misunderstanding each others' contributions' and a tendency toward 'tribalism'.

Cooper et al. (2001) and Reeves et al. (2006) acknowledge that there are many practical obstacles and organisational barriers to development of IPE programs (e.g. cost, timetable and scheduling clashes, varied approaches to assessment, resistance from teaching and administrative staff). The impact of these should never be underestimated. However, according to Pecukonis et al. (2008), a significant factor sometimes limiting attempts at establishment of IPE programs across medicine, nursing and other health profession courses is difficulty reconciling the various professional cultures, each with their own view of what constitutes an optimum teaching approach and learning environment.

To address this issue, and in particular to avoid the development of *profession-centrism* in students, they suggest that students need to acquire *interprofessional cultural competence* (CC). This is essentially a capacity to work cooperatively and effectively with colleagues from across the health care professions, whether informally or in integrated interprofessional teams. Although this may be partly achieved through effective programs of interdisciplinary training, it also requires review by each health discipline to ensure that their curricula are promoting *interprofessional CC* and not acting as barriers to it. Importantly, Pecukonis et al. (2008, p. 422) maintain that '... training health care professionals in isolation creates *profession-centric* practitioners'.

Having very briefly touched on some issues in the development of IPE within medicine, nursing and other health profession courses, this article will now consider how the separate goals of CC for students (to enable them to interact effectively with patients and peers), along with the interprofessional CC to enable them to work effectively with health care colleagues and in integrated interprofessional teams, may be jointly met.

## Cultural competency training – A vehicle for the development of interprofessional CC?

IPE is partly based on the premise that there are '... certain skills that every health professional needs and [which can] be taught conjointly by interprofessional teams' (Pecukonis et al., 2008, p. 425). These include clinical communication skills like interviewing, gathering information, presenting diagnoses or findings and negotiating treatment. They can include clinical skills like physical assessment and the use of electronic health documentation systems (Barnsteiner et al. 2007). They could also include academic skills like researching information, effective academic writing and giving oral presentations. In courses with a clinical component, and in training of professionals for involvement in integrated interprofessional health care teams, case-based and problem-based approaches to

interprofessional education and training have been adopted (Bratman et al. 2008). According to Barnsteiner et al. (2007), a common clinical experience can form the basis for effective interprofessional learning, particularly when there is a focus on collaboration and shared decision-making. This is supported by Clark (2002, cited in Hall 2005) who stresses the value of experiential learning in IPE.

However, in addition to these skills and approaches are other shared areas of learning, one of which is the acquisition of CC. It is now widely accepted that CC is an attribute required in all health professional graduates, and that health professional courses across the full range of disciplines must take a role in developing CC in their students (Association of American Medical Colleges, 2005; Dogra & Karim, 2005; Shams-Avari, 2005; O'Toole, 2008). The driver for this is increasing diversity within societies and health care, and the recognised need for health providers to demonstrate CC and cultural proficiency in their interactions with patients (Wells, 2000). Less widely appreciated is the role that CC training could play in IPE, acting as a platform for the development of *interprofessional CC* in students across all health disciplines.

There are particular features of CC training which may make it particularly well suited to addressing interprofessional cultural differences. These will now be examined.

## Shared objectives of CC training and IPE

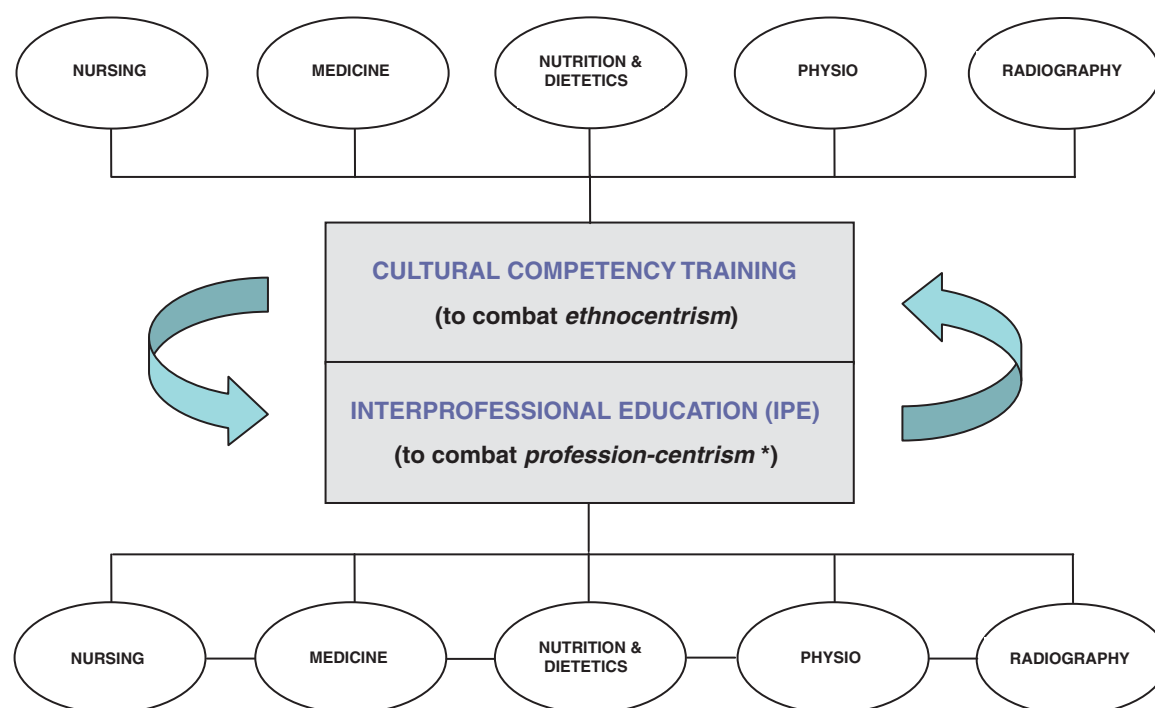
In CC training emphasis is often placed on cultural differences in communication styles, and on students developing culturally appropriate and effective communication skills for interacting with patients, families and colleagues (Shams-Avari 2005; O'Toole 2008). Ways of understanding are also explored, including culturally based health beliefs and practices such as beliefs about the causes and treatments for medical conditions (Carter et al. 2006). In the case of IPE, tolerance, respect and understanding of the various professional cultures within health care is an objective underpinning much of the learning, even where not explicitly stated in course objectives. Therefore, there seems to be considerable alignment between CC and IPE in terms of both the underlying and sometimes core aims and objectives (Table 1).

This alignment or overlap is not surprising given that IPE like CC training seeks to foster positive attitudes towards difference and aims to equip students with skills to work effectively in culturally diverse settings. In the case of CC training that diversity often relates to linguistic, ethnic and social difference, particularly when addressing communication issues within clinical contexts. In the case of IPE that diversity relates to differences in health professional cultures.

A further area of alignment between CC training and IPE is in the value placed on case-based and experiential learning. As noted above, case-based, problem-based and experiential learning have been found to be particularly useful in interprofessional learning (Hall 2005; Barnsteiner et al. 2007; Bratman et al. 2008). Similarly, effective CC training often involves consideration of critical incidents, exploration of

**Table 1.** Some key aims and objectives of CC training and IPE.

Some aims and objectives of CC training	Some IPE aims and objectives
<ul style="list-style-type: none"> <li>• Foster cultural sensibility (awareness of our own perspectives and how they influence our interactions with others; Dogra &amp; Karim 2005)</li> <li>• Avoid miscommunication (Dogra &amp; Karim 2005)</li> <li>• Consider and acknowledge cultural value systems (Carter et al 2006)</li> <li>• Consider alternative world views (Dogra &amp; Karim 2005)</li> <li>• Understand 'culturally-rooted health beliefs' (Carter et al 2006)</li> <li>• Understand (patient) expectations (Dogra &amp; Karim 2005)</li> <li>• Improve healthcare outcomes (Dogra &amp; Karim 2005)</li> </ul>	<ul style="list-style-type: none"> <li>• Foster sensitivity to alternative health professional values (Baker &amp; Shaw 2007)</li> <li>• Change attitudes (Baker &amp; Shaw 2007; Forte &amp; Fowler 2009)</li> <li>• Reduce prejudices (Baker &amp; Shaw 2007)</li> <li>• Challenge pre-existing (professional) socialisation (Baker &amp; Shaw 2007)</li> <li>• Challenge underlying beliefs, values and assumptions (Baker &amp; Shaw 2007)</li> <li>• Challenge stereotypes (Baker &amp; Shaw 2007; Forte &amp; Fowler 2009)</li> <li>• Improve patient experience (Forte &amp; Fowler 2009)</li> <li>• Foster attitudes and skills conducive to teamwork (Baker &amp; Shaw 2007; Barnsteiner et al. 2007; Forte &amp; Fowler 2009)</li> <li>• Improve health outcomes for patients (Baker &amp; Shaw 2007; Barnsteiner et al. 2007)</li> </ul>

**Figure 1.** Undergraduate CC training delivered through an interdisciplinary approach to jointly foster both CC and *interprofessional CC\**

\*Pecukonis et al. (2008).

issues and the use of learning methods such as role play and simulation (Carter et al. 2006; Aeder et al. 2007; Miller & Green 2007). Whereas CC training uses these methods to highlight and address the stereotyping, intolerance for difference and narrow world view characteristic of *ethnocentrism*, IPE seeks to address similar tendencies characteristic of *profession-centrism* (refer Figure 1).

In IPE the process of learning is at least as important as the content. It is through the shared experience of learning and interacting together that potential barriers and stereotyping are thought to be lessened (Baker & Shaw 2007; Forte & Fowler 2009). Similarly, in CC training the fostering of appropriate awareness and attitudes is a first priority (Tervalon & Murray-Garcia 1998; Campinha-Bacote 2002), and arguably more essential at the outset than the development of knowledge and

skills, which can come later. The development and reinforcement of student awareness of culture and attitudes to diversity form the foundation for future learning. This emphasis on process over content is another area of alignment between CC training and IPE.

In relation to CC training for medical students Kripalani et al. (2006) recommend a framework for interactions across cultures developed by Berlin and Fowke titled LEARN. This acronym stands for Listen, Explain, Acknowledge, Recommend and Negotiate, steps in a process which aims to ensure that practitioners elicit patients' (often culturally-based) understandings of their conditions and preferences for treatment. Of interest is that this framework could serve equally well as a basis for communication across health professional cultures.

## Interdisciplinary CC training in practice

As attributes and skills of CC have been increasingly mandated by professional bodies and health authorities, and embraced by university administrations and faculty, the inclusion of CC content in curricula has become increasingly necessary. This has sometimes occurred in a somewhat *ad hoc* fashion, within individual courses and schools, rather than through a more coordinated approach.

This article is not suggesting that development of interdisciplinary CC training programs across health profession courses would necessarily be an easy or smooth process. As noted by Wells (2000, p. 195), 'cultural development [of which cultural competence is a major component] is indeed challenging because it requires [both] individual and institutional change'. Opportunities for collaboration between disciplines in addressing CC aims and objectives, and thus indirectly also important components of IPE, would become more achievable when there is alignment of not only desired course content but also institutional and organisational values and goals. A step which would seem necessary as a precursor to development of interdisciplinary CC training programs, is an 'audit' of curricula to determine the range of CC content and approaches adopted within schools and faculties to establish possible areas for collaboration. It would involve identifying opportunities for collaboration and shared learning and then overcoming the potential barriers, whether related to timetabling, administration, teaching and learning philosophy, resources, resistance from staff and students or other issues. For those situated within the 'silos' which sometimes characterise health profession courses and disciplines (Hall & Weaver 2001; Ladden et al., 2006; Thistlethwaite & Nesbit, 2007), these potential synergies and opportunities for collaboration may not always be obvious. Those working across health profession curricula, for example teaching into various courses or providing broader support to learning within faculties, may sometimes be better placed to note these.

It is in the early undergraduate years of courses that an interdisciplinary approach to CC training may best be considered. This is a formative time in the students' development and a time when their exposure to the clinical environment tends to be more limited. It is a time when perhaps students may be particularly open to the development of shared values based on tolerance and acceptance of difference. In addition, achieving initial IPE aims and objectives through the vehicle of CC training at a foundation stage of the student's learning may help overcome some of the resistance to IPE noted in the literature (e.g. Arkesog (1994) and Davidson and Lucas (1995), both cited in Cooper et al. (2001)).

Although the author has not had the opportunity to deliver an IPE-based CC program in practice, there is at least one example of such a program in the literature. Brown et al. (2008) report on an interprofessional elective course at the University of Cincinnati involving students of Nursing, Pharmacy, Social Work and Allied Health Sciences which was designed to promote both interdisciplinary team skills and greater CC. An important feature of the learning approach adopted was use of discussions which promoted *positive interdependence* – that is,

a degree of consensus was required between all participants in order to meet task completion requirements, thus promoting genuine interaction. *Group processing* was also used, involving time allocated for each group to reflect specifically on aspects of their interprofessional awareness and skills learning. Brown et al. report that their evaluation of this course suggested positive effects both in the development of interdisciplinary team skills and awareness and in progression along a continuum with cultural proficiency as the end goal.

Brown et al. thus report on a program addressing both IPE and CC objectives at one North American university. Clearly there will be other examples of similar developments within this area. Through his involvement in delivery of CC training at the undergraduate level to different health profession courses, the author is currently engaged in exploring opportunities for establishment of similar interdisciplinary programs. This may form the basis for future research and a future article outlining these developments.

## Conclusion

This article is suggesting that in the course of acquiring values, attitudes and skills consistent with a culturally competent practitioner, students may simultaneously develop a capacity to apply these same skills and attributes to their relationships with other health professional students across various disciplines (and in the longer term, with practitioners from other health care professions and within integrated interprofessional health care teams). In this way the shared acquisition of CC through an interdisciplinary approach, particularly if involving experiential learning, may foster attitudes of tolerance between students of various health profession disciplines and serve to lessen the tendency towards establishment of professional barriers as students are socialised into their respective professional cultures. According to Hall (2005, p. 194), interprofessional teamwork has the potential to '...facilitate...a common conceptual framework (Sands et al. 1990) based on common values which will transcend those of each specific profession'. Perhaps interdisciplinary CC training delivered in the foundation years of health professional courses can provide the platform for fostering these common and shared values.

**Declaration of interest:** The author reports no conflicts of interest. The author alone is responsible for the content and writing of this article.

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