UNSW

FACULTY OF MEDICINE

Interim draft report to Department of Immigration and Multicultural Affairs

Productive Diversity Partnerships Program (Resource Development Projects)
Project 8: The Intersection of Health and Culture

A proposed multicultural health program at University of New South Wales: Productive diversity for the health of the people of Australia

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Executive Summary

Working definition: This paper is prepared as part of the effort, in the context of diversity management, to develop approaches that recognise cultural diversity and assist diversity management education in Australia. The initiatives presented on multicultural health education and research are an example of 'getting things done' in a university curriculum for productive diversity.

Context and issues: Elements of Productive Diversity management practices for a medical school are little different to those that apply to business: assessing the diversity skills of the medical student and staff population to determine how those skills can be used for benefit; improving recruitment and promotion strategies to select medical students and staff with language and cultural skills relevant to servicing diverse patients in domestic and overseas niche markets; improving communication in the medical school and teaching hospital and health care system so that it is open and involves all staff; equipping clinical supervisors with skills to appropriately manage and support a diverse workforce; and improving service to patients through the use of well-trained staff with cultural and language skills appropriate to multicultural health settings. **Capitalise on linguistic and cultural skills:** Medical students and other graduate students within the Faculty's programs are drawn from many ethnic, cultural and language groups. This spread does not necessarily make them culturally competent. Our philosophy of delivery and the course content should maximise the potential for learning brought by this polyglot body of students. **Remove impediments to effective management of diverse workforce (and patients):** We face an imperative to train doctors and other health professionals to provide culturally relevant health care (not just to those who are immigrants). The training will also make students better at working with people from their own cultural background.

Method and curriculum implications: Ensuring every medical graduate achieves defined level cultural competence, with the potential to develop national benchmarks. Developing postgraduate courses in multicultural health and cultural diversity in the context of public health, leading to a national consortium. Championing a multicultural health research agenda, building into a national Centre of Excellence. Identifying Centres within and beyond the University as points of synergy, leading to regional influence. Acting, in partnership with government and tertiary institutions, State and Commonwealth government, community, and consumers, forming a national resource. The program has three components:

(1) Undergraduate medical curriculum: *The learning process*: The students should be encouraged to draw on their personal experiences of health and illness. *The learning environment*: Immersion of all students in neighbourhoods from which their patients may be drawn. *The content*: Multicultural health will be included in health scenarios integrated within each year, and in learning groups integrated along the six years of the course. *Assessment*: Formative assessment of attitude changes, particularly reduction in avoidance of the culturally 'foreign'. *Selection of learners*: Appraisal of inquisitive learning should include openness to exploring perceived 'strangeness' of people of various cultural backgrounds. Medical students who do not speak another language might be given credit for making the

effort to learn one. Overseas born medical students may need, with the help of culturally skilled mentors. The international context will be emphasised, where there are lessons from comparisons between health in Australia and the Asia Pacific.

(2) **Postgraduate education in Public Health:** With its emphasis on training public health students to think critically and to design research on multicultural aspects of public health, the proposed innovation is *evidence based*. With its emphasis on training students in the industry to apply their multicultural understanding to the health workplace, it is *practice based*. **Multicultural health will be infused into all existing courses in public health.** The proposal will equip the Public Health workforce with improved skills in managing health care in culturally diverse settings (including international health). It rests on competence in qualitative research methods to support health development.

(3) **Research agenda:** The research agenda should be multidisciplinary, involving disciplines such as medicine, psychiatry, public health, nursing, social work, occupational therapy, anthropology, sociology, history and demography, and education. Health service related research questions include: what programs are effective in improving health and preventing disorders in various cultural groups? What health promotion resources and skills do doctors and other health professionals require to better meet the needs of cultural groups? What are the benefits for the newly arrived, especially refugees? How can doctors translate clinical practice into forms appropriate for multicultural Australia while retaining the integrity of existing practice?

The business case: Participation by culturally diverse medical students and medical faculty staff will lead to increased productivity of staff as result of inclusive work culture. The diversity of the learning environment will lead to *all* students (not just NESB) becoming competent in dealing with Australian health in the context of the Asia-Pacific region. This will lead to better export products as a result of improved understanding overseas networks. Culturally diverse students will act as passport to local communities. This will lead to improved marketing by using local migrant communities. Reciprocal training involving diverse students and staff will extend the thinking of the entire organisation about migrant communities, with improved customer service to clients in migrant communities. **Competitive advantage:** Creating a marketable pool of culturally competent practitioners and researchers in medicine and in public health will lead to competitive advantage. **Empowerment and involvement of employees:** The use of culturally diverse students and medical educators will empower employees in the Faculty of Medicine and in the associated Teaching Hospitals. It will promote diversity management involving senior Faculty members both on campus and at teaching hospital sites. And it will enable staff and students to learn from culturally different experiences of health and to take the initiative in productive diversity.

Gaps, constraints: Curriculum changes will work only if the cultural climate in the organisation is ready to receive the medical graduates emerging from the program. The program is a long term initiative demanding continuity and unified purpose, given that the intake of 2003 will be functioning at the peak of career 2030. By then, the cultural landscape of Australia may be changed beyond recognition; today's graduates will need to be trained to respond to all future contingencies in diversity.

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The relevance to health of Productive Diversity

On the eve of the new millennium, the Australian Government launched its New Agenda for Multicultural Australia (Commonwealth of Australia 1999). According to the New Agenda, 'the term Australian multiculturalism recognises and celebrates Australia's cultural diversity' – with glimmerings of the celebration echoed in diversity health (Hey 1994; Tizard 1995). For multiculturalism to be a unifying force for developing nationhood, it needs to be inclusive, for all Australians including indigenous Australians as well as those of Anglo-Celtic origin, not just for minority and ethnic groups. Multicultural principles include *cultural respect* – which includes diverse health beliefs and traditions; *social equity* – which includes access to culturally acceptable health care; and *productive diversity* – which maximises for all Australians for value of health-maintaining beliefs and practices held by diverse communities. The refocusing of multiculturalism by making it inclusive has clear implications for health and medical education.

The Australian Government is committed to highlighting the economic benefits of Australia's cultural diversity and the range of skills, languages, business networks and experience that it has to offer. Through its Productive Diversity strategy (managed by the Department of Immigration and Multicultural Affairs), the Government encourages Australian business to consider this unique resource and to capitalise on its ability, for example, to increase manufacturing productivity, enhance export growth, and to improve customer service to cultural groups within both the domestic and international marketplace.

Research has indicated that while many Australian managers acknowledge the benefits of diversity, they do not have the management skills or 'know how' to adequately address diversity issues. This need for diversity management skills has also been increasingly recognised in recent years by business educators in Australia. Diversity management education in Australian increased significantly between 1994 and 1998.

This paper is prepared as part of the effort to demonstrate the business and economic benefits available to Australian business through diversity management strategies; identify practical ways in which Australian business can implement diversity management practices; consider current diversity management theory and develop approaches that may strengthen a strategic management model that recognises cultural diversity; and develop approaches that assist diversity management education in Australia.

This report is the background document for a paper to be delivered at a conference that will move discussion from 'deficit' to 'dividend' thinking. We want to show that, in health education, and medical education in particular, there are major outcomes relevant to academic organisations such as: development of a new model/s of diversity management; recognition of the business benefits of cultural diversity management; techniques and approaches for managing cultural diversity (for managers); techniques and approaches for teaching diversity management (for educators); development of core curricula for diversity management education; and increased ownership and advocacy for diversity management from both business, academic and employer organisations. It is hoped that the initiatives presented on

multicultural health education and research will be showcased as an example of 'getting things done' in a university curriculum for productive diversity.

Background and Research

Productive Diversity is an expression that recognises the economic value of Australia's culturally diverse society. It is defined in terms of two main themes: capitalising on the linguistic and cultural skills, knowledge of overseas markets and experience in business practices often available in people born and educated overseas; and removing impediments to the effective management of a culturally diverse workforce (e.g. cross-cultural awareness, vocational English training, etc). The past decade has seen a growing recognition among health care executives that 'managing the melting pot' is essential to workforce diversity in health care (Eubanks 1990). Health care executives can capitalize on the demographic revolution and convert diversity into a competitive advantage once its boundaries are understood (Gardenswartz & Rowe 1993; Gardenswartz & Rowe 1994; Gardenswartz & Rowe 1998; Kerfoot 1990; Shea et al. 1992).

Management practices

Health care systems are becoming aware of the importance of management of diversity (Alexander & Brisbon 1993; Davidhizar et al. 1999; Davidhizar, Dowd, & Newman 1999) (Davis 1995; Dreachslin 1999a; Dreachslin 1999b; Dreachslin, Hunt, & Sprainer 1999; Dreachslin, Hunt, & Sprainer 2000; Epting, Glover, & Boyd 1994; Evans 1999; Fitzsimmons & Eyring 1993; Hunt 1994; Muller & Haase 1994; Roberts 1992; Timmons & Slaughter 1996; Vavala 1993; Wallace, Jr., Ermer, & Motshabi 1996), with modest effects on curricula of courses in health services administration (Williams 1996). Diversity management should apply to the health workforce no less than to any business organisation. Elements of Productive Diversity management practices for a medical school are little different to those that apply to business, and include: assessing the diversity skills of the medical student and staff population to determine how those skills can be best used for benefit; improving recruitment and promotion strategies to select medical students and staff with language and cultural skills relevant to, for example, servicing diverse patients in domestic and overseas niche markets; improving communication in the medical school and teaching hospital and health care system so that it is open and involves all staff; equipping clinical supervisors with the skills to appropriately manage and support a diverse workforce; improving service to patients through the use of well-trained staff with cultural and language skills appropriate to multicultural health settings.

Government research indicated that Australian businesses appeared not to have taken up the challenge to use their human resources as a competitive tool. D'Netto observes wryly that as the economy continues to improve, job opportunities for professional migrants are becoming increasingly scarce (D'Netto 2000). It is also true that Australian medical schools and teaching hospitals until recently had not seen the management of diversity as a priority for their own business.

If one regards the teaching hospital and the university, as business organisations, the UNSW initiative fits in well with the three areas in which the Government could advance diversity education: strengthening the case for diversity through the development of authoritative Australian data sets; encouraging teaching programs to work closely with industry by establishing sites where human resource

managers can demonstrate what an effective diverse workplace looks like; and exploring the desirability of a set of common diversity education curricula.

Furthermore, there is a broader context of international management theory and strategic models relevant to ‘managing diversity’, including the existence of an Australian management model of 'Productive Diversity' as proposed by Bill Cope and Mary Kalantzis in 1997 (Cope & Kalantzis 1997). Managing diversity was applied to health in the early 90s’ (1992). Health care providers do not reach their potential in differentiating themselves in the health care marketplace, a failure that can be overcome by managing diversity in health care (Gardenswartz & Rowe1998).

Diverse workforce

The proposed multicultural health program assumes the Schools of the Faculty of Medicine at UNSW, including its teaching hospitals, to be the workforce. In this context, the education and research workforce in medicine and public health is most effective when it as diverse as local and global environments in which organisation lives (viz. Cope & Kalantzis, 1997)

Theme: Capitalise on linguistic and cultural skills

Medical students and other graduate students within the Faculty’s various programs are drawn from many ethnic, cultural and language groups. The Faculty’s database shows that this year, of 1,145 currently enrolled undergraduates, less than half were born in Australia; the rest were born in countries such as Hong Kong (11 per cent), Malaysia (9.2 per cent), Vietnam (4.7 per cent), and South Korea (3.6 per cent). Less than half the enrolled students speak English at home; the rest speak Cantonese (15.4 per cent), Mandarin (9.7 per cent), Vietnamese (4.2 per cent), Korean (4.1 per cent), other Chinese dialects (2.7 per cent), Tamil (2.6 per cent), Arabic (1.8 per cent), Hokkien (1.6 per cent), Persian (1.6 per cent), and Malay and Indonesian (1 per cent each). 166 of the total 1,145 were in Australia as overseas students. This spread does not necessarily make them culturally competent. Yet the NSW Medical Board has indicated that it responds to the cultural diversity of the NSW community in terms of the cultural diversity of medical students. It is essential that our philosophy of delivery and the course content should maximise the potential for learning brought by this rich polyglot body of students. We also must ensure that students can best contribute their personal experiences of health and illness, highlighting rather than minimising their divergent ethnic and cultural backgrounds.

There are long-term regional issues at stake. A number of foreign-born medical students will eventually return to practice medicine in their countries of origin. There is evidence that in some disciplines, such as psychiatry, there is an uncritical acceptance of Western theories and methods across national and cultural boundaries in Southeast Asia, with undesirable consequences of the diffusion of Western medical knowledge (Higginbotham & Marsella 1988). By extending the thinking and cultural competence of this group during their medical training, such an outcome can be protected against.

Theme: Remove impediments to effective management of diverse workforce (and patients).

We face an imperative to train our future doctors and other health professionals to provide culturally relevant health care (not just to those who are immigrants). We are obligated to include in their life long learning a foundation of cultural awareness, knowledge, understanding, sensitivity and competence, to equip them to keep abreast of the changes that inevitably will continue in Australia's ethnic and cultural mix, and to tune their clinical 'best practice' according to this moving scene. People from non-English speaking backgrounds comprise approximately 20 per cent of the national population {Sozemenou1998}. They represent a diverse range of cultures and are characterised by different needs, problems, and understandings of health and illness. The presentation of patients from NESB will be much higher in some Area Health Services because there are higher numbers – and the UNSW teaching hospitals are in these areas of higher representation. And the specific requirements and problems of groups and individuals within a community may vary markedly. Given Australia's history and its response to adversity in the Asia Pacific region, it is likely that we will experience continued and unpredictable changes in our cultural diversity. The kind of training proposed in this document will also make students better at working with people from their own cultural background.

The essence of the proposed multicultural health program is a conceptual move from deficit to dividend thinking

Benefits for business

Participation by culturally diverse medical students and medical faculty staff – the resident nascent 'experts on the region' will lead to increased productivity of staff as result of inclusive work culture

The diversity of the learning environment will lead to *all* students (not just NESB) becoming competent in dealing with Australian health in the context of the Asia-Pacific region. This will lead to better export products as a result of improved understanding overseas networks

Culturally diverse students – if trained – will act as passport to local communities (patients & their networks). This will lead to improved marketing by using local migrant communities

Reciprocal training involving culturally diverse students and staff will extend the thinking of the entire organisation about migrant communities. By strategically locating staff from relevant cultural backgrounds, there will be improved customer service to clients in migrant communities.

In summary, the proposed multicultural health program is propelled by the use of diversity in human resources as a competitive tool for medical education and research development.

The Report by the National Multicultural Advisory Council (NMAC) notes the error that exaggerates the costs of multiculturalism arises from claims by some critics that all government services and payments that go to Australians from a non-English-speaking background should be counted as costs resulting from multiculturalism (National Multicultural Advisory Council 1999). The NMAC Report notes this allocation of costs is clearly wrong because all such services are directed to

the whole community, of whom some – a minority – happen to be from a non-English-speaking background. A multicultural health program in medicine and public health will promote access to general health programs by ethnic minorities as their right as Australians, not as a separate group.

Cultural competence

Cultural competence has been defined as 'the ability to identify and challenge one's cultural assumptions … the ability to see the world through different cultural lenses … to analyse and respond to the 'cultural scenes' and 'social dramas' in ways that are culturally and psychologically meaningful … for client and professional alike … and the ability to turn such thinking into praxis … providing meaningful, satisfying and competent care' (Fitzgerald, 1999). Cultural competence is the taxonomic pinnacle of cultural awareness, cultural knowledge, cultural understanding, and cultural sensitivity (Lister 1999). We see cultural competence applied to health care in many areas (Bucher, Klemm, & Adepoju 1996; Davidhizar, Bechtel, & Giger 1998; Felder 1996; Flores 2000; Grossman 1994; Hanley 1999; Hewitt 1993; Holland & Courtney 1998; Johnson et al. 1998; Jones, Bond, & Cason 1998; Jones, Bond, & Mancini 1998; Kataoka-Yahiro & Abriam-Yago 1997; Kavanagh et al. 1999; Langer 1999; Lavizzo-Mourey & Mackenzie 1996; Lavizzo-Mourey & MacKenzie 1995; Lester 1998a; Lester 1998b; Lu 1996; May 1992; Peragallo 1999; Richardson 1999; Rogers 1995; Setness 1998; Sharts-Hopko 1996; Smith 1998a; Smith 1998b; Taoka 1997) and even in non-Western settings (Crane 1994; Luna 1998). In nursing, where cultural competence has held sway for the longest time, it is used in the context of staff development (Marrone 1999; Stewart 1991) and education (Campinha-Bacote, Yahle, & Langenkamp 1996; Chrisman 1998; Napholz 1999; Silva 1994; St.Clair & McKenry 1999; Stewart 1998) and scholarship and research (Alpers & Zoucha 1996; Campinha-Bacote & Padgett 1995; Meleis 1996; Sawyer et al. 1995; Smith1998b) and subjective experience (Jackson 1995). Efforts have been made to measure cultural competence (Campinha-Bacote 1999; Salimbene 1999; Taylor 1998). In medicine and health sciences, cultural competence has been applied to a range of disciplines and issues:

- Ethnopharmacology (Campinha-Bacote 1994b),
- Diabetes education (Brown et al. 1999), patient education (Freda 1997),
- Psychotherapy and counselling (Sue 1998), antisocial behaviour (Coatsworth et al. 1997), occupational therapy and mental health (Dillard et al. 1992), mental health managed care {Anon1999W}, refugee health (Gervais 1996) including that of refugee women (Downs, Bernstein, & Marchese 1997),
- Parent child relationships (Tsai 1999), child and adolescent psychiatry (Kim 1995) and child health (Campinha-Bacote 1997) and child care (Lynch & Hanson 1992), adolescent health (Martinez 1998), perinatal paediatrics (Willis 1999),
- Primary care for women (Rorie, Paine, & Barger 1996), domestic violence (Williams & Becker 1994), gynaecology (Im, Meleis, & Lee 1999), lesbian and gay health (McGarry, Clarke, & Cyr 2000),
- Drug abuse (Kurtines & Szapocznik 1995), domestic violence (Campbell & Campbell 1996), sexual abuse (Austin et al. 1999),

- HIV/AIDS care (O'Connor 1996),
- Care of the elderly (Bakalchuk et al. 1991),
- Community based experience (Baldwin 1999), health promotion (Poss 1999), health consumer satisfaction (Bushy 1995), managed health care (Campinha-Bacote & Campinha-Bacote 1999; Like 1999),
- Ethical issues in research (Gil & Bob 1999),
- Critical care (Hadwiger 1999), and transplantation (Washington 1993).

Notwithstanding this list, there remain many gaps in the medical curriculum.

Cultural competence is establishing a toe-hold in other health care professions, such as dentistry (Lund 1999; Mercado Galvis 1995). Few reports e.g. Warda (2000) consider cultural competence from the vantage point of the populations served. There is only one report linking cultural competence with indigenous health (Weaver 1999)

Cultural competence would seem to underpin workforce diversity management (Shaw-Taylor & Benesch 1998). Although cultural competence signals a substantial theoretical advance over the old 'cultural sensitivity' or 'cultural relevance', one gets the feeling that in some instances the term is bandied as jargon. With the exception of the odd critical lens (Carberry 1998; Tervalon & Murray-Garcia 1998; Walker 1995), the burgeoning fashion of cultural competence is taking root in one or another part of medical education. Although it has been tried in some schools of nursing (Palmer 1997), to the best of our knowledge cultural competence has never been embedded within the architecture of the entire program of a Medical School.

National guidelines accreditation medical schools

The need is to add multicultural health to the mission of the Faculty of Medicine, in this way enriching current benchmarks in medical theory and practice, all the while retaining the scientific integrity of clinical training and practice. There are National and State imperatives for cultural competence in medical education. As pointed out by Eisenbruch (1989) in referring to the Doherty Committee of Inquiry into Medical Education and Medical Workforce, there are implications for accreditation by the Australian Medical Council. The most recent Australian Medical Council guidelines for accreditation of medical schools call for 'an appreciation of the diversity of human background and cultural values', and note 'the specific health needs of minority ethnic groups' as an emergent topic requiring special emphasis which needs to be incorporated into the organisation of the curriculum (Australian Medical Council 1998). To illustrate from the mental health sector, the priority health targets (adapted by me from the National Mental Health Promotion and Prevention National Action Plan, January 1999) are:

- Promote resilience and enhance protective factors for illness and disorders among individuals and families from diverse cultural and linguistic backgrounds
- Reduce risk factors for illness among individuals and families from diverse cultural and linguistic backgrounds
- Increase access to culturally relevant promotion and prevention initiatives and services

- Promote health literacy and reduce stigma related to illness amongst people from diverse backgrounds
- Promote culturally sensitive responses and illness prevention interventions among health care providers
- Promote community capacity building to address health promotion and prevention for people from diverse backgrounds.

If our medical graduates are to be adequately equipped to meet this set of national benchmarks, the Faculty of Medicine must seize the opportunity afforded by the new curriculum.

The point can also be made that cultural competence in communicating with patients is currently recognised as a requirement but in an ethnocentric way. Overseas trained doctors are assessed on interpersonal skills and rapport with patients in the AMC Clinical Examinations through simulated consultations. There are not the same requirements in place to ensure that Australian medical graduates have effective interpersonal skills or rapport with patients of culturally diverse background.

A multicultural mission for the Faculty of Medicine at UNSW

The proposed multicultural health program at the Faculty of Medicine UNSW can provide leadership and direction to

- Ensuring every medical graduate achieves defined level cultural competence, with the potential to develop National benchmarks
- Developing postgraduate courses in multicultural health cultural diversity in the context of public health, leading to a National consortium
- Championing a multicultural health research agenda, building into a National Centre of Excellence
- Identifying Centres within and beyond the University as points of synergy, leading to regional influence
- Acting, in partnership with government and tertiary institutions, State and Commonwealth government, community, and consumers, forming a National resource.

With the cultural competence banner unfurled, and with the mission of infusing cultural breath into the Faculty of Medicine, the multicultural health program at UNSW includes three components.

(1) Undergraduate medical curriculum

How does multicultural health fit into the components of a proposed new undergraduate curriculum?

A multicultural orientation is essential in the new undergraduate curriculum. It is a key ingredient in establishing an interconnected integrated and organised knowledge base.

- *The learning process*: The students in large group teaching, small group learning, and individual study should be encouraged to draw on their personal experiences of health and illness. Respect should be paid to the accounts brought by all students, no matter what their cultural background. Learning diaries and casebooks could be written in English or even (if the student prefers) in community languages other than English. The experiential learning cycle – stimulated by clinical encounters with patients of various cultural backgrounds – should draw extensively on the experiences brought by these young student participants. And the development of 'knowledge streams' should model the thinking of mainstream doctors and, at the same time, of those considered by the ethnic/cultural community of the patient to be experts. All of this will be limited by the amount of preparation of the academic staff to support such a learning process. Clinical teachers, through demonstrating that cultural assessment of all patients is no less important than physical or psychological assessment, will model ideal behaviour for the medical students.
- *The learning environment*: A conducive learning environment for multicultural health is the *immersion* (as opposed to voyeuristic and non-participatory observation) of all students in the neighbourhoods from which their patients may be drawn, and which are somewhat different than that to which they are accustomed. These experiences should form a legitimate database for small group learning.
- *The content*: Multicultural health can be included in many horizontally integrated health scenarios. It is a key ingredient of interactional skills. And it can be included in vertically integrated learning groups.
- *Assessment*: All the multicultural principles and examples cited can be incorporated in the evaluation of qualitative learning, as in peer and self-assessment. At another level, assessment of higher order cognitive outcomes can include formative assessment of attitude changes to ethnic and cultural issues, particularly the reduction among Anglo-Saxon/Celtic students in avoidance of the initial strangeness of the culturally 'foreign', and the reduction among other students of shame or avoidance of cultural difference. Critical incident approaches can be used for assessment. Assessment of cultural competence should be 'normalised', adopting models already familiar in medicine as, for example, the use of 'cultural differential diagnosis' can be assessed in the same way, for example, as a biomedical one.
- *Selection of learners*: An appraisal of factors that will facilitate inquisitive learning should include openness to exploring 'strange' value systems and concepts of health and illness borne by people of various ethnic and cultural backgrounds; an ability to engage in interaction with people ethnically and culturally different from the student; and broad interests that encompass the social, economic, political or other concerns of the people living in Australia's regional Asia-Pacific neighbours.

What will it do enhance the qualities of the medical graduate?

Cultural competence is part of the personal and professional development of medical students. It should be seamlessly interwoven throughout the course, and integrated across disciplines. And – taking the line of Barak (2000) that the inclusive workplace

includes the ecosystem outside the work organisation – it should be taken beyond the physical limits of the medical school and teaching hospital. A multicultural orientation will increase the student's self-reflective capacity, their understanding of emotional responses, tolerance of ambiguity, recognition of personal limits, and awareness of stress on doctors. It will make them better doctors.

To enhance the multicultural qualities and skills of 'doctor as a person', the multicultural focus will

- Enable the medical student to understand their prejudices and fears of cultural health beliefs unfamiliar to them (self-reflective capacity and understanding emotional responses);
- Understand the complementarity between Western and traditional methods of maintaining health and treating illness, and the role of the world's main medicine traditions (recognition of ambiguity);
- Appreciate that multicultural medicine, rather than a mastery of 'the facts' about each culture, is about learning to be respectful of the limits of biomedicine to solve all problems in a multicultural setting (awareness of stress on doctors);
- Be aware of the traditional family structures of various immigrant groups and the impact on health maintenance, with recognition that culture is dynamic and that cultural identity changes in the course of the life cycle and across generations (awareness of life stage needs); and
- Grasp the ways that patients of any cultural sort (not only immigrants) may simultaneously believe in and use traditional healing practices alongside those offered by the doctor (adaptable and capable to view situations from different perspectives).

To enhance the multicultural qualities and skills of 'doctor and the patient', the medical student will be encouraged to

- Explore the day-to-day experiences of culturally diverse patients (including as age and gender, as well as immigrants and refugees) and their encounters with health systems (sensitivity; doctor patient relationship; and integration of biopsychosocial factors in patient care).
- Encounter the consequences of compliance by ethnic communities with medical interventions that violate their moral beliefs or teachings (awareness of 'micro' ethical issues and dilemmas)

To enhance the multicultural qualities and skills of 'doctor, professional, and health system', the medical student will

- Extend their hospital-based observations of services to ethnic and cultural groups, by spending time in ethnic community networks, perhaps in 'community internships', in this way observing the barriers to access, and the alternatives used (critical evaluation of health care settings)
- Appreciate the impact of Western biomedicine on the social structure (leadership, role of traditional and religious authorities, family values and customs) of ethnic communities (awareness of 'micro' ethical issues and dilemmas)

- Be aware of health systems as cultural systems that reflect the culture of the society, that culture affects the kind of interactions one has within the systems e.g. between doctors as other health professionals and administrators

To enhance the multicultural qualities and skills of 'doctor and the community', the medical student will

- Find partners and become involved in the activities of at least one local ethnic or cultural community or umbrella organisation (sense of responsibility to the broader community; sense of social conscience; awareness of how others see doctors)
- Gain a basic understanding of relevant social science and other disciplines such as sociology of medicine, medical anthropology, cross-cultural psychology, or international health (overlap of medicine with other professions)
- Become sensitised to community issues (emphasis on population health; concepts of health versus disease; importance of preventive medicine)

Another overarching principle in self directed lifelong learning is that students should develop a collaborative rather than dependent relationship with their teachers – and this has happened successfully in problem based learning medical courses. There are anecdotal reports (but no evidence), however, that students from some cultural backgrounds may find the Australian style of group 'cooperation' alien, preferring instead to work on their own toward the task of passing the exam. If the assessment process extends itself to evaluating the perceived degree of cooperation between medical students in their doctoring role, such students, if not helped to change too, may experience even greater difficulties.

How to use the health scenario as a key multicultural learning activity

The medical student in this multicultural work will benefit from learning activities that are *community based* outside the campus and hospitals, with positive links and service to diverse communities; encourage a sense of *connection* between the medical student and Faculty; are *experientially* rooted in the multicultural society; *integrated* into a biopsychosocial framework; *iterative* in revisiting the same issues at different contexts; and encouraging a sense of *responsibility* for the wider community.

The 'health scenario' is one of several possible learning activities, and is used as the key multicultural one. Each clinical case scenario will deal with a practical problem in patient care for which ethnic, cultural and social class concerns created a significant issue for care givers. At the end of the sessions, guidelines for clinical approaches to such problems will be recommended and discussed.

The culturally informed case scenarios will work iteratively, spiralling through issues during each year of the course. Culture is a thread that weaves and connects all the disciplines of the medical course.

Core themes to be drawn upon in creating each health scenario include

- Anatomical theme (cultural definitions of the body, its inner structure and functions; implications for eating disorders, obesity, self-mutilation, surgery)

- Nutritional theme (the cultural and religious meaning of food and diet; why some immigrant diets are healthier than local Australian food habits; diseases of Western civilisation due to dietary changes; ethnic and lifestyle risk factors for obesity, diabetes, cardiovascular diseases; culturally appropriate management; nutritional problems among immigrants; culture and malnutrition in developing countries; cross-cultural comparison of infant feeding practices)
- Ethnophysiological and ethnopharmacological themes (biologically determined differences between ethnic groups in body functioning, the placebo effect, drug dependence, and in drug metabolism; the effects of culture on compliance with prescription protocols)
- Communicable and infectious diseases theme (harnessing cultural beliefs to overcome barriers to 100 per cent condom usage to stop HIV/AIDS; more on the social and international health context of particular infectious diseases)
- Epidemiological theme (cultural factors in epidemiology of disease; national and international differences in diagnostic and treatment methods)
- Obstetric theme (ethnic and cultural traditions in antenatal, natal, and postnatal birth practices and the consequences of modifying these in the medicalisation of birth in the Australian context. Religious attitudes to termination of pregnancy)
- Gender theme (ethnic issues in gender culture, and in men and women's health; cultural attitudes to infertility and reproductive technology; cultural stereotypes about gender and feminist issues e.g. traditional practices that stigmatise women, including the infrequent but dramatic cases of female genital mutilation among immigrants from certain African and Southeast Asian countries, and the legal and ethical issues for doctors [see NSW Education Program on FGM. Special issues for women with refugee backgrounds, e.g. experiences of sexual assault.]
- Transcultural psychiatry, including specialty areas such as child psychiatry (culturally appropriate measures of quality of life that include spirituality; cultural issues in the diagnosis of schizophrenia and depressive disorder; risk behaviour and suicide; cultural patterns of gambling; cultural issues in suicide; recovery from torture and trauma, including recent arrivals from East Timor or Kosovo, as well as older arrivals from countries like Cambodia; the use of traditional healers as indigenous psychotherapists; postnatal depression among immigrants)
- Family medicine and general practice theme (when is alternative healing actually mainstream for certain ethnic and cultural communities; multicultural consumer, carer and community participation in partnership with doctors; working with non-English speaking or overseas-born doctors; interpreter use by general practitioners; the impact of casemix on ethnic health)
- Paediatric theme (cultural perceptions of child development and concepts of time; ethnic and cultural traditions in childrearing and the folk perceptions of childhood illness including cancer, and the psychosocial consequences of modifying these in the Australian context; cultural factors in primary health care [PHC] e.g. cultural perceptions of diarrhoea, acute respiratory illness,

failure to thrive, childhood epilepsy; the use of local community resources in PHC)

- Geriatrics and gerontology theme (the place in society of the elderly, and the impact of modernisation and life in Australia; life satisfaction post-retirement among ethnic communities; cultural attitudes towards care and Alzheimer's disease)
- General medicine theme (lifestyle and ethnic risk factors for certain diseases e.g. diabetes – case of gestational diabetes (GDM), and diabetic retinopathy and nephropathy among Islander patients; ethnic and cultural attitudes to particular illnesses such as cancer)
- Oncology theme (the cultural meaning of cancer, mortality and death; palliative care among ethnic community groups; religious rulings on brain death and life support)
- General surgery theme (cross-cultural issues in personal and social pain behaviour; cultural issues in blood donation, organ transplantation and donation; cultural understanding of traumatic brain injury and performance indicators that health/community agencies can use to assess the extent to which they provide culturally sensitive services and provide educational material for staff working in the field; cultural factors in risk taking e.g. road trauma; culturally shaped sequelae of injury)
- Addiction, alcohol, tobacco and drug theme (variations in alcohol and drug metabolism; cultural patterns in alcohol consumption, smoking behaviour, IV needle sharing; cultural barriers and pathways to health promotion e.g. religious objections to safe injection room)
- Disability (stereotypes about ethnicity and Workers Compensation; cultural issues in work injury such as 'back syndrome'; cross cultural and religious attitudes to disabled people in society – as punishment for sin; obligations or lack of obligations to the disabled; the legitimisation of the illness experience, adaptations and lifestyle adjustments)
- Other disciplines such as anaesthesiology (issues of informed consent, and cultural understanding of consciousness/unconsciousness)
- Other issues such as communicating with patients including work with interpreters; working with nurses, psychologists, social workers, and occupational therapists in a culturally diverse community; racism in medicine from patients or allied health workers to doctors, and from doctors to patients or allied health staff

As a start, two or three of these case scenarios could be trailed with colleagues already working using similar approaches (e.g. School of Psychiatry at Liverpool; Unit of General Practice at Fairfield) in collaboration with NSW agencies such as the NSW Transcultural Psychiatric Unit.

Other methods to incorporate cultural competence across the curriculum

The same clinical case scenarios with an overarching cultural theme can be developed for use in each year of the course. Year 1 students can 'bookmark' the case for

discussion of cultural influences on biomedical themes and, by the time they move to later years, they 'bookmark' the same case with the cultural influences on clinical management themes. This iterative method will lessen the burden of 'new' content in the overloaded curriculum.

The Ethnic Affairs Commission of NSW has long advocated the restructuring of degree course requirements or arrangements to better allow for cross crediting of languages other than English study at university level in medical degrees. Cooperative arrangements between universities should further the issue of cross-crediting. The Commission has also noted the need for recognition of completed post-secondary language study and of study providing cross-cultural skills.

Recommendation 29 of the NMAC report advocates for proficiency in languages other than English. The New Agenda for Multicultural Australia commits a high priority to teaching languages other than English, but this policy does not yet extend into higher education in medicine and health. As part of the proposed UNSW Multicultural Health program, medical students who do not speak another language would be given credit for making the effort to learn one. Medical students those who speak languages other than English might be given credit for using them. They should be given the opportunity to participate in hospital or community work in association with local multicultural health teams. This technique has been developed at the University of Pennsylvania (Larson, Luiggi, & Lee 1999). Those who wish to participate can have their names on a roster indicating their level of proficiency in those languages, and will be available by pager to attend critical incidents in the hospital or community, and to assist in all aspects of the history, examination and management. In this way, their skill will be used and they will be encouraged to feel that their cultural background is of worth in clinical care.

Not all medical students use Western scientific reasoning, and this reasoning is strongly affected by culture. Since the students – as well as the patients – are culturally diverse, the learning environment should exploit that diversity. Small group discussions of case scenarios, rather than creating premature closure, should leave room for open debate that draws out differences in scientific logic used by the students. Overseas born medical students may need more support in handling the challenges of learning, possibly with the help of culturally skilled and experienced mentors.

As shown by nursing educators such as Lindquist, it is essential to help students to develop a global perspective as they prepare to practice in a world of increasingly dependent peoples (Lindquist 1990). The Centre for International and Multicultural Health can provide the international context, where there are lessons to be learned from comparisons between health and illness in Australia and the Asia Pacific region from which so many medical students and their future clients originate.

Students should be offered a professional route to devote more time to the study of culture and health. Undergraduates with a background in social sciences may be attracted to combined arts/medicine degrees – the multi-major in the USA is proving very popular. Postgraduates could combine the medical degree with an MPH with a concentration in multicultural health. Combined medical and PhD programs may also be offered. Options for cross-university enrolment should also be explored.

(2) Postgraduate education in Public Health

Australia faces an imperative to train our future public health professionals to provide culturally relevant health care to all Australians including indigenous people (not just to those who are immigrants). At the professional level, many students in health care education programs across Australia either were not born in Australia or do not speak English at home - however, they are not necessarily culturally competent. There is a wealth of empirical evidence showing the relevance of multicultural issues in public health.

This is not simply an issue of providing public health services for culturally diverse people. There is a lack of *an evidence base* for multicultural health concerns to the mission of the Australian health higher education sector, all the while retaining the scientific integrity of public health training and practice. There is a perceived gap in terms of the *capacity* for driving research in multicultural aspects of public health. We need to include the study of relevant social and behavioural sciences towards building that capacity.

Any public health policy or strategy – not just those to do with immigrants or people of non-English speaking background (NESB) – has to be examined from a cultural as well as social perspective, ensuring that we are not leaving out a part of the community. Issues to do with Aboriginal and indigenous health, for example, are seldom articulated with those affecting other people living in Australia, and we believe that much can be learned with mutual benefit. Similarly, issues of cultural diversity for people living in Australia are seldom articulated with those affecting people offshore, even when the cultural backgrounds are similar. Finally, a focus on multicultural and diversity underpins and will enhance our training and research program in the whole of public health.

The Centre for Public Health at UNSW is responsible for postgraduate education in Public Health. The Centre has designated 'responding to diversity' as a key theme of its innovation proposal for Public Health Education and Research Program of the Commonwealth.

Responding to diversity: an innovation in Public Health

The proposed innovation has two strings to its bow: with its emphasis on training public health students to think critically and to design and evaluate research on multicultural aspects of public health, it is *evidence based*. With its emphasis on training students in the industry to apply their multicultural understanding to the health workplace, it is *practice based*.

Our graduates in public health must be equipped to do more than deal with culturally diverse communities. It is essential that our graduates can contribute to minimal standards of good practice in multicultural Australia, standards that have never been benchmarked in this country. In order to deal with diversity health we need to train health professionals in cultural competence, to work in partnerships and to undertake appropriate research. The experience of the Centre for Public Health is that this diversity can be acknowledged and addressed through a settings approach, such as a village or a city. The context is integral to the whole and the influences on health that arise from the physical, structural, and organisational environment are addressed. Social relationships are recognised, cultural patterns harnessed and the collective energy of the community living in a particular setting is utilised.

Curriculum

There has been a keen interest in enrolment in courses to do with Multicultural Health, and enquiries have touched on broader topics in diversity health, including, for example, culture and mental health, child health, disability, and ageing. In response to this strong interest, new modules of study are being introduced.

The Area of Concentration in Multicultural Health at UNSW was established during 2000. It coincided with the strategic development of a proposal for the establishment of a Centre for International and Multicultural Health. The two Areas of Concentration, in International Health, and Multicultural Health, reflect the complementary areas of interest and orientation of the new Centre.

The Centre for Public Health has a rich foundation supporting the understanding of multicultural health and methods of addressing it. The underpinning disciplines include sociology, medical anthropology, social epidemiology, behavioural sciences e.g. community psychology, organisational psychology, demography, health economics, education, population demography and human geography.

The Area of Concentration aims to meet the need to train health professionals to provide public health services and health care that are socially and culturally relevant. The Area of Concentration provides the foundation for cultural competence. We see multicultural health in the broader context of 'diversity health', which takes into account culture, ethnicity, language but also gender, sexuality, and disability as sources of diversity.

The Area of Concentration in multicultural health has intellectual links with other Areas such as *international health* (there are mutual lessons to be derived from on-shore and off-shore material); *health promotion* (the settings approach, in which social relationships are recognised, cultural patterns harnessed and the collective energy of the community is utilised); and the *social basis of health and health care* (theoretical underpinnings and social and community orientations). There would be strong links with such areas of concentration.

It is planned to **infuse multicultural health into all existing courses in public health.** We have carried out preliminary work with colleagues in the University and with other tertiary and service centres within the State. Collaboration with the South East Sydney Area Health Service Multicultural Health Unit has begun, and we have plans for students from the industry to enrol for Graduate Certificate/Diploma/MPH, and to provide placements for MPH students seeking appropriate sites for major projects in a multicultural field. Discussions are under way with other bodies such as NSW Transcultural Mental Health Centre, and the NSW Refugee Service, to collaborate in the development of new courses. Interest has been shown from Women's Health, HIV/AIDS, and other public health sectors in the Area Health Service, to enable public health employees to pursue training in multicultural and diversity health.

This sort of training, unlike other fields, calls for intensive, face-to-face experiential learning. It can be complemented – with our partner institutions – by the development of Web-based distance education.

Practice in all public health settings should be informed from a firm basis in evidence. Australia needs a coherent national agenda of research to develop evidence appropriate to the national circumstance. Public health graduates from the

multicultural health Area of Concentration will develop their research skills with a view to spanning the clinical – population based spectrum; the basic sciences – health services spectrum; the psychosocial – biomedical spectrum; and the local – international health spectrum.

Collaboration and partnerships

It is proposed that this innovation be designed and implemented by a consortium of universities. Each university currently offers training in some aspect relevant to multicultural health. Training courses addressing these areas are largely confined to units or subjects within full-time degrees that do not allow health professionals on-the-job training or restrict many who cannot gain entry to post-graduate education and few courses are offered through flexible delivery and distance learning.

Besides their proven capacity to teach in these three areas, collaboration between these universities is also justified by the following: Small consortia make more efficient use of funds, are easier to administer, and allow for choice of compatible partners; Different parts of Australia are characterized by different issues in cultural diversity (e.g., multicultural, indigenous health); Different universities possess people with different skills. The universities have large numbers of international students who work alongside Australian staff and students adding to cross-cultural learning.

The proposed innovation program consists of:

- The development and cross-campus delivery of a series of intensive short courses in the three specified areas including Graduate Certificates for those who cannot currently gain access to MPH
- The development of collaborative partnerships with state health services to provide on-the-job training.

Desired Outcomes

A diversity and multicultural health initiative will lead to focus will lead to more and improved training in qualitative research skills and research application. And it will provide the necessary cultural competence for better health social policy development and policy evaluation skills in Australia. In this way, the multicultural initiative will lead to PHERP's desired innovation in the Health Social Sciences.

The proposal will equip the Public Health workforce with improved skills in promoting health, including managing health care and service delivery in culturally diverse settings (including international health). It rests on competence in qualitative research methods (especially action research, operational research, participatory research especially ethnographic and rapid anthropological methods, formative research, and policy analysis) to support health development.

(3) Research agenda

The multicultural health research agenda will be driven in partnerships across the University and the State. Active collaboration should be sought in partnership with other universities with an established track record or interest in transcultural health.

We need to collaborate with Australian investigators to form alliances with transcultural and multicultural research units in other States and who are already

working on these problems, or who already have ‘burning questions’ but lack the leadership and mentorship to get their research off the ground. Through strategic collaboration, we must raise our competitiveness to gain nationally funded research grants from NHMRC and ARC.

The research agenda should be multidisciplinary, involving a wide net of professions and disciplines such as medicine, psychiatry, public health, nursing, social work, occupational therapy, anthropology, sociology, history and demography, and education. The Multicultural Health Units of certain Area Health Services – notably, Southeastern and Southwestern – have promoted multicultural research and would be appropriate partners. The NSW Transcultural Mental Health Centre’s research steering group, and similar groups in other sectors of multicultural health, would also be involved in planning and partnering. It is essential that stakeholders from the ethnic communities, as well as carers, would also be meaningfully represented.

The research agenda will span a number of dimensions: the clinical – population based spectrum; the basic sciences – health services spectrum; the psychosocial – biomedical spectrum; and the local – international health spectrum.

A research agenda will be multimethodology. It will include the adaptation and validity testing of instruments used among ethnic communities. Multicultural health research, rather than simply adapting Western methods and techniques, should use appropriate tools (Henderson et al. 1992). These tools, which will include qualitative methods, may need to be drawn from the social sciences such as medical anthropology and critical sociology, and from behavioural sciences such as cross-cultural psychology. Ethnographic methods are already being used in some multicultural research projects in NSW, and will need to be more systematically extended as appropriate. They need to be combined with current questionnaire and epidemiological methods [viz. (Stuart et al. 1993)] that are the bread and butter of medical research. In gathering data, the cultural diversity of families should be honoured (Hanson, Lynch, & Wayman 1990). Alternative ways of looking at research diagnostic categories may be needed (Foulks, Westermeyer, & Ta 1998). In all this, care is needed with ethics and with issues of representation, and the pathologisation of ethnicity is a trap to be avoided.

The curriculum should not privilege quantitative methods over others, but all these multidisciplinary and multimethodology approaches should also be brought to the awareness of medical students, In this way, once they graduate they will be better prepared to read, evaluate, and eventually try out qualitatative and culturally appropriate research methods alongside the already accepted methods.

Basic sciences - health services spectrum

There is a continuing need for more data on the prevalence of various disorders among cultural groups [viz. (Stuart, Klimidis, & Minas 1998)]. There will be encouragement and technical support for investigator-driven basic research in disciplines such as clinically applied medical anthropology, medical sociology, human geography, critical sociology, and population health. We need to investigate the social and cultural roots of disease and suffering, as well as the changing social meaning of ill health. Topics could include illness narratives, for example, or explanatory models and attributions of illness among people of diverse cultural backgrounds.

Within Australia, there is a groundswell of service related transcultural research: bilingual professionals in community health (Mitchell, Malak, & Small 1998) and lowering the language barriers (Stolk et al. 1998); multicultural workers' competencies; cross-cultural issues in the disclosure of cancer (Mitchell 1998); patterns of acculturation (Ranieri, Klimidis, & Rosenthal 1994), and the health implications of intergenerational issues (Rosenthal, Ranieri, & Klimidis 1996) among immigrants and their children.

Health service related research questions include: what programs are effective in improving health and preventing disorders in various cultural groups? What health promotion and prevention information resources and skills do doctors and other health professionals require to better meet the needs of various cultural groups? What are the benefits of promotion and prevention programs for the newly arrived, especially refugees? What of those in detention? How can doctors best translate clinical practice of established effectiveness into forms appropriate for multicultural Australia while retaining the integrity of existing practice? What interventions are most effective in reducing the secondary and transgenerational effects of vulnerability to poor health on children and adolescents?

Psychosociocultural - biomedical spectrum

Collaboration would be developed – and, in the case of existing collaborations, extended – with established research groups at UNSW and at other centres of learning and research.

With the NSW Transcultural Mental Health Centre, the Centre for Refugee Research and Centre for Cross-Cultural Social Work, and the Psychiatry Research Unit Teaching Unit and STARTTS, on psychosocial aspects of health among immigrants and in particular refugees, especially recent arrivals. Research should include pathways to mental health care, and utilisation of services.

With groups at UNSW and with clinical researchers in Area Health Services already working on key issues including sociology of health and illness; health ethics applied to clinical issues such as informed consent (collaboration with Law); and gender issues such as postnatal depression among immigrant women.

- With clinical groups at UNSW and in Area Health Services dealing with medical, surgical, gynaecological health issues where the cultural context affects diagnosis and management. These include cancer, cardiovascular disease, and endocrine disorders such as diabetes.
- With research groups in NSW interested in the cultural context of health promotion. This includes healthy schools, and culturally effective techniques to promote healthy parenting.
- With special health and occupational therapy units, such as the Faculty of Health Sciences at University of Sydney, dealing, for example, with disability and rehabilitation, in partnership with community agencies.
- With NSW government such as Education and Training, to apply multicultural research to promoting child health including mental health. Links with State initiatives such as Partnership with Young People Project. Exploration of the cross-cultural significance of mental health promotion {Naccarella1999}.

- With UNSW General Practice/Community Medicine, Centre for Health Equity Training Research and Evaluation, and NSW government to identify role for health sector in minimising health consequences of the stress of unemployment among ethnic and cultural groups.
- With the Faculty Curriculum Unit and with educational research groups to review the existing evidence base and develop a stronger evidence base for effective medical education in culturally diverse settings.
- With groups such as the Australian Institute of Criminology, on issues such as marital violence against women of diverse cultural backgrounds.

Local - international spectrum

A synergy between multicultural and international health research is logical. The foci for collaborative research include

- Culturally appropriate health promotion in the context of the normative beliefs and practices in the countries of origin of groups resettled in Australia
- The cultural barriers and solutions to dealing with communicable diseases, in particular HIV-AIDS (the fastest growing communicable disease problem of the region) as well as malaria and tuberculosis
- The cultural context of non-communicable diseases, including international aspects of mental health, risk behaviour and maternal and child health
- The cultural determinants of health, disease, disability and death - both the specific cultural context of health and illness in developing countries and the implications for multicultural health among Australia's ethnic communities, many of whom are derived from the Asia Pacific region
- Cross-cultural differences in student learning goals and styles, and in academic teaching goals and styles, and the implications for curriculum within Australia and in the region

International Health Development focuses on maintaining, protecting and promoting the health of people in the developing world. Within Australia, our multiethnic population and multicultural orientation has direct relevance to international health in the region, given the cultural overlaps between our international students, and the groups upon which we focus in the same Asia Pacific regions as our international students.

Timing

National consultations (Status: Within State and Commonwealth (tertiary institutions, business, community metropolitan and rural organisations, health industry).

Goal: An authoritative data set regarding the question 'What are the costs and potential savings in relation to productivity in health/education?', which will strengthen the 'bottom line' or business case for diversity management

Planning audit

Proposal

Approval

Implementation

Set-up

Mid-term review against key performance indicators

Further needs based development

Gaps and constraints

Managing diversity is not simply a matter of expanding the list of dimensions beyond the usual stereotypic ones of culture or gender. Managers can become frustrated with diversity management if the groundwork has not been done in helping employees to understand the meaning of diversity (Montgomery 1997). Montgomery has proposed a 'hierarchy of diversity', in which innate, attitudinal and situational dimensions are used to broaden diversity management intervention. The proposed multicultural health program at UNSW, while starting out with a focus on culture, will need to ramp up other dimensions of diversity appropriate to the local and national settings. It should emphasise inclusiveness no less than diversity.

Challenges to fundamental strategies of hospitals/Medical schools: There are real challenges to diversity leadership in medical education, involving both personal obstacles and external pressures. Preceptors need to be trained and prepared as role models for students and other medical educators (Williams & Rogers 1993). Assuming five years to set up the proposed multicultural health program and a further six years before the first graduates emerge in 2010, there is much preparatory work with the Faculty and the teaching hospitals, to change the fundamental strategies of the organisation and, in due course, to induce second order change to basic culture of organisation. Without this preparatory work, the curriculum and research initiatives will fail.

There is a lack of definition in medical education and research of diversity management and cultural competence with Aboriginal and Torres Strait Islander communities.

Above all, there remains a yawning gap in the evidence base for diversity management and cultural competence in medicine and health, a gap that will leave half-baked programs, with the best of intentions, open to produce the worst of results. A vigorous research agenda will help to ameliorate that critical gap.

Outcomes

Short-term

An improved learning environment in the medical school and teaching hospitals

Capacity building in cultural competence and in clinical governance in medicine and public health

- Graduates in medicine and in public health trained to care, cure, teach, and investigate the health of Australians – of any cultural or linguistic makeup – with good practice outcome – with a flow on to areas of tertiary education other than public health

- Enhanced cultural diversity of medicine and public health education curricula – providing a model for universities nationally
- A research agenda for multicultural health including where appropriate the regional Asia Pacific context – a best practice model in regional and rural as well as national and metropolitan contexts
- Support of an Australian national multicultural health network including development of a web-based infrastructure
- Leadership in a co-ordinated approach across Australia in education and research in multicultural aspects of medicine and public health – with implications for national education and workforce training, welfare, immigration, refugees, employment and productive diversity
- Public health graduates to care, cure, teach, and investigate the health of Australians no matter what their makeup
- Intellectual exchanges between medicine and public health and behavioural, social science, and other disciplines
- A research agenda for diversity health and enrich partnerships with other centres of learning, in the context of New South Wales and the Asia Pacific region

Mid-term

Competitive advantage: It is anticipated that, through creating a marketable pool of culturally competent practitioners and researchers in medicine and in public health, the proposed multicultural health program will lead to competitive advantage.

Empowerment and involvement of employees: The program, through the use of culturally diverse students and medical educators, will also empower and involve employees in the Faculty of Medicine and in the associated Teaching Hospitals. It will promote better diversity management involving senior Faculty members both on campus and at teaching hospital sites. And it will promote an approach to what Amanda Sinclair has termed the ‘border crossing’ among staff and students, enabling them to take the initiative in learning from culturally different experiences of health and to take the initiative in productive diversity.

Long term

Beyond that, the proposed multicultural health program is a long-term initiative demanding continuity and unified purpose, given that the intake of 2003 will be functioning at the peak of career 2030. By then, the cultural landscape of Australia may be changed beyond recognition; today’s graduates will need to be trained to respond to all future contingencies in diversity.

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Appendix: Curriculum development for diversity health

In North America, health education is being adapted for cultural diversity across the range of professions (Koshi 1976; Leininger 1978), especially in nursing (Baker & Burkhalter 1996; Clinton 1996; Henkle & Kennerly 1990; Stern 1986; Wing 1998). Home visiting to patients of other cultural groups is included as part of development of cultural competence (Williamson et al. 1996). Student exchange programs have been developed to immerse nursing students in the experience of other ethic groups (Huttlinger & Keating 1991). Leininger's transcultural nursing concept has been picked up in Australia (Omeri 1996).

In at least one nursing program, the students are placed in developing countries for a period of immersion to extend their understanding of cultural issues (Levine 1997). Integration of cultural content has been used with the aim of reducing student anxiety (Mattson & Johnson 1992). The Faculty of Health Sciences at University of Sydney started a cultural immersion program in 1995, with community placements for occupational therapy, physiotherapy, leisure and health, and orthoptics (using the Community Based Rehabilitation (CBR) model in India. In 1999, students went to Fiji.

Nursing schools have used regional networking to identify barriers to teaching cross-cultural concepts and to overcome those barriers (Ryan et al. 1996). And it has been proposed that member of ethnic minorities should participate (Fuller 1997). In one model for nursing education, known as Pathways, the learning styles of each student are assessed – taking into account the cultural diversity of the student – and serve as maps or guides through the professional learning sequence and into future professional careers (Rew 1996). Even the internet has been systematically integrated into nursing education in an effort to integrate cultural diversity and global awareness (Kirkpatrick, Brown, & Atkins 1998). Nursing education as it continues its innovations in cultural diversity will have lessons for those of us in medicine.

In medicine and health, cultural competence is gaining prominence as a key learning objective in university and community based education. Changes are afoot in psychiatry (Yager, Chang, & Karno 1989), paediatrics (1999), health promotion (Huff & Kline 1999) and health administration (Fischer 1995), and in maternal-child health (Gany & de Bocanegra 1996). Work has been done to reduce insensitive behaviours towards medical students, recognising that cultural diversity applies to faculty and students alike (Johnston 1992).

Cultural competence is informing occupational therapy training at the University of Sydney. Programs in psychology are using various approaches to training in cultural competence: in research programs with minority communities; in diversity seminars with participation of local community; in one-off 'cultural safety' workshops or in ongoing groups; and in changing the learning environment of the program {Harrell1999}. Critical attention is being paid to the outcome of cross-cultural training in psychology (Yutrzenka 1995). Cultural competence is becoming a part of nursing education (Campinha-Bacote 1994a). In Australia, the Australian Psychological Society has insisted that cross-cultural and indigenous psychology be taught at an undergraduate level (Sonn, Bishop, & Garvey 1999).

The need for culturally sensitive health education has been identified across the span of life, including adolescence (van Bekkum 1995) and geriatrics and

gerontology (Yeo & Gallagher-Thompson 1996), where a lack of cultural understanding can lead to wrong diagnoses (Wilder et al. 1995). In all this, communication with the patient has be culturally sensitive right through to old age (Wood 1989). And the need can be inferred from studies of the influence of culture in various disciplines of medicine, including child health (Rankin & Kappy 1993), obstetrics (VanMuiswinkel 1984), psychiatry (Okpaku 1998), and the behavioural sciences (Vandervoort, Luis, & Hamilton 1997). Despite the evidence of increased need for education in transcultural health, at least in some medical programs there has been a *decrease* or neglect in cultural training (Moffic et al. 1987).

In health and education, the Harvard Human Development and Psychology Program has developmental psychology at its core, but it also involves anthropology and linguistics, as well as studies of risk and strategies for intervention. Cross-cultural and sociolinguistic studies survey the contexts of learning and performance. Fieldwork in other cultures tests the generality of such findings. Comparative study of child environments and development include cultural diversity in parental goals and strategies and in mother-infant interaction; the effects of schooling on reproduction and maternal behaviour in contemporary Third World societies; ethnic, racial, and cultural differences in motivation for schooling and achievement; youth cultures in Asia, the United States, and elsewhere; enculturation of the child and the acquisition of cultural representations of self in African, Asian, and other non-Western societies; and cultural differences and similarities in cognitive, language, and socioemotional development.

How does the foreign born student handle the curriculum?

We know rather less about the impact of the cultural background of the student: cultural differences in goals and perceptions, and how these cognitions affect learning and adjustment of overseas students in Australia. Pseudoscientific thinking has been found among allied health students no matter what their cultural background (Duncan et al. 1992). In science education, there is evidence that cultural background affects the understanding of scientific concepts and that non-Western students are at a cultural disadvantage when studying Western science curricula; ‘according to the Piagetian concept of mental equilibrium, whenever a conflict arises between prior knowledge and new knowledge, there is a risk that disequilibrium will cause the rejection of new concepts in favour of old concepts’ (Baker 1995). This fact flies in the face of local stereotypes that ‘Asian’ students are ‘good’ with computers. Scientific reasoning lies at the heart of the medical curriculum, and we need urgently to pinpoint not only *what* is being included in the medical curricula but also *how* it is being presented to culturally diverse students. The gap between Western and non-Western understandings of science could be bridged. There is some Australian evidence that the differences between Southeast Asian and locally born students at University of Western Australia tends to diminish after the first year (Volet & Renshaw 1995), but more research is needed.

The stresses on the foreign born medical student are obvious, in particular when they are in exchange programs and have not had time to acculturate. In an innovative ‘transcultural mentoring’ program at the University of Ottawa, foreign nursing students are assigned to transculturally sensitive mentors. The professors who mentored the students experienced a transformation along with their protégés (Morales-Mann & Higuchi 1995).

What has been done in medical schools?

It has been argued that a multicultural perspective in medical education is a cost effective investment in the long term (Lefley & Pedersen 1986), but is this message pervading medical education? The evidence is mixed. In an international survey of educational programs for medical students, of 1456 studies identified by the literature search, 17 met the criteria for cultural diversity. Of the 17 selected programs, 13 were conducted in North America. Eleven programs were exclusively for students in years 1 or 2. Fewer than half the programs were part of core teaching. Only 1 required program reported that the students were assessed on the session in cultural diversity (Loudon et al. 1999). These are dismal results.

On the other hand, there are many reports of advances in cultural diversity and health education. Undergraduate programs systematically teach cultural aspects of medicine, in some cases right from Year 1 (Wells, Benson, & Hoff 1985). Multiculturalism has been incorporated into the Doctor-Patient Encounter course at Yale (Gupta, Duffy, & Johnston 1997). It is being started around the world for example at University College London, University of Capetown Medical School. Diversity seminars have been introduced for first year medical students at Harvard (Fischbach & Hunt 1999). An innovative approach has been developed at the University of Sydney to train medical students to interview patients of non-English Speaking Background; community volunteers from various cultures were used, and students inquiry skills and empathy evaluated on videotape by independent raters (Farnill et al. 1997).

Several North American medical schools offer combined MD/PhD or MD/MPH degrees that allow medical students to gain a foundation in medical anthropology and related disciplines. Recognition of the importance of cultural information in psychiatry has advanced to the point where the American Psychological Association and the American Psychiatric Association are instituting criteria for cultural competence in training programs and several US states are developing quality assurance evaluation standards for culturally responsive care.

Multicultural training for residents as the next step in lifelong learning

There is a growing need for residents in community medicine and general practice training, to learn how to care for patients of many cultural backgrounds (Zweifler & Gonzalez 1998). It is becoming a part of the curriculum in family medicine (Culhane-Pera et al. 1997; Like, Steiner, & Rubel 1996). Cultural differences often coexist with social and economic deprivation. The needs of particular groups, such as those who arrived as refugees (Tobin & Friedman 1984), will have to be understood by health professionals. Psychiatric residents, in responding to the cultural background of their patients, draw on their own ethnocultural identity, and on the degree of exposure to patients from different cultures, as well as their formal training in transcultural psychiatry (Rousseau, Perreault, & Leichner 1995). Residency training directors are more likely to notice the need for culturally sensitive training in settings where there is exposure to patients of diverse ethnic and cultural backgrounds (King, Koopman, & Millis 1999).

Many North American psychiatric residence programs now include multicultural education (Thornton 1987), and there is a reported need for more teaching materials, cross-cultural references, academics familiar with different

cultural groups, and cross-cultural supervision (Baker et al. 1997). Some provide a systematic curriculum in multicultural topics over four years, including historical context, comparative aspects of epidemiology and psychopathology, and clinical areas including health service utilisation of various ethnic groups (Thompson et al. 1996). Similarly, programs in behavioural sciences including psychology (Yutrzenka, Todd-Bazemore, & Caraway 1999) are developing a cultural orientation. The implications for other specialty residency training, such as gynaecology (Lazarus 1997), and communicable diseases such as HIV/AIDS (Lechky 1997), have also been noted.

A flourishing program in culture and health has developed at Harvard Medical School under the stewardship of Arthur Kleinman. 'Culture, Ethnicity & Health Care' is a multi-sited, meaning-centred medical anthropology project on multiculturalism in medical settings. Review of current uses of the concepts of ethnicity and culture in clinical practice are used to interpret findings from interviews and participant observation in local medical settings. These data are used as a foundation for enhancing cultural competence among health care providers and health researchers. The 'Mind-Body Relations in Their Cultural Context' research program focuses on a study of: Therapeutic Narratives, the Reflective Practitioner and the Management of Hope in Oncological Clinics. The goal is to identify both successful and unsuccessful aspects of therapeutic communication in the local moral world of the oncology clinic.

McGill Centre for Transcultural Psychiatry offers courses on the anthropology of psychiatry; and on multicultural primary care.

In primary health, departments of Family Medicine and Internal Medicine at the University of Rochester have examined the value of qualitative approaches (the critical incident and the focus group) to assessing the transcultural experience of international and American medical graduates. Themes of struggles for acceptance, fear of rejection, and fear of disappointing patients were identified from analysis of the written narrative, while themes of struggle to express caring transculturally were identified from the focus group transcript. Based on these findings, significant changes were made to the residency training curriculum

There is Australian evidence that mental health practitioners find training in general cultural awareness to be of little interest but that training in specific areas of clinical practice, such as cross-cultural assessment and treatment, is much in demand {Klimidis1999}. Of the requested topics, top of the list was beliefs about causation and treatment. Similar sentiments are expressed in other fields of health science, such as occupational therapy, where students do not want cultural awareness training because they feel they already are aware, but no one has helped them to develop the skills and competencies they need. These students say that they want culture specific quick or step-by-step answers. Some, armed with enough cultural awareness to fear making a mistake, avoid interaction with anyone who is obviously from another cultural background – a case of what Fitzgerald calls 'cultural paralysis'.

The need for a monitored asset oriented continuum of increasing levels of personal and institutional cultural and linguistic competency has been recognised in a managed care setting (Tirado 1998). These levels are (1) culturally resistant; (2) culturally unaware; (3) culturally conscious; (4) culturally insightful; and (5) culturally versatile. Miguel constructed self-assessment tools to determine where the health practitioner fitted on the continuum. Underlying the self-assessment is the principle of Melanie Tervalon that 'the notion of cultural humility is to be distinguished from that of cultural competence' (Tervalon & Murray-Garcia1998,

p:9), in which the development of skills and attitudes is a lifelong commitment in which one moves along a process of continuous improvement. Four areas of competency are measured: knowledge of patients (from not noticing cultural difference to holding diversity in high esteem); practice related behaviours (from paternalism and expecting less of patient compliance to readily adapting practice to different cultural situations); attitude toward diversity (from lacking curiosity about other cultures, to promoting superiority of own culture, to ethnocentric acceptance of other cultures, to perceiving as equal contributions by other cultures); and practice patterns (from believing one size fits all patients, to incorporating cultural insights, to adapting clinical approaches in line with new knowledge).