

Beyond Cultural Competence: Critical Consciousness, Social Justice, and Multicultural Education

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Abstract

In response to the Liaison Committee on Medical Education mandate that medical education must address both the needs of an increasingly diverse society and disparities in health care, medical schools have implemented a wide variety of programs in cultural competency. The authors critically analyze the concept of cultural competency and propose that multicultural education must go beyond the traditional notions of “competency” (i.e., knowledge, skills, and attitudes). It must involve the fostering of a critical awareness—a critical consciousness—of the self, others, and the world and a

commitment to addressing issues of societal relevance in health care. They describe critical consciousness and posit that it is different from, albeit complementary to, critical thinking, and suggest that both are essential in the training of physicians. The authors also propose that the object of knowledge involved in critical consciousness and in learning about areas of medicine with social relevance—multicultural education, professionalism, medical ethics, etc.—is fundamentally different from that acquired in the biomedical sciences. They discuss how aspects of multicultural education are

addressed at the University of Michigan Medical School. Central to the fostering of critical consciousness are engaging dialogue in a safe environment, a change in the traditional relationship between teachers and students, faculty development, and critical assessment of individual development and programmatic goals. Such an orientation will lead to the training of physicians equally skilled in the biomedical aspects of medicine and in the role medicine plays in ensuring social justice and meeting human needs.

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In response to the increasing diversity of many industrial societies, numerous professional organizations have called for educational efforts aimed at educating medical trainees to address the needs of a culturally heterogeneous patient population.^{1–3} The importance of this mission is underscored by an ever-increasing body of evidence of disparities in a variety of areas in health care delivered to ethnic minority populations.⁴ These disparities often go unnoticed⁵ and reflect historical inequalities in education, housing, and employment.⁶ To address these issues, the Liaison Committee on Medical Education (LCME) has mandated that all medical schools in the United States

and Canada include cultural competency among their central educational outcomes.²

Exactly how this goal is implemented, however, is unclear. Although many have recommended the expansion of multicultural education, even use of the term “cultural competency” is controversial,^{7–9} and often cultural competency initiatives are implemented without an explicit link between the notion of working with culturally diverse populations and the other part of the LCME directive: the need for medical students “to recognize and appropriately address gender and cultural biases in health care delivery.”² There is a distressingly common failure to connect the idea of diversity with the underlying core concept of social justice in health care.

The purpose of this article is twofold. First, we critically discuss the notion of cultural competency. Second, we propose that educating physicians skilled at addressing the health care needs of a diverse society involves not the fulfillment of a competency as some sort of educational nirvana, but the development of an orientation—a critical consciousness—which places medicine in a social, cultural, and historical context and which is coupled with an active recognition of societal problems and a

search for appropriate solutions. The outcome is therefore one of social justice—the open acknowledgment of the dignity and autonomy of, and delivery of high-quality medical care to, *all* members of society, regardless of gender, race, ethnicity, religion, sexual orientation, language, geographic origin, or socioeconomic background.

Cultural Competency: A Critique

As Gregg and Saha⁹ have written, the disconnect between multiculturalism and social justice is often so great that one may focus on the former while completely ignoring the latter. For example, in a recent study by Beach and colleagues¹⁰ of cultural competency programs for health care providers, activities as varied as international study abroad experiences, work with medical translator services, and lessons in medical Spanish for emergency department physicians were included as part of cultural competency education. If social justice is an educational goal of cultural competency, discussions of racism should be prevalent in curriculum content; however, only 2 of the 34 different cultural competency curricula studied by Beach et al involved discussions of racism.¹⁰ Admittedly, multiculturalism involves—as implied by the term—multiple and diverse cultures. However, if one focuses on

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acquiring knowledge about “other” cultures and treats the concept of culture as static, one runs the risk of objectifying individuals whose appearance, language, national origin, religion, or sexual orientation is different from the majority into overly simplistic categorical descriptions of character and behavior.^{7–9,11,12}

Furthermore, focusing exclusively on the cultural mores of nondominant groups threatens to turn cultural competency education into what Wear⁸ has termed cultural “safaris”—a medical education paradigm in which the notion of “novelty” replaces that of “equality” in approaches to patients’ health.

There is, however, another fundamental problem with the concept of cultural competency that is epistemological in nature. The term “competence” may be defined as a state or quality of being adequately or well qualified or possessing requisite or adequate knowledge or skills in a particular area.¹³ In education, these competencies are often categorized into learning outcomes involving knowledge, skills, and attitudes to allow for educational approaches which address each of these areas. Consequently, “cultural competency” is frequently approached in ways which limit its goals to *knowledge* of characteristics, cultural beliefs, and practices of different nonmajority groups, and *skills* and *attitudes* of empathy and compassion in interviewing and communicating with nonmajority groups. Achieving cultural competence is thus often viewed as a static outcome: One is “competent” in interacting with patients from diverse backgrounds much in the same way as one is competent in performing a physical exam or reading an EKG. *Cultural competency is not an abdominal exam.* It is not a static requirement to be checked off some list but is something beyond the somewhat rigid categories of knowledge, skills, and attitudes: the continuous critical refinement and fostering of a type of thinking and knowing—a critical consciousness—of self, others, and the world.

Critical Thinking, Critical Consciousness, and Different Ways of Knowing

Medical school curricula frequently focus on the development of critical thinking, which is conceptualized as analytical, evaluative, synthetic, and logical.^{14–17} In

clinical practice, critical thinking may involve analysis and evaluation of clinical and laboratory data, consideration of possible differential diagnoses, and synthesis of appropriate treatment plans. In discussing critical thinking, Burbules and Berk describe the critical thinker as “a critical consumer of information: He or she is driven to seek reasons and evidence. Part of this is mastering certain skills of thought: learning to diagnose invalid forms of argument, knowing how to make and defend distinctions, and so on.”¹⁶ This ability is, of course, an essential component in the cognitive processes underlying clinical decision making; however, we would argue that in the context of the social practice of medicine, development of critical thinking alone may lead to great technical skill without an accompanying understanding or ability to effectively address health-care-related issues confronting society.

Critical consciousness both contrasts and complements critical thinking. Having its conceptual roots in the critical theory of the Frankfurt School and the work of the Brazilian educator Paulo Freire,¹⁸ critical consciousness posits that the thinking subject does not exist in isolation but, rather, in relationship to others in the world. The development of critical consciousness involves a reflective awareness of the differences in power and privilege and the inequities that are embedded in social relationships—an act that Freire calls “reading the world”¹⁸—and the fostering of a reorientation of perspective towards a commitment to social justice. The development of this type of consciousness—a process that Freire calls “conscientization”—is both cognitive and affective and leads to engaged discourse, collaborative problem-solving, and a “rehumanization” of human relationships.¹⁸

Critical Consciousness and Multicultural Medical Education

The introduction of humanism, medical ethics, professionalism, and multiculturalism into medical education involves linking the professional training of physicians with human values, an orientation of education and practice towards addressing human needs and interests. Critical consciousness plays an essential role in these areas of medical education. From a pedagogic perspective,

development of true fluency (and not just “competence”) in these areas requires critical self-reflection and discourse and anchors a reflective self with others in social and societal interactions. By “critical self-reflection,” we do not mean a singular focus on the self, but a stepping back to understand one’s own assumptions, biases, and values, and a shifting of one’s gaze from self to others and conditions of injustice in the world. This process, coupled with resultant action, is at the core of the idea of critical consciousness. In areas like multicultural education, professionalism, and medical ethics, the basic orientation of education and learning is fundamentally different than in the biomedical or clinical sciences or practice-related fields. In the biomedical or clinical sciences, the basic orientation is to build a foundation of knowledge to be applied in practice, but in fields seeking to incorporate humanistic values into medical education, it is directed towards fostering critical self-awareness, acquiring an understanding of social issues (both interpersonal and societal) in medicine, and developing an individual approach to reflective, ethical practice.

If we try to move beyond cultural competency and instead focus on the development of this critical consciousness, what is its object of knowledge? In other words, “What stuff should we learn?” The object of knowledge is not just a series of lists of cultural attributes (which can quickly degrade into dehumanizing stereotypes), nor is it a skill set of questions and demeanors we should assume when encountering a patient who is not like us. We propose that the object of knowledge of these educational efforts is the development of critical consciousness itself, that is, the knowledge and awareness to carry out the social roles and responsibilities of a physician. This way of knowing is a different type of knowledge than that required when studying the biomedical sciences—complementary, but different all the same.

If development of critical consciousness is the goal of multicultural medical education, how do we achieve it? There are many pitfalls in this area, including limiting curricular time devoted to this area to isolated, “drop-in” lectures or discussions, treatment of culture as a

static entity, use of lists of “cultural characteristics,” and inadvertent reinforcement of stereotypes in case examples and discussions.^{7–9,11} There are others: imposition of one person’s opinions and values—especially those of the instructor—on the rest of the group; either the silencing of individuals from marginalized groups or, paradoxically, forcing them into a position of acting as “spokespersons for their people”; avoidance of conflict surrounding issues of diversity; treatment of issues such as racism, sexism, homophobia, or class privilege as subjects of abstract discussion when they may represent intensely personal struggles for some students; undermining of discussions by those hostile towards diversity; or heated debates that degenerate into personal arguments.^{12,19–24} In what follows, we describe aspects of the multicultural curriculum at the University of Michigan Medical School that illustrate our overall conceptual orientation. We discuss activities and techniques designed to foster and enhance critical consciousness in medical students. Although we have not effectively solved all of the obstacles facing multicultural education described above, we and others have designed the curriculum in an attempt to address some of the most prominent of these challenges.

Multicultural Education at the University of Michigan Medical School

As part of a major undergraduate medical school curriculum revision in 2003, our institution incorporated multicultural education in several different ways. During the first two years, discussions and lectures on topics in multicultural education are incorporated into a clinical skills course, the Clinical Foundations of Medicine (CFM), and into two small-group-based activities, the Family Centered Experience (FCE), which uses scheduled visits to patients’ homes and their stories of illness and its treatment to teach patient-centered care,^{25,26} and the Longitudinal Case Studies (LCs) course,²⁴ in which different clinical cases are introduced during a two- to three-week period in conjunction with the students’ core lecture series. A critical element of the LCs is to allow the students to explore in a small-group setting issues of unequal treatment, problems with health care access, and health care disparities, as well

as other issues in medical ethics, patient safety, health care economics, and death and dying. The integration of the multicultural curriculum into major components of the first- and second-year curricula at University of Michigan Medical School reflects a philosophy that multiculturalism should be “woven” as an essential part into the undergraduate curriculum rather than added on as a “stand-alone” course in such a way that may allow it to be overlooked or ignored. To achieve this end, the director of multicultural education (M.L.L.) works closely with the director of the FCE and LCs (A.K.K.) to plan and implement activities within the FCE, LCs, and the CFM clinical skills course during the first and second years and to extend small-group discussions on diversity, bias, ethics, and social justice into the third clinical year.

A critical element in these activities is dialogue. With regards to work in small groups, we agree with Branch and others^{27,28} that small groups are superior to lecture formats in fostering reflection on students’ own values, perspectives, and biases in a safe and comfortable setting. We would extend this observation by stating that to foster the development of critical consciousness, discussion alone is not enough. We wish to stimulate engaged, interactive, honest dialogue within small groups on potentially contentious social issues of relevance to the practice of medicine. These are groups in which individuals bring themselves—their identities, values, ideas, perspectives, backgrounds, and experiences—into collective (but not necessarily unified) expression to consider the basis of moral action.^{18,29} To achieve this goal, we have designed the small groups such that 10–12 students remain together with the same clinician facilitator for the FCE, LC, and multicultural sessions for the two years of the program. This arrangement allows for a degree of comfort and familiarity when discussing deeply personal issues and views.²⁸ To this end, we also encourage each group to develop their own “ground rules” for discussion during their first session and to explicitly refer to these rules as guidelines during difficult exchanges. This type of interaction also presupposes the minimizing of power differences within the group and requires the instructor, in whom most of the authority resides, to learn to facilitate the

discussions rather than to act as the sole source of knowledge and teaching.²⁹

Implicit in these remarks is the belief that the relationships of the faculty and students in this setting must change—from the traditional “top-down” approach to one in which teaching and learning are bidirectional. This is not to say that the authority the faculty instructors possess is ignored; rather, there is an explicit recognition of the importance of the lived experiences that students bring into the small group as a resource for collective learning.

A conceptual foundation for this approach comes from Freire’s¹⁸ distinction between the “banking concept of education” and the “problem-solving” model of teacher–student interactions. According to Freire, traditional educational systems—including, we would argue, medicine—often view teachers as the possessors of all knowledge and students as its passive recipients. Teachers “deposit” knowledge into the minds of the students, whose sole task is to file, organize, and store the information. Although this “expert-as-teacher” approach is perhaps appropriate in the biomedical and clinical sciences, areas oriented towards addressing human and societal interests and needs, such as multicultural education, medical ethics, professionalism, and the physician–patient relationship, require a different approach. In these areas, education must involve the development of a professional and personal perspective and critical, reflective awareness that incorporates the student’s own values, worldview, and experiences. In this approach, which Freire terms “problem-solving education,”¹⁸ the student is an active agent in his or her own learning and uses newly and collaboratively constructed knowledge to identify and act to solve problems and injustice in the world.

Faculty development

So, one may ask, “Who teaches the teachers?” In these activities, faculty instructors are expected to facilitate exchanges rather than lecture, to stimulate critical reflection and critical analysis of personal assumptions, biases, values, and perspectives, and to facilitate the type of discourse described above. Furthermore, they are expected to model the same type of reflective approaches in their teaching that is expected in the

students.³⁰ To prepare for small-group discussions, the faculty instructors are provided with reference and background materials, thought pieces, and self-reflective exercises to use in their groups and to provide a foundation for their facilitation. Instructors engaged in teaching in the FCE and LCs also receive extensive faculty development, including workshops on active learning and facilitation, providing feedback, and stimulating reflective learning.

With regard to multicultural education, we collaborated with a theater troupe to design a workshop using interactive theater techniques for faculty instructors to prepare them to facilitate potentially contentious discussions on diversity and social justice.²⁴ The activity involved a brief sketch of a heated argument about race within a small group, followed by “freezing” the actors in character and allowing instructors in the audience to ask the characters about their thoughts, feelings, beliefs, and perspectives. After taking suggestions from the audience, the actors then incorporated them into a “replay” of the action.²⁴ A follow-up study of the workshop participants suggested that the forum theater techniques allowed deconstruction of destructive small-group dynamics, heightened awareness of the classroom experiences of women and students of color, and led to self-reported changes in the instructors’ work as facilitators.²⁴ The goals we wish students to achieve are modeled in the faculty development sessions: Faculty development activities, as well as ongoing individual feedback from course directors, are meant to enhance self-reflection on assumptions, biases, and perspectives and to foster refinement of critical consciousness in the instructors themselves. Indeed, fostering a collaborative learning environment for both students and faculty within this setting is evidenced by the effect of the small-group discussions on the faculty instructors. A recent study by one of the authors (A.K.K.)³⁰ documented that facilitation of these small-group discussions enhanced reflective approaches to patient care and teaching and stimulated personal and professional growth and development among faculty instructors in the FCE and LC courses. This process calls to mind Freire’s¹⁸ comment about collaborative learning:

The teacher is no longer merely the-one-who-teaches, but one who is himself taught in dialogue with the students, who in turn, while being taught, teach. They become jointly responsible for a process in which all grow.

However, an additional challenge to multicultural education presents itself in such a design for small-group exchanges. How does one avoid students’ acting as passive recipients of a “bag of virtues,”³¹ on the one hand, and moral relativism on the other? In other words, how does one prevent students from parroting unreflective, “politically correct” views while at the same time avoiding the position that any view, regardless of how antihumanistic or bigoted, is all right as long as it’s expressed? We agree with Hafferty³² that training in professionalism—and multicultural education, for that matter—involves a development of “the professional self,” that is, an internalization of the professional values and virtues of medicine, as opposed to conformation to an externalized set of standards. Therefore, imposition of the faculty’s or administration’s views—no matter how humanistic—on medical students is not our goal. Our approach to this dilemma is to focus on the critical nature of the self-reflection we wish to achieve in small groups. In the discussions, students are encouraged to critically reflect on the moral basis of their beliefs and assumptions, given the overall professional mandate to provide effective health care to all members of society. In this sense, engaged discourse and interactions with a diverse group of peers allow for the testing of the moral validity of one’s positions in a supportive, safe environment and the formulation of a reflective orientation for action²⁹ as the basis of clinical practice.

Specific techniques

In the following sections, we briefly discuss some examples of approaches and techniques we have incorporated into the multicultural curriculum, FCE, and LCs at our institution to assist in fostering critical consciousness in our students.

Stories. One of the greatest challenges facing the multicultural curriculum in particular and medical education in general is to teach students to advocate and care for individuals who may be very different from themselves.³³ Medical students have privileged status, not only in terms of educational background, but for many students, privilege is also

derived from relative youth and health and from racial/ethnic, gender, sexual orientation, or socioeconomic class identities.^{34,35} In this sense, multicultural medical education often involves teaching social justice to privileged groups.³⁶ The use of first-person narratives or other stories in this context is particularly relevant, because they may engage the student in experiential, cognitive, and affective domains, allow for a “constructive engagement with otherness,”³⁷ foster perspective-taking, and enhance empathic connections with others.^{25,38–40} Stories provide immediacy and relevance to issues of social justice⁴¹ and may affect perspectives in subtle, but important, ways. In the FCE and the LCs, we have used stories from volunteers, literature such as *The Spirit Catches You and You Fall Down*,⁴² the Medical Reader’s Theatre version of William Carlos Williams’ “Faces of stone,”⁴³ and the Robert Phillips Story from the *Worlds Apart* video series⁴⁴ to put a human face on cultural conflicts, health care disparities, and implicit (or explicit) personal biases and assumptions in the health care setting.

It should be noted, however, that the use of stories as a means to foster identification with the other is not enough; vicarious distress in hearing of another’s suffering or trauma alone does not lead to justice—action does. As Boler⁴⁵ suggests, although this empathic connection is important, use of stories of injustice to arouse empathy without simultaneously stimulating both critical reflection on one’s own biases, privileges, and assumptions and acknowledgment of one’s own personal responsibility to understand the causes of the suffering and seek effective solutions may lead to a reader or listener to conclude, “yes, now I know what he/she/they experience” and leave it at that. Stories of injustice per se are necessary but not sufficient to enhance the development of critical consciousness. *How* the stories are introduced and discussed—the pedagogic approach to using these stories—is the crucial link in their effectiveness. In this regard, we have made specific use of techniques to create a “cognitive disequilibrium” in students as a way to enhance critical reflection.

Cognitive disequilibrium. Evidence from developmental psychology suggests that significant learning and personal

growth may occur when one encounters an experience, idea, perspective, or identity with which one is unfamiliar—when one goes through what Piaget refers to as “cognitive disequilibrium” in moving from one developmental stage to another, more advanced level.^{28,31,46} Such an encounter with the unfamiliar and the disequilibrium that may ensue stimulate what Habermas²⁹ terms a “hypothetical attitude”: a perspective which involves turning a critical gaze on one’s own values, assumptions, experiences, and opinions and questioning the moral validity of the state of affairs in the world. This questioning of personal and societal “status quo” may in turn give rise to a worldview that is more complex, inclusive, and oriented towards moral action.^{29,47} In the FCE and LCs, faculty facilitators are trained to create this disequilibrium through facilitation of discussions of volunteers’ stories and other narratives, clinical and “real world” experiences, and case examples in order to prompt questioning and reflection and to create what Boler⁴⁵ terms “a pedagogy of discomfort” that enhances the growth of a professional, socially engaged self.

Instructors are specifically trained to pose questions to stimulate reflection and engaged discussion.^{18,48} The types of questions are designed to present the group with an ill-defined problem or paradoxical situation. The point of this approach is not to get the “right” answer but to personalize the situation to stimulate reflection on the impact of culture on patient and physician preferences, the nature of patient-centered care, the potential emotional impact of being the target of prejudice, and the different types of prejudice (e.g., individual, institutional) that may arise in health care settings. Instead of an abstract discussion, the focus is on answering the questions, “How would *you* feel or what would *you* do if you encountered such a situation?” or “Who benefits from labeling a patient as ‘noncompliant’ or looking at him/her in this way?”

“**Keeping it current.**” In standardized or paper cases, there is unavoidably an aspect of unreality, which may inadvertently lead to using stereotyped examples when discussing issues of race/ethnicity, gender, sexual orientation, or class.^{9,49} The two-dimensionality of case examples may be reduced to a certain extent by the use of selective narratives, as

mentioned above. In addition, building flexibility into the curriculum to allow for discussion of teachable moments on multicultural topics may stimulate engaged discussion on issues of immediate relevance.

For example, in the days immediately following the devastation wrought by Hurricane Katrina, which triggered the greatest public health disaster in U.S. history, we designed an educational response to the events. The scheduled LC was dropped, and the small groups were asked to research and discuss Hurricane Katrina and its aftermath and to develop and explore questions related to the public health and societal issues and controversies highlighted by the event. During the crisis, small groups discussed many related questions: What are the public health and health care dangers facing individuals affected by Katrina and its aftermath? By those who were evacuated? By those who remained? Who stayed/was left behind? How have those who were evacuated fared? What about those who remained? This ad hoc session gave a sense of immediacy and emotional power to issues of health care disparities. Refocusing the sessions also stimulated important and critical discussions on race, poverty, responsibilities (and responses) of the federal, state, and local governments, as well as responsibilities of individuals—including physicians and other health care providers—in addressing specific societal needs.

Evaluation

How does one evaluate the effectiveness of critical consciousness development in multicultural education? If, as we have maintained, the type and object of knowledge is fundamentally different from that of the basic or clinical sciences, multiple-choice exams alone are neither sufficient nor relevant. Furthermore, we agree with Hafferty³² that solely focusing on evaluating behavior, as opposed to assessing value orientations and motives, provides an incomplete picture of the effectiveness of such efforts.

The numerous challenges faced in assessing the effectiveness of multicultural education have been articulated in detail and include problems with measuring responses biased by social desirability, the problematic nature of fact-based evaluations of students’ knowledge of disenfranchised groups, and devaluation of the multicultural curriculum

and methods to evaluate it as “soft science.”¹¹ We maintain that assessment should focus on expressions of internalized, patient-centered orientations, including openness and critical reflection in the area of working with patients in diverse societies. Furthermore, we recognize the potential risks that linking assessments in multicultural education to the traditional components of competency possesses: the danger that knowledge, skills, and attitudes may be quickly reified into rather inflexible categories that test competencies empty of internalized values.³²

Part of the answer to these challenges on an individual student level lies in the assessment of the expressions of critical awareness—thoughtful discussions, essays, interpretive projects, etc.—over time. This type of assessment may be done in the type of longitudinal small-group activities that we have described. On a programmatic level, the value that multicultural curricula bring to the development of physicians prepared to work with diverse patient populations may be assessed through studies employing mixed methodologies. We have used qualitative studies to assess the effect of the FCE volunteers’ stories on students^{26,40} and on faculty instructors.³⁰ Similarly, we have used focus-group-based qualitative methods to explore students’ understanding of, and suggestions regarding, the multicultural curriculum at our institution.⁴¹ In addition, to assess the effectiveness of our curricular efforts, we are currently conducting a multiyear, longitudinal survey (based on the undergraduate Michigan Student Study²⁸) of medical student attitudes towards diversity. We do not claim to have all the answers in this regard; however, we believe that a reorientation in the goals of multicultural education must be accompanied by both a reorientation of the traditional teacher–student paradigms and of assessment methods in this crucially important area of medical education.

Conclusions: Critical Consciousness, Social Justice, and Medical Education

At the very heart of efforts to instill professionalism, humanism, and cultural openness and humility in medical students is the notion of justice: to treat all patients as individuals—with all the emotional, experiential, and cultural richness and

depth that comprise an individual's identity—with fairness and compassion. In much the same manner that the “habit of professionalism” develops,⁵⁰ so does a critical consciousness of oneself and others in the world, as well as a commitment to alleviate suffering and address disparities through action. The development of this critical awareness is a central goal in multicultural education, and efforts to achieve this goal must take the form of an educational praxis, i.e., action informed by an overarching theoretical framework. In this way, we may educate ourselves in the process of training physicians who are capable of addressing society's needs.

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