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BECOMING CULTURALLY COMPETENT: CLINICAL SERVICE LEARNING IN PHYSICIAN ASSISTANT EDUCATION

by

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A Dissertation submitted to the Faculty of the Graduate School,
Marquette University,
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the Degree of Doctor of Philosophy

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ABSTRACT

BECOMING CULTURALLY COMPETENT: CLINICAL SERVICE LEARNING IN PHYSICIAN ASSISTANT EDUCATION

Pinna Rea Katz, MS, PA-C

Marquette University, 2011

Background: Even though the need for culturally accessible, acceptable, and appropriate medical care for diverse populations is well established, there is a lack of research on how cultural competencies are developed in physician assistant education. There are no studies that address the intersections among cultural, clinical, and psychosocial competencies from the viewpoint of the physician assistant student. Although accreditation standards for physician assistant educational programs provide general guidelines for inclusion of cultural competency in the curriculum, core competencies in physician assistant education focus primarily on biomedical content rather than address cultural competencies. Because experiential education, such as service learning, offers physician assistant students and opportunity to interact with the "other," this study explores students' perspectives on cultural competence as reflected in their service learning experiences.

Methods: The development of four case studies is based on a series of in-depth interviews with four recent graduates from a physician assistant program. This phenomenological study takes a naturalistic, exploratory, and descriptive approach to understanding the informants' behavior by using inductive methods that provide the researcher access to the underlying meanings that guide those behaviors. Using content analysis, five themes emerge from the data: (a) clinical service learning is less influential than pre-matriculation experiences; (b) the clinical setting matters; (c) language serves as a proxy for culture; (d) labeling patients as "other" is problematic; and, (e) clinical, cultural, and psychosocial competencies overlap.

Conclusion: The results of this study indicate that there is a need to infuse the physician assistant biomedical curricula with content and strategies for developing cultural competencies to better prepare students for clinical practice with the diverse populations they will encounter during their clinical service learning experiences, clinical rotations, and careers. The implications for physician assistant programs and educators are discussed, including suggestions for future research.

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Pinna Rea Katz, M.S., PA-C

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Chapter I. Introduction

Providing accessible, acceptable, and appropriate medical care to a diverse patient population in the United States poses a challenge to the medical practitioner. Despite the fact that most physician assistant (PA) students, and students of other health professions, as well as health care practitioners, would not consider themselves prejudiced, it is apparent that generalizing and stereotyping can infect treatment plans (Smith et al., 2007). This has generated policy statements from several medical education and professional organizations on the importance of diversity training for students as well as clinicians. For example, the Institute of Medicine (IOM) report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Smedley, 2003) singles out cultural competency training for both practicing and in-training health care professionals as one strategy to reduce health disparities among various ethnic groups. The report outlines how clinicians can reduce disparities in their practices by engaging in cross-cultural education, communicating clearly with their patients, and respectfully exploring the patient's understanding of his or her condition, while simultaneously practicing evidence-based medicine to avoid conscious or unconscious decisions based on prejudice or stereotypes. In 1999 the American Medical Association published the *Cultural Competence Compendium*, which stressed the importance of training physicians to work with patients from diverse backgrounds but, at the time, did not necessarily encourage integration of the cultural competency curriculum into the core medical competencies. In contrast, the 2010 Liaison Committee on Medical Education (LCME) accreditation

standards (*Functions and Structure of a Medical School*, June 2010) include one standard that requires medical schools to foster cultural competences:

> ED-21. The faculty and medical students of a medical education program must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments.
>
> Instruction in the medical education program should stress the need for medical students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on patients' health. To demonstrate compliance with this standard, the medical education program should be able to document objectives relating to the development of skills in cultural competence, indicate the location in the curriculum where medical students are exposed to such material, and demonstrate the extent to which the objectives are being achieved. (p. 10)

Development and implementation of physician assistant programs followed the same science-based curricular model that all physician education adopted after 1910 under the influence of the sweeping recommendations of the *Carnegie Foundation for the Advancement of Teaching Bulletin Four: Medical Education in the United States and Canada* (Flexner, 1910). Like that of their physician colleagues, physician assistants' education now focuses on pathophysiology, disease by organ systems, and evidence-based medicine in order to master the management of disease through history, physical examination, appropriate diagnostic studies, pharmaceuticals, and other medical therapeutics. The compatibility of curriculum content provides commonality of method, terminology, and goals in the medical practice for both groups of clinicians. For both disciplines, medical and physician assistants, this commonality in the educational and clinical approach to the provision of health care influenced the way that both service learning and cultural competency training are integrated the curricula

Mirroring physician education physician assistant programs began incorporating cultural competency curricular components about 15 years ago, even before the Accreditation Review Commission for the Physician Assistant (ARC-PA) *Standards for Accreditation, 3rd Edition* (2007) made it a specific requirement. Its most recent edition, the ARC-PA *Standards for Accreditation, 4th Edition* (2010), includes two references to diversity and to including cultural matters in the physician assistant curriculum. One acknowledges diversity among both the patient population and among fellow health care providers, mandating curriculum that addresses these realities:

> [Standard] B1.06 The curriculum *must* include instruction to prepare students to provide medical care to patients from diverse populations.
>
> ANNOTATION: Quality health care education involves an ongoing consideration of the constantly changing health care system and the impact of racial, ethnic and socioeconomic health disparities on health care delivery. Instruction related to medical care and diversity prepares students to evaluate their own values and avoid stereotyping. It assists them in becoming aware of differing health beliefs, values and expectations of patients and other health care professionals that can affect communication, decision-making, compliance and health outcomes. (p.13)

This standard, with its accompanying annotation, provides a working definition of cultural competence for physician assistant medical education that includes the concepts of cultural awareness, knowledge, and skills needed to provide quality health care to diverse populations, which would serve to reduce barriers to health care for all people.

The other standard that addresses cultural competency focuses specifically on understanding how to provide appropriate patient education and counseling:

> [Standard] B2.09 The program curriculum must include instruction in basic counseling and patient education skills.
>
> ANNOTATION: Instruction in counseling and patient education skills is patient centered, culturally sensitive and focused on helping

> patients cope with illness, injury and stress, adhere to prescribed treatment plans and modify their behaviors to more healthful patterns. (ARC-PA, 2010, p.15)

This standard, with its accompanying annotation, offers an overview of the psychosocial pedagogy required in physician assistant education, which prepares students with appropriate interpersonal and communication skills to create a respectful, therapeutic relationship with patients from diverse backgrounds.

In the ARC-PA explanatory materials entitled *Comparison of ARC-PA Accreditation Standards for Physician Assistant Education, 4th Edition (2010), To the Competencies for the Physician Assistant Profession*, the agency defines diversity as "Differences within and between groups of people that contribute to variations in habits, practices, beliefs, and values" (p. 12). These standards are further translated into recommended competencies that should be reflected in the curriculum of programs that educate physician assistants. These include helping students to recognize "and appropriately address gender, cultural, cognitive, emotional, and other biases," as well as instilling and reinforcing a "sensitivity and responsiveness to patients' culture, age, gender, and disabilities" (p. 10). However, the term "culture" is not even included in the ARC-PA's general working definition of competency:

> Professional competencies for physician assistants include the effective and appropriate application of medical knowledge, interpersonal and communication skills, patient care, professionalism, practice-based learning and improvement, systems-based practice, as well as an unwavering commitment to continual learning, professional growth and the physician-PA team, for the benefit of patients and the larger community being served. (pp. 1–2)

This standard lays out a comprehensive definition of what constitutes professional competency, which includes proficiencies within the clinical setting. When referring to clinical competence, this study will focus on the clinical aspects of the above definition: medical knowledge, interpersonal skills, communication capabilities, and application of medical knowledge in patient care. The ARC-PA accreditation standards acknowledge the need for competencies that address the diversity of the patient population but do not mandate specific curricular components. The absence of the word "cultural" in the definition of competency might imply that addressing diversity is a matter of competence in one or more of the other pedagogical areas listed, such as the psychosocial and medical aspects of patient care.

The application of these directives and standards can be recognized in the various courses and instructional activities offered at Rosalind Franklin University of Medicine and Science. Cultural competence education for physician assistant students has been comprised of elements from several different courses in the first year curriculum. This includes two introductory, interdisciplinary, mandatory, university-wide courses, *Interprofessional Healthcare Teams* and *Culture in Healthcare*, which involve first year students from three colleges, the Chicago Medical, Scholl College of Podiatric Medicine, and the College of Health Professions and address socio-cultural issues pertinent to the health care professional. In addition, social, interpersonal and cultural topics can be found throughout the PA program's first year curriculum including as learning objectives and instructional elements in the following courses: *Psychosocial Aspects of Patient Care*, *Professional Issues and Ethics,* and *Population Medicine*. The RFUMS PA Department's clinical service learning and the two aforementioned university-wide interprofessional

courses also address both social justice and leadership aspects of service learning by focusing on interprofessional collaboration and community needs. Service learning continues to be a central component of *Interprofessional Healthcare Teams* course with the interprofessional service learning project focusing on health maintenance and disease prevention. These projects range from teaching about healthy eating to a class of middle school students to teaching a group of developmentally delayed adults' appropriate personal hygiene. In contrast, service learning in the PA program focuses on the provision of direct patient care to peoples of diverse backgrounds. The PA students have one-on-one clinical encounters with patients who have availed themselves of the free health care offered at the Healthy Family Clinic. The patients usually have backgrounds that differ from those of the PA students based on educational level, ethnicity and socio-economic status. The informants in this study participated in both types of service learning experiences at RFUMS during their first year in the PA program.

Based upon these aspects of the physician assistant curriculum at RFUMS, cultural competence curricular elements brings together psychosocial elements such as the development of empathy and appropriate communication skills within the biomedical model, along with developing respect for and appreciation of people from diverse backgrounds . The service learning opportunities offer a chance for physician assistant students to study and work in interprofessional teams to become competent in both knowledge and skills related to cultural issues. This experiential learning activity along with the classroom discussions offers a springboard to considerations of the systemic causes of disparities in health care delivery and in health care status, and critical thinking about personal, educational, and institutional solutions to these inequities.

The current study was designed to explore the emic perspective of newly graduated physician assistants on the subject of cultural competence, as they reflected on experiential learning both on campus and off (e.g. service learning, clinical rotations), as well as in light of their pre-matriculation experiences, the PA didactic curriculum, and post-graduation clinical practice. This inductive inquiry began by focusing on clinical service learning (CSL) experiences, which represented a spectrum of experiential learning that focused on students working in the community to address community-identified health problems during the didactic year of their education. Clinical service learning afforded opportunities to interact with patients from backgrounds different than those of the PA students. This, therefore, seemed like a logical place to begin the discussion of what the informants understood as cultural competence in the clinical setting; however, throughout the research process, we delved into the informants' experiences in other clinical settings, which provided a more nuanced appreciation of the informants' understanding of the concept of cultural competence in the clinical setting.

Rationale for the Study

Extant research in the area of cultural competency in physician assistant education has explored the ways in which diversity and cultural issues are woven into the programmatic curricula (Lisman, 1998; Stanton, Giles, & Cruz, 1999), but has not looked at the students' perception of cultural competence. A search of the term "cultural competence" in the only journal dedicated solely to PA education, the *Journal of Physician Assistant Education* (*JPAE*) (formerly *Perspective on Physician Assistant Education*), resulted in ten articles that covered a range of issues:

- a summary of two workshops previously presented at a conference for PA educators (Morton-Rias, 2006);
- a description of a funded initiative to increase clinical sites in medically underserved areas and improve recruitment of minority applicants (Legler & Stohs, 2003);
- the integration of culture issues in health care into both the didactic and clinical year curriculum (Sullivan, 2001; Miller & Morton-Rias, 2001; Jacques, 2004; Parish, 2004; Parkhurst & Ramsey, 2006; Marion, Van Rhee, Hilderbrandt & Lischke, 2007; Straker & LeLacheur, 2007);
- an assessment of the impact of a single book on the "literature [of] cultural competence, medical ethics, and the provision of culturally competent medical care" (Parish, 2004, p. 131);
- original research that provide survey result describing cultural competence curricula within PA programs, (Chang, 2004; Symington, Cooper, & Wallace, 2006).

Furthermore, there are no studies that address the intersections among cultural, psychosocial, and clinical competence from the viewpoint of the physician assistant student. If we are to develop and refine curricula that undertake critical inquiry and analysis of the role of culture in health care, we must understand how physician assistant students' perceive their own cultural competence, how they understand the place of cultural competence in the clinical encounter, and their appreciation of the intersection among essential practitioner competencies: cultural, clinical, and psychosocial. In

addition, an appreciation of how the PA student integrates cultural, psychosocial and clinical competencies during his or her educational program and beyond will afford insight for curriculum development.

Statement of Problem

This study examined the concepts derived from a review of the service learning and the cultural competence literature using the qualitative methods described in the Methods section. Specifically, I selected the venue of a clinical service learning site because it was space where physician assistant students had the opportunity to interact with the "other," i.e., people unlike themselves. As experiential learning, this encounter with patients and families from different ethnic, educational, and socioeconomic groups in a clinical setting afforded the PA student an opportunity to appreciate, learn, and apply cultural competence.

Attaining cultural competence can represent a process for the student in which he or she becomes aware of, gains knowledge of, and practices skills that "do more than provide unbiased care as they value the positive role culture can play in a person's health and well-being" (National Alliance for Hispanic Health, 2001, p. 13), while also honing skills in interpersonal relationships and the psychosocial aspects of patient care. This process may rely also on self-reflection that includes understanding of one's own background and a contemplation of one's interactions with the "other." As with clinical competency, students are confronted by ambiguity and uncertainty when charged with the care of people whose worldview, language, values, beliefs, and behaviors differ from

their own. The students may crave certainty through the knowledge of particular ethnic groups but may have to rely on respectful curiosity and cultural humility to learn from their patients.

Using a framework that is familiar to health care professionals in the United States (i.e., population medicine and clinical medicine), cultural competence in the clinical encounter can be understood as a balance between population-based and clinical-based competencies. Population-based competencies might include knowledge about historical inequities and how they are related to disparities in health care, the study of particular ethnic groups, and the mechanics of working with non-English speakers (e.g., learning a foreign language, learning how to work with interpreters, etc.). Out of many definitions listed in the Kaiser Family Foundation's *Compendium of Cultural Competence Initiatives in Health Care* (2003), the one offered by Lavizzo-Mourey and Mackenzie (1996) reflects a population-based competency:

> "Cultural competence" is the demonstrated awareness and integration of three population-specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. But perhaps the most significant aspect of this concept is the inclusion and integration of the three areas that are usually considered separately when they are considered at all. (p. 6)

Clinical-based cultural competencies center on the clinician-patient (family) dyad that is often learned best through experience and modeling. This aspect of cultural competence may be harder to define. Do we know cultural competence when we see it? Can we spot cultural insensitivity in a clinical encounter? The Department of Health and Human Services provides two useful definitions that apply this concept of clinical-based competency: (a) "'Cultural competence is defined simply as the level of knowledge-

based skills required to provide effective clinical care to patients from a particular ethnic or racial group' (DHHS, HRSA)" and (b) "Cultural sensitivity is 'the ability to be appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic or cultural heritage'(DHHS, OMH, National Standards for CLAS, 2001)" (Rees & Ruiz, 2003, p. 6).

These two facets of cultural competence are reflected in the approach practitioners take to appreciate, understand and cope with cultural issues that arise in the clinical encounter (Nunez & Robertson, 2006). The process of becoming a culturally competent health care provider entails capabilities in three spheres: 1) awareness of one's own attitudes, prejudices, beliefs about others, and an appreciation of one's own cultural background; 2) knowledge of one's patients' cultural beliefs, behaviors and values; and 3) skills that incorporate both awareness and knowledge into a culturally sensitive approach to patient care (Culhane-Pera, 1997; Purnell & Paulanka, 1998; Nunez & Robertson, 2006). Following a review of pertinent literature, I explored these concepts with the informants by focusing on their experiences with and perceptions of cultural competence in the clinical setting starting with their clinical service learning sessions at Healthy Families Clinic.

Study Outline

The following are the four research questions around which I constructed the semi-structured interviews. These questions focused on the informants' experiences during their clinical service learning sessions at the Rosalind Franklin University of Medicine and Science (RFUMS) Healthy Families Clinic (HFC), although our

conversations ranged further to include pre-matriculation experiences, other service learning experiences, and clinical encounters during the first few months of their careers as physician assistants. The questions were:

1. During their clinical service learning how do PA students understand the patients' and their families' experiences at Healthy Families Clinic?
2. What do the PA students discover about people with backgrounds different from their own during their clinical service learning?
3. What influence does the clinical service learning experience have on the PA students' clinical practice during their clerkships?
4. How does this clinical service learning experience impact the PA students' perception of their own cultural competency?

As I deemed appropriate, each interview session explored cultural competency themes that were derived from the review of literature explored in the next chapter. In addition, as we will see from the interviews in Chapter Four, other themes evolved organically from the conversations with the informants. In addition to the four questions that focused on the informants' experiences at Healthy Families Clinic, I explored their perception of the process of becoming cultural competent using the following themes derived from the review of literature. The themes are listed as they relate to the three spheres discussed above:

- Awareness
    - Self reflection: recognition of one's own background, limitations and abilities

    - Curiosity: open to and comfortable with differences
- Knowledge
    - Ethnic studies: values, beliefs and behaviors for specific populations
    - Social justice: impact of disparities in health care
    - Democracy: health care policy
- Skills
    - Clinical dyad: inter-personal interactions, effective communication
    - Respect: avoid making assumptions
    - Humility: self-reflection that leads to a more balanced relationship between clinician and patient
    - Ambiguity and uncertainty: ability to hold multiple considerations while providing patient care

If a term did not arise spontaneously from our conversation, I would ask the informant about his or her reaction to the term or ask him or her to define the term or sometimes ask the informant to describe an incident when he or she observed a clinical interaction that embodied the term or theme.

Conclusion

This qualitative investigation explored the emic understanding of cultural competence through in-depth interviewing of four recent graduates of the RFUMS physician assistant program. The physician assistant student or recent graduate voice has not been heard directly and may provide insight into the implementation of academic standards and the actualization of competencies among this group of health care

professionals. The review of literature, which follows in Chapter Two, helps to inform the discussion about the part that the curriculum and service learning plays in the process of becoming a culturally competent clinician.

Chapter II. Review of Literature

Overview

This review focuses on research, theory development, and other literature that represents the intersection between service learning and cultural competence. In addition, I review research and other publications that addressed the clinical encounter as an intercultural interaction and service learning as an approach to addressing disparities in health care and health status as they relate to intercultural understanding. As an adjunct to reviewing the physician assistant and medical education, I look at the theoretical and research literature from two other professions with long-standing, well-developed scholarship in cultural competence: nursing and teacher education.

Historical Confluence: Service Learning and Physician Assistants

The late 1960s witnessed the emergence of both the physician assistant profession and service learning in higher education, which were both emblematic of societal unrest of that era. These two phenomena reflect a social imperative to serve the medically underserved and to foster the empowerment of communities, respectively. The first class of physician assistants, combat experienced medics who had served in the Vietnam War, graduated from Duke University in 1967 with the intention of addressing our nation's lack of access to medical care (Jones, 2007). That same year, Robert Sigmon and William Ramsay coined the term "service learning" to describe the potential interdependence of both college student and community development by consciously combining educational goals and activities that meet human needs in underserved communities (Stanton et al.,

1999). Today's incarnations of the PA profession and of the service learning model in higher education can be understood as products of an era that also saw the creation of Peace Corps, VISTA (Volunteers in Service to America), and President Johnson's War on Poverty. The Comprehensive Health Manpower Act of 1972 fostered the growth of the PA profession through federal funding of a rapidly growing number of programs. Within a this time frame, service learning was gaining traction in post-secondary education through grants from the U.S. Department of Education's Fund for Improvement of Post-Secondary Education (Stanton, et al., 1999).

Despite their contemporaneous birth in 1967, these two social innovations did not cross paths for more than two decades. Even though the major objective for PA education has been to train primary care practitioners for rural and urban medically underserved regions, the programs have evolved into educating clinically competent generalists who can practice in any medical specialty. The curriculum in the 24-month professional training programs (which were originally undergraduate level) was unlike that in undergraduate liberal arts schools. A limited time frame in which to assimilate vast amounts of medical knowledge left little space in the curriculum for activities such as service learning within the preclinical, didactic phase of learning, and there are no accreditation related recommendations or standards for service learning (ARC-PA, 2007). The 12-month clinical preceptorships that followed the didactic year were often based in community clinics, private practice settings, and hospitals that served the medically indigent. These clinical experiences parallel the clinical medical education for medical students and residents in that the emphasis was on the student's acquisition of clinical knowledge and skills to care for individual patients (Seifer, Zlotkowski, Hermanns, &

Lewis, 2000), rather than the development of needed cultural competencies to work with community organizations and underserved populations Instead the concept of direct service to the community has centered on the career choices by some graduates from PA programs to work or volunteer in medically underserved areas of the United States. The first article that described service learning in a PA program appeared in 2000 authored by Fahringer, Assell, Harrington, Maschio, and Stone and described an interdisciplinary service learning curriculum including PA students during the clinical phase of their education who were working with students from nursing, medicine, pharmacy, dentistry, and other allied health professions at the University of Kentucky. That was followed by a publication describing another interprofessional project (Scott, Harrison, Baker, & Wills, 2005) in which physician assistant students worked with students from the departments of clinical laboratory sciences, health management, nutrition, occupational therapy, and physical therapy on a variety of prevention and health education projects in community-based organizations, such as AIDS clinics, community health clinics, community mental health centers, boarder babies homes, and homeless shelters. Knight, Moser, and Groh (2007) described a service learning activity in which didactic-year PA students worked with the urban poor in shelters, food pantries, and soup kitchens at University of Detroit Mercy. The study showed a slight increase the PA students' leadership skills and in their awareness of social justice issues as a result of their participation in the service learning project.

More recently, PA programs have embraced service learning to address both cultural competency and interprofessional curricular elements (Fahringer, Assell, Harrington, Maschio, & L. Stone, 2000; Knight, Moser, & Groh, 2007; Scott, Harrison,

Baker, & Wills, 2005). Service learning projects represent an experiential learning opportunity in which students can appreciate cultural, socioeconomic, and ethnic diversity in a community, as well as gain experiences in areas of leadership, civic engagement, and social justice (Lisman, 1998; Seifer, 1998; Stanton et al., 1999). Service learning sites can also be a place where students from several health profession programs can work together to address community-identified needs and address public health issues such as prevention and health education (Blumenthal, 2000). What better place than in a community setting to learn how to be part of an interdisciplinary health care team where students understand "intersecting lines of communication and collaboration" (Clark, 1999, p.645) among different professions in order to enhance patient care?

Clinical Service Learning

Creating a Definition. The present incarnation of service learning in post-secondary education finds its roots in the social and political turmoil of the 1960s, including the civil rights and women's liberation movements, and the resultant pressure on the universities and colleges to address issues of poverty and inequality in their communities. The primary learning goals were to inculcate in students the importance of civic engagement through the lens of social justice. College- and university-educated students were to become concerned citizens through recognition of social problems; direct engagement with community institutions that address social ills; and the ability to critique, analyze, and reflect on their experiences (Lisman, 1998).

In many universities and colleges, service is touted as an equal to education and research (Rhoads, 1998; Weigert, 1998), but what exactly is meant by service can vary

according to the institutions' primary educational mission. This is as true for students as it is for faculty in these institutions. For example, in professional schools, such as medical and physician assistant programs, service can be understood specifically as training professionals to perform their particular societal functions, i.e., the practice of medicine, through clinical training (Pollack, 1999). And although medical education has used patients living in poverty and those without medical insurance to practice on, it is only in the past two decades that this system has been reframed as community-based health care (National Area Health Education Center Organization, http://nationalahec.org/home) in which the academic institution and community-based health care organizations work together to serve the medical and health care needs that are identified by the community.

The inclusion of service learning in medical education not only reframed clinical medical education that occurs in medically underserved communities, but it also allowed clinicians-in-training to appreciate the key attributes of population medicine: understanding and meeting the health care needs of a community, not just the individual. The focus of service learning for medical and PA students in the preclinical phases of their education typically does not incorporate direct patient care, but rather often focuses on other aspects of patient-centered care such as patient education and prevention, and population or policy issues such as resource allocation and ethical concerns, as well as health care organization and delivery issues. In addition, depending on the project's site, interdisciplinary student teams may provide some participants with the opportunity to practice the skills and knowledge particular to their professions while others in that team may not have that opportunity.

The type of service learning arranged for preclinical PA students through Healthy Families Clinic focuses on direct service to individual pediatric patients. The students are given the opportunity to practice their clinical knowledge and skills and then to reflect on their experiences. I am designating the type of the activity that combines tasks that meet genuine human needs, conscious educational growth, and critical reflection (Stanton et al., 1999)—and at the same time mirror the knowledge and skill set of a particular profession—as clinical service learning (CSL).

CSL can be recognized a subset of service learning in which the real world experiences offer students the opportunity to practice their craft while still accruing the other benefits of service learning. For physician assistant students, that would mean direct patient care using the clinical skills and knowledge that students are learning. The clinical service learning setting provides an opportunity to practice patient-centered care and at the same time to focus on practitioner competencies. In the context of PA education a CSL experience would occur during the didactic phase of the program and before the student begins his or her preceptorships. The clinical preceptorships are less amenable to being rendered a service learning experience, with their emphasis on fostering the traditional PA–MD and student–faculty relationship. In addition, the clinical year should maximize direct patient care as students apply their medical knowledge and clinical skills in a variety of medical settings. These health care sites may be community-based, in underserved areas, or even located in developing countries, but the primary learning goal during the clinical year is for the PA student to synthesize and apply skills and knowledge learned during his or her didactic year. Although service learning, or CSL, does not appear in the ARC-PA standards under which a program acquires accreditation,

and does not represent a substitute for the clinical rotations that constitute the post-didactic phase of PA education, it represents an opportunity for real-life practice of interview, history-taking, physical examination, and diagnostic skills that students are concurrently learning from lectures, reading, and on-campus skills labs for the preclinical student.

The challenge for this type of service learning is to raise it to equal value with the other important aspects of community-based clinical education and service learning, which might include health promotion and prevention as well as addressing community, financial and ethical, and other broad determinants of health (Seifer, 1998; Blumenthal, McNeal, Spencer, Rhone, & Murphy, 2000). Direct patient care can be exactly what the collaborating community agencies and members need in terms of addressing access to health care services in their community. CSL addresses the specific disparity in health care delivery that community partners may identify (Jimenez et al., 2008; Fournier, Harea, Ardalan, & Sobin, 1999; Brush, Markert, & Lazarus, 2006).

Therefore the definition of clinical service learning (CSL) for preclinical PA and medical students combines the precepts of service learning—with its emphasis on experiential learning, community engagement, and community self-reflection—with the practicality of community-based clinical education. CSL differs from traditional clinical education in a community setting by affording an equal emphasis on (a) reciprocal learning among students, faculty, and community members; (b) community-identified concerns along with individual health issues; (c) critical reflection along with observation and clinical practice; and (d) integration of community organizations in the CSL experience (Seifer, et al., 2000).

Considering that the history of the PA profession lies in training mid-level practitioners to work in urban and rural medically underserved areas of the United States, the sites of most CSL experiences in presently medically underserved areas seems a good fit with PA education. One might consider CSL sites where students work with people from backgrounds different from their own vis-à-vis income, culture, language, access to care, and education as a modern day equivalent to the low income communities in which many teaching hospitals and medical schools were and are still located.

Clinical Service Learning in Medical Education. Searching the extant literature for health care service learning projects that could be described primarily as clinical service learning revealed that two projects in New Jersey and Ohio. Jimenez et al. (2008) describe a comprehensive primary care clinic, Promise Clinic, which provides health care services to low-income residents in New Brunswick, NJ, staffed by attending physicians from the University of Medicine and Dentistry–Robert Wood Johnson Medical School. They supervised first- and second-year medical students who recorded the patients' presenting complaints and check vital signs (e.g., height, weight, temperature, and blood pressure measurements) and third- and fourth-year medicals students who take medical histories, perform focused physical examinations, and develop treatment plans. Although there were many differences in the organization and implementation of the projects, this preclinical CSL experience more closely resembles the Healthy Families Clinic CSL project than the two other CSL projects found in the literature search. The first- and second-year medical education focuses on classroom learning of the basic sciences and basic history-taking and physical examination skills. Similarly, the first-year physician

assistant education is classroom based, encompassing a broader range of medical knowledge as described previously. In this way the first- and second-year medical students and the first-year PA students provided similar functions in the two clinics: taking the patient's chief complaint and performing measurement of vital signs. Unlike the Healthy Families Clinic program, the Promise Clinic experience was an elective.

Like the Promise Clinic, the health fairs described by Fournier et al. (1999) were a student-led initiative in which first- and second-year medical students from the University of Miami School of Medicine provided blood pressure and vision screenings, performed screenings for cervical cancer (i.e., Pap tests) and breast examinations, performed prostate examinations, gave immunizations, and applied the tuberculin skin tests. Some of these clinical skills were taught as part of the usual first-year curriculum but were "supplemented [for those students who volunteered to work at the clinic] with special preparation for taking Pap smears, performing prostate and breast exams, giving immunizations, and performing phlebotomy and intradermal tuberculin inoculations" (Fournier et al., 1999, p. 49). Unlike the Promise Clinic and Healthy Families Clinic, the health fairs were one-day events involving hundreds of medical students working together. However, all three CSL projects allowed preclinical students direct patient care experience in response to a community's assessment of inadequate access to health care services. Like the Promise Clinic, the health fairs provided a venue for social services and community organizations to provide prevention services and health education information.

At the Tulane University School of Medicine—as at the RFUMS Healthy Families Clinic—service learning was a required course (Burrows, Chauvin, Lazarus, &

Chehardy, 1999), with an average of 39 hours of service per student per year. Offering a wide range of service learning opportunities, the only one that would be considered CSL was at a homeless shelter where students administer tuberculosis skin tests. The other service projects ranged from tutoring high school students in math and science to providing support and networking to pediatric oncology patients and their families. All three medical schools that offered CSL (Burrows et al., 1999; Fournier et al., 1999; Jimenez et al., 2008) to their first- and second-year students foster student involvement in both the development and implementation of the program to ensure sustainability.

Literature addressing CSL experiences targeted at preclinical medical students revealed descriptions of free clinics developed, staffed, and sustained by universities, but there were no specific references to the type of tasks that first- and second-year medical performed at these sites (Seifer et al., 2000; O'Toole, J. Hall, & Freyder, 2000). Both articles described filling a community need for direct patient care in homeless shelters and using the sites as both clinical rotations for medical students (third and fourth years) and residents under faculty supervision.

The majority of service learning projects in medical and physician assistant schools focused on prevention, health education, screening, and referrals. The literature highlighted other benefits students accrued from service learning projects such as working in teams of interprofessional students and faculty to become familiar with the needs of at-risk communities and populations (Clark, 1999; Cauley et al., 2001; Sebastian, Skelton, & Hall, 2002; Scott et al., 2005; Elam et al., 2003; Blumenthal et al., 2000). Other authors discussed service learning as a key in improving relationships between academia and a community by the development of trust (Bernard et al., 2000;

Ferrari & Cather, 2002; Averill et al., 2007) and collaboration between the medical students and community partners in addressing barriers to health care (Borges & Hartung, 2007; Averill et al., 2007). Some educators argued that offering a broad range of service learning sites in schools, community organizations, health departments, and nursing homes improves student interest and participation (Burrows et al., 1999; Knight et al., 2007; Banks & Heaney, 2000). Often these service learning projects developed from a comprehensive community needs assessment that represents the first step in university and community collaboration (Sebastian et al., 2002; Elam et al., 2003).

A recurring theme in service learning for medical students was whether the experience affected an individual's career choice. By being exposed to public health issues and barriers to health and social services in a given community (Elam et al., 2003; Ko, et al., 2005), students may choose to work in medically underserved areas. Davidson (2002) did find a loose correlation, while Brush et al. (2006) and Borges & Hartung (2007) found no association between participation in service learning and the interest of medical students in going into primary care specialties or practicing in areas with medically underserved populations or people from lower socioeconomic groups and diverse cultural backgrounds. Similar research has not been done to track career choices for physician assistants who have participated in service learning during their training.

Summary. This section tracked the origins of service learning as a way to connect students and faculty in higher education to the communities in which they live and learn. Educators in medicine and in physician assistant studies took the existing enterprises of both community-based medical care and medical care in underserved areas

where teaching hospitals thrived, and married these with the concepts of civic engagement, reciprocity, and collaboration with the community partners, and self-reflection to develop what I have labeled as clinical service learning. It is in these clinical service learning venues where physician assistant students are likely to encounter patients whose backgrounds—ethnic, socioeconomic, and educational—are unlike their own, and therefore, the students are challenged to provide health care in a culturally competent manner.

Cultural Competence

Considering culturally appropriate healthcare. Although many of the articles reviewed in the previous section imply that service learning is one path to help students of health care professions understand the socio-cultural background of their patients, and especially of patients who are different from themselves, less than half make any direct reference to cultural influence on health and disease. Of the two projects I have identified as exclusively CSL, only the health fair (Jimenez et al., 2008) mentions cultural understanding as an important outcome of the students' experience. However, a description of a wide range of community-based clinical sites established by the University of Washington School of Medicine included a reference to teaching cross-cultural medicine based on medical students' service learning experiences (Dobie et al., 2000); although it is unclear from this description what tasks preclinical students performed at the clinical sites.

Some authors used a place marker for the cultural competency component of service learning by couching concepts of awareness, knowledge, and skills needed to

afford competent health care to people from diverse backgrounds as (a) community-based education (Seifer et al., 2000; Fournier, Harea, Ardalan, & Sobin, 1999), (b) behavioral or psychosocial science (Cauley et al., 2001; Elam et al., 2003), and (c) urban poor (Cauley et al., 2001). An additional review of community medicine initiatives that included service learning in *Academic Medicine* (2002) revealed multiple references to cultural competency training, but most refer to rotations for clinical-year medical students and residents in primary care specialties, which do not fall into the purview of this study.

Developing a definition of cultural competence. The essential goal of including cultural competence in the PA curriculum is to incorporate the spheres of awareness, knowledge and skills into students' clinical practice, as they encounter patients from diverse background based upon race, gender, ethnicity, religion, national origin, socioeconomic status, age, sexual orientation, and mental/physical abilities (Anand, 1999). Developing and encouraging the facility to navigate the clinical encounter with the "other" would allow physician assistant students and clinicians to afford acceptable and appropriate medical care to people who "may be subject to being labeled, marginalized, and excluded [and in] the clinical setting … presumptions [may be made] about the values, morals, and beliefs of specific groups [that] may have implications on clinical decisions that are made" (Boutin-Foster, Foster, & Konopasek, 2008, p. 2). In the United States the confluence of the concepts of cultural diversity, medically underserved populations, and disparities in health care delivery reflects the ethical, political, and pragmatic reasons for training culturally competent health care providers (Bayer, 1994). For example, Fort and McClellan (2006) appreciated the importance of developing a

curriculum that includes cultural competency skills in communication and negotiation that are aimed directly at addressing racial and ethnic disparities and augmented with the opportunity to both explore the practitioner's own biases and prejudices and to appreciate the research that reveals the magnitude and multifactoral causes of the problem. Without offering any critical evaluation of the list of cultural competence curricular resources, the authors recommended that medical schools develop local, expert faculty, with personal commitments to reducing health disparities that will model and teach appropriate clinical behavior in addition to using these recommended resources.

On the clinical level, cultural competence represents the shift from disease-based medicine to a patient-centered, contextual perspective of illness and disease that includes communication and negotiation skills to "optimize outcomes that work within the patient's world" (Nunez & Robertson, 2006, p. 371). However, the conundrum faced by educators in the health professions is how to effectively teach cultural competence. Dogra & Karnik (2003) described a "categorization" model, a content-driven development of core competencies with learning objectives that can be objectively assessed and with a focus on awareness, knowledge, and skills, and compare it to the "sensibility" model, in which curriculum is developed around the clinician–patient relationship. In a qualitative study of medical students along with medical and social science professionals in a British medical school, Dogra, Giordano, and France (2007) found that the students preferred gaining factual information about specific ethnic groups and learning the steps to provide culturally appropriate care that avoids diagnostic failure and medico-legal consequences. On the other hand, the professionals interviewed for the study posited that true patient-

centered care that is culturally appropriate would be enhanced by the clinicians' ability to handle ambiguity and uncertainty in the clinical encounter.

A questionnaire-based study with U.S. medical students (Dogra & Karnik, 2003) concluded that the "categorical" model of teaching cultural competence emphasized the need to learn about groups that are different from one's own group by understanding these groups as discrete and homogenous entities. This represented a population approach to understanding the "other" by emphasizing the individual as a member of a group. In contrast, the authors described "sensibility" as a more nuanced pedagogy that goes beyond superficial knowledge by challenging students to question their own perspectives without judgment. This particularized approach is actually more congruent with medical practice, which addresses disease, health, and behaviors for individual patients.

Interestingly, a search of the American Anthropological Association's Society for Medical Anthropology's flagship journal, *Medical Anthropology Quarterly,* from 1997 to 2009, yielded only one article that references the term "cultural competence," and that article addresses this issue of "sensibility" vs. "categorization." Janelle Taylor (2003) used a discussion of a popular book, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* by Anne Fadiman (1998), to explore how appreciating the struggles of individuals may lead to generalizing an entire ethnic group. Using an anthropological context, the author argued that cultural competence curricula should provoke curiosity, invite an exploration of meaning, and recognize culture as a process, instead of being merely a presentation of a fixed package of customs, beliefs, and behaviors applied to a population. This conceptualization supported the conclusions found in both Dogra and Karnik (2003) and

Dogra, et al. (2007) that the culturally competent medical practitioner is one who listens to the patient, appreciates both the unique and culturally embedded aspects of the patient's life, and asks respectful questions to gain understanding of the patient's perception of his/her illness.

Joining together PA education and cultural competence. Over the past 15 years, PA programs have addressed issues of diversity and cultural competence through targeted recruitment of minority students, increasing the exposure students have to people from diverse backgrounds and fostering leadership and civic engagement (Lisman, 1998; Stanton et al., 1999). Reviewing the literature on PA education revealed a commitment to programmatic and curricular cultural competency initiatives over the past 12 years (Morton-Rias, 1998), including a regular feature in *The Journal of Physician Assistant Education* entitled "Cultural Perspectives," in which authors can publish opinion pieces, essays, and brief program descriptions about diversity initiatives in education. There is a tacit assumption that a culturally competent clinician will be more medically competent, i.e., provide more effective and comprehensive patient care. A 2004 study by Chang based on a Web search of PA programs' curricula found that 13% of programs had standalone cultural competency courses; 28% included cultural competency in other courses (e.g., Behavioral Medicine, Public Health, Issues in Health Care). The remainder of the PA programs appeared to include cultural content within other courses, but the specific content of those courses was not explored. Jacques (2004) argued that if PAs are to be competent primary care providers, the educational curricula should "include learning objectives that contribute to the development of those competences that will help

. . . bridge cultural and linguistic barriers" (p. 102). He described how cultural and diversity topics are woven throughout the PA curriculum in the Medical University of South Carolina physician assistant program. Addressing the dearth of cultural content in most physician assistant programs, Chang and Jacques both argued that, because there are consistent standards for biomedical core curricular components, the same consistency should be expected for a cultural competency core curriculum.

Although there is a paucity of research in this area, PA educational print and online media offer forums for opinion and discussion of the role of intercultural understanding for clinical practice. For example, *The Journal of Physician Assistant Education* addressed the cross-cultural clinical encounter with two brief pieces published in the "Cultural Perspectives" feature—Barker's (1999) tips and a presentation of a cultural history form (Sullivan, 2001). The former provided no critical context to a list of suggested cultural topics that might be relevant in the clinical encounter. The latter also lacked any critical content, but did correctly situate the cultural history as a subset of the patient's social history, which, in turn, is part of standard medical history.

Referring to the striking description of cultural conflict between Western medicine and the Hmong culture in *The Spirit Catches You and You Fall Down* by Anne Fadiman (1998), Parish (2004) concluded that clinical cultural competence has more to do with providing a space in the clinical encounter for a patient to express his or her beliefs, customs, and values than knowledge about specific cultures or ethnic groups—a sensibility or responsiveness pedagogy. While there were calls for a standardized cultural competency core curriculum for all PA programs (Chang, 2004; Jacques, 2004), there exists no specific recommendations for programmatic and curricular content.

Summary. The literature from the fields of medicine and physician assistant studies wrestled with the content of the cultural competency curricula. Arguments were made for the importance of appropriate modeling of cultural sensitivity to parallel the modeling of other clinical competencies. There was also discussion of a set of interpersonal or psychosocial skills that represent cultural competence, including the ability to communicate well, to show respect, to be nonjudgmental, and to negotiate effectively with patients in the clinical setting. On the other hand, factual knowledge about a group's or individual's values, beliefs, and behaviors, i.e., culture, were also considered invaluable in the provision of culturally competent health care. In the end, I found no consensus as how best to teach these two aspects of cultural competence.

Cultural Competence in Other Professions

Nursing Education. While the medical model of health care taught in medical and physician assistant schools was seen to approach cultural competence as a clinical adjunct that can address the inconsistent disease-related outcomes that might be due to ethnic and racial disparities in the provision and access to health care (Cardarelli & Chiapa, 2007; Fort & McClellan, 2006; Smith et al., 2007; Williams, 2007), the nursing profession has focused its education and research on the nurse–patient dyad (Brathwaite, 2005; Suh, 2004). In the last 20 years, the nursing profession has deliberately turned its attention to conceptualizing and contextualizing cultural competency in nursing practice (Brathwaite, 2005; Suh, 2004). Unlike the medical literature, which often focuses on particular diseases, conditions, or health status, nursing researchers and educators focused

on the psychosocial components of health care to develop nursing models for cultural competency.

At least three cultural competency models have been applied to develop appropriate nursing curricula, and all address the complexity of the concept. In their book *Transcultural Health Care: A Culturally Competent Approach*, Purnell and Paulanka (1998) proposed a comprehensive model covering both the unconscious and conscious components of providing culturally competent nursing while taking into account multiple levels of consideration: global, community, family, and individual. Their approach covered multiple aspects of culture, including beliefs and behaviors regarding heritage, spirituality, pregnancy, death, nutrition, work, family, communication, and health care. These nurse authors outlined a range of topics pertinent to medically oriented professionals such as physician assistants and physicians. However, the complexity of this model, including 12 micro-domains and four interacting macro-domains, would not be practical for direct clinical application, for example, during the history-taking portion of the clinical encounter.

Although originally devised as an organizing framework for the assessment of particular ethnicities, other models described by Lipson and DeSantis (2007) include a "Transcultural Assessment" model developed by Giger and Davidhizar (2003) that reflects the nursing profession's emphasis on interpersonal skills by elevating the cognitive and psychomotor skills needed to become culturally competent. They compared this to Campinha-Bacote's *Process of Cultural Competence in the Delivery of Healthcare Services* model (1999), which emphasized the health care providers' abilities, skills, and

attitudes to apply cultural knowledge. These and other models (Leininger, 1993; Leininger, 1998; Papadopoulos & Lees, 2002) offered complex and comprehensive, paradigms that are better suited to pedagogy and classroom discussion than to direct clinical application.

The nursing profession views cultural competence as a process in which the health care professional continually attempts to achieve the knowledge and skills to work with the cultural context of the individual patient, the family, and the community (Campinha-Bacote, 1999). The concept of stages or a continuum of competency was seen throughout the literature (Burchum, 2002; Cross, Bazron, Dennis, & Isaacs, 1998; Suh, 2004; Wells, 2000). Culturally competent nursing can also be appreciated in the context of understanding another human being, which can result in empathy and compassion with the "other." Kim Westerholm (2009) advanced the notion of the individual, who cannot be known as a conglomeration of ethnic characteristics but must be encountered as a dynamic personality.

In her model of cultural competence, Suh (2004) reflected the nursing profession's interest in self-reflection by emphasizing the professional's (i.e., nurse's) (a) abilities to resolve cultural disparities between nurses and their patients; (b) openness to accept non-judgmentally the reality of the patients' lives; and (c) flexibility to adapt to different situations and appreciate other cultures. This self-awareness was emphasized, as well, in many of the previously cited articles. It was also a component of qualitative nursing research, in which journaling of reflections, feelings, and emotions by students placed in community-based experiences with patients from diverse backgrounds becomes a data source (Anderson, Calvillo, & Fongwa, 2007; Lipson & Desantis, 2007).

In summary, the nursing model of cultural competence revolves around interpersonal relationships developed in the clinical setting that honor the patient's background, preferences, and heritage, while also requiring the nurse to reflect on his or her own background, prejudices, and worldview. Cultural competency in nursing is a process of educating empathetic and compassionate health care providers who open-mindedly partner with their patients. To accomplish this, nursing education looks to community-based experiences to foster students' appreciation of diversity.

Teacher Education. Previously, I reviewed of some of the service learning literature, which reflected a teacher preparation paradigm for collaboration between higher education and community-based organizations to provide experiential educational experiences for students and services for clients and constituents. This section explores the multicultural literature in teacher education scholarship, which also grew out of the mid-twentieth-century civil rights struggles, as one way to address racism against African Americans. The critique of multiculturalism in education has centered around its emphasis on respecting "ethnic, cultural, and/or linguistic differences," while often ignoring "any corresponding recognition of unequal, and often untidy, power relations that underpin inequality and limit cultural interactions" (May & Sleeter, 2010, p. 4). It is the debate among education scholars about the meaning, place, and implementation of multiculturalism in education as it applies to preparing teachers that enriched this literature review.

The term "multiculturalism" used in the teacher education most closely approximates the concepts of cultural competence in the nursing and medical professions

that has been discussed previously in this paper. The call for inclusiveness and parity in health care—cultural competence— paralleled a similar call in teacher education, which underscores principles of democracy and social justice in the preparation of students' becoming knowledgeable and engaged citizens:

> Multicultural education is a philosophical concept built on the ideals of freedom, justice, equality, equity, and human dignity as acknowledged in various documents, such as the U.S. Declaration of Independence, constitutions of South Africa and the United States, and the Universal Declaration of Human Rights adopted by the United Nations. It affirms our need to prepare students for their responsibilities in an interdependent world. It recognizes the role schools can play in developing the attitudes and values necessary for a democratic society. It values cultural differences and affirms the pluralism that students, their communities, and teachers reflect. It challenges all forms of discrimination in schools and society through the promotion of democratic principles of social justice. (National Association for Multicultural Education, para. 2)

Teacher education has had a longer history of systematically engaging with the issues of diversity, inclusiveness, and cross-culturalism to prepare teachers with work with students who come from increasingly diverse backgrounds based on socioeconomic factors, language spoken at home, race, or ethnicity (Abbate-Vaughn, 2006). Becoming a culturally competent teacher has, since the civil rights movement of the 1950s and 1960s, meant focusing on issues of social justice and democracy in the school, the classroom, and the curriculum. Addressing the diversity of the U.S. student population, teacher educators have advocated multicultural education (Banks, 1994; Delpit, 1995; Nieto & Bode, 2008), which prepares teachers to meet the needs of all students. Although there is vast educational literature on institutional, societal, and political inequities that impact schools and students, this review focused on teacher education and preparation to become culturally competent educators.

Banks (2001) outlined five dimensions of multicultural education: curricular content, knowledge construction process, reduction of prejudice, an equity pedagogy, and empowerment of the educational institution. The first three dimensions focused on the students' abilities to learn, gain skills, and modify their racial attitudes. In summary, Banks argued that an "equity pedagogy exists when teachers modify their teaching in ways that will facilitate students from diverse racial, cultural, ethnic, and gender groups" (2001, p. 13), thus preparing all students to become educated and participatory members of a democratic society. Other educators asserted that good pedagogy in our heterogeneous society is by definition multicultural, i.e., an education that addresses school and student underachievement by taking into account the students' diverse backgrounds and experiences in the development of their critical and analytical abilities (Nieto and Bode, 2008), while others questioned why multicultural or diversity education is often a separate track in teacher training (American Association for Higher Education, 2005).

The second concept that the teacher education has added to this discussion of cultural competence is that of social justice, which in health care literature was often couched as disparities in both health status and access to health services. In teacher preparation literature, the discussions went beyond universal access to education to address the social situations in which students live and in which schools are located. Field experiences and student teaching have both been the vehicles that have provided experiential opportunities for students to learn about inequities, the power of the relationship of teacher to student and to parents, prejudice and discrimination, and unequal access to resources. Reviewing the extant research on preparing students to teach

diverse populations from 1990–2010, Hollins and Guzman (2005) concluded that the studies show that activities such as field placements or student teaching placements in schools with students from diverse ethnic and socioeconomic backgrounds (i.e., different from that of the student teacher) have mixed results, which reflects the complex interaction among many factors: the education student's background and experiences, the mentor teachers with whom the student teachers work, and the content of the didactic portion of diversity training. The authors looked at both fieldwork experiences early in the education student's training (e.g., tutoring, placement in a social service agency, observation in a classroom) and student teaching practicums. The former may be equated to clinical service learning, while the latter is more akin to the clinical year of PA education. For example, studies of student teaching practicums reveal that experiences in urban schools and schools with a diverse student population can result in a more "complex understanding and awareness of cultural and experiential differences" (2005, p. 495) compared to students who were placed in suburban schools or schools with more predominately white and higher socioeconomic student populations. The research on the fieldwork experiences offered less clear benefits, including some short term reduction in prejudice; the ability to communicate and form relationships with those from different backgrounds, including their peers, mentors, and the children they worked with; and expanding their knowledge of and perspective on diversity.

The culturally competent teacher, therefore, would be described as a skilled professional who is knowledgeable about and responsive to his or her students' ethnicities and learning styles, adapting his or her teaching style and curriculum following a multicultural framework (Banks, 2001). In contrast a culturally competent

clinician would not fundamentally alter his or her medical practice based on the patient's ethnically influenced behaviors and preferences, but rather might work around those differences as long as the patient's behaviors are not harmful or interfere with a treatment plan. The culturally competent educator provides an equitable pedagogy through adapting learning strategies and materials to his or her students' backgrounds, which may include using language and understandings that reflect the students' home and community environments (Ladson-Billings, 1994). Similar to patient-centered care in health care (nursing and medicine), in which the patient's worldview and background is understood and honored, teachers who practice a student-centered pedagogy reflect a higher level of culturally responsive education that includes (a) establishing inclusion by treating all students equally, (b) relating instruction to students' previous knowledge and experiences, (c) enhancing meaning by fostering critical thinking about relevant events, and 4) engendering competence by using multiple tools to assess learning outcomes (Wlodkowski & Ginsberg, 1995). Delpit (1995) has argued that a culturally competent teacher is one who creates culturally competent students and citizens by facilitating the students' abilities to navigate the dominate culture while respecting the integrity of their familial and ethnic backgrounds.

The premise for social justice through education speaks to issues of class and power that are reflected in the preparation of teachers to educate students from diverse backgrounds. Teacher education scholarship has long addressed the power differentials that affect the teacher's ability to teach and the student's ability to learn, which goes beyond sensitivity to an individual's particular background, and even beyond appreciation of another's beliefs, values, and customs—the hallmarks of cultural

competence. As (Freire, 2000) wrote in *Pedagogy of the Oppressed*, the humanistic teacher (read: culturally competent) is one who engages and challenges adult students in such a way that learning becomes a reciprocal activity that fosters mutual respect and individual liberation. Freire's contention that education must be situated in the lived experience of the participants could be understood as cultural competency in that educational activities would be grounded in the students' beliefs, values, and behaviors. Whether this type of adult education would, in turn, foster a wider social revolution led by the oppressed classes, as claimed by Freire, is an unanswered question.

Scholars such as John Ogbu have identified pervasive, institutional, and societal racism against African-Americans as a prime example of why some minority students consistently underachieve. He argued that both academic and personal achievement are closely tied to class, caste, and ethnic community, but that teachers can offer students a path to success by creating trust, providing role models, creating culturally responsive curricula, and being open about involuntary minority students' possible ambivalence about educational success (Ogbu & Simons, 1998). Ultimately, Ogbu and Simon (1998) noted, "cultural-ecological theory places great weight on formidable nonschool community forces that affect school success" (p.183) that represents an arena in which educators have less power to effect change than they do in the educational institutions in which they work. In 1978, Ogbu contended that the only lasting resolution to blacks' academic struggles is abolition of the caste-like system in the United States, which initiated an uncomfortable debate

> about power, success, change and adaptation which people make when they move from one cultural context into another remains challenging today. The interplay of ethnicity, identity, belonging (or not belonging) and the desire to have a stake in

> the future is a complex process. These issues will continue to pose a challenge for all societies that attempt to meet the educational, social, economic and political needs of many communities and of different generations within those communities. (Bhatti, 2006, p. 134)

The same could be said for disparities in health care—that those disparities cannot be addressed without addressing social inequities. But, interestingly enough, that is not how the argument for cultural competency in health care is usually framed. Unlike the teacher education scholarship, which often engages head-on with the small picture–big picture controversy, the fields of medicine and nursing have focused on theoretical and practical solutions rather than political and philosophical debates.

In summary, the teacher preparation scholarship sampled in this section brings to the discussion several concepts largely glossed over in the cultural competency literature that comes out of medicine and nursing. Multicultural education focuses on the amelioration of societal inequities and injustices through institutional and professional attention to not only cultural topics such as language, ethnicity, and gender, but also social topics such as racism, class struggle, and power differentials within a community.

Conclusion

The themes that have arisen from this review of scholarship relevant to the education of physicians, physician assistants, nurses, and teachers included concepts of inclusiveness, diversity, and addressing social inequities. The literature review provided the following themes that are relevant to cultural competency, and which can be categorized within the spheres of awareness, knowledge and skills. The three

spheres provide a theoretical framework that encompasses the process of becoming a culturally competent health care practitioner:

- Awareness
  - Self reflection: recognition of one's own background, limitations and abilities
  - Curiosity: open to and comfortable with differences
- Knowledge
  - Ethnic studies: values, beliefs and behaviors for specific populations
  - Social justice: impact of disparities in health care
  - Democracy: health care policy
- Skills
  - Clinical dyad: inter-personal interactions, respectful communication
  - Respect: avoid making assumptions
  - Humility: self-reflection that leads to a more balanced relationship between clinician and patient
  - Ambiguity and uncertainty: ability to hold multiple considerations while providing patient care

The Methods section that follows describes the manner in which these themes and concepts are woven into and inform the design and methods of this ethnographic investigation.

Chapter III. Methods

Overview

I have employed an empirical phenomenological theoretical framework for this study, which takes a naturalistic, exploratory, and descriptive approach to understanding people's behavior by using inductive methods that provide the researcher access to the underlying meanings that guide those behaviors (Hammersley & Atkinson, 1995). Qualitative methods employed in this case study were informed by the principles of ethnographic research, including participant observation, focused interviews, and the gathering and assembling of data from multiple sources (Spradley, 1980; Lofland & Lofland, 1995). In defining the case studies, I determined that the unit of analysis is the individual PA expressing his or her experiences and perceptions. The case report format afforded me the ability to thoroughly appreciate emic perspectives of recently graduated physician assistants on the acquisition and definition of cultural competence during their education and beyond. In focusing on the each informant's reflections, experiences, and perceptions during clinical encounters with patients from diverse backgrounds, I sought to provide the reader a parallel "to actual experience, feeding into the most fundamental processes of awareness and understanding" (Stake, 2000, p. 442) through the use of naturalistic, ethnographic case reports.

As a participant observer, I assumed a dual role by working as clinician and educator, as well as researcher, but not contemporaneously. First, I participated with the all members of the PA class of 2010 in the provision of health care at HFC and thus observed their interactions with patients. I also participated in the education of the

informants, working with them as teacher, advisor, and mentor in all aspects of the physician assistant curriculum, including during clinical service-learning, in the classroom, and for skills laboratory sessions and OSCEs. The role of researcher came later as I sought to decipher the students' experiences at HFC and their understanding of the concept of cultural competence in the clinical setting. Using formal ethnographic interviews, I accomplished what Hammersley and Atkinson (1995) described as turning informants into participant observers by tapping "their knowledge about a particular cultural scene; [and] making use of their informal skills as participant observers" (p. 124).

The method employed in this study centered on a series of individual interviews of four recent graduates from RFUMS Physician Assistant Department class of 2010. Through exploratory, open-ended inquiry augmented by the informant's own analysis of written and audio visual materials from his or her years as a PA student, I sought to understand each research participant's story (Moustakas, 1994). As each interview built on the previous ones through open-ended questions and dialogue, I endeavored to derive the emic perspective of the informant's experiences, starting with the clinical service-learning sessions at Healthy Families Clinic and, to a lesser extent, Kids First Health Fair. Depending on whether the interviewee was job hunting or working as a PA, we expanded the range of topics to include an understanding of his or her values, beliefs, points-of-view, and perceptions (Morse, 1992), both as a recently graduated PA student and as a practicing clinician.

My data came from three sources: observational report forms (ORFs), observed standardized clinical encounter DVDs, and the individual interviews. The varied data

sources were complementary and helped further clarify, elaborate on, and explain the realities of their experiences. Through an inductive process I analyzed the data to determine what the CSL experiences meant for the informants in light of subsequent clinical experiences, as well in light of experiences they had prior to matriculating into the PA program. To provide thick description of these experiences, I collected rich data sets (Lofland & Lofland, 1995) through interviews that included the informants' reflections on their own ORFs and OSCEs. In addition, I subjected all the ORFs from the PA class of 2010 to text analysis, which served as both a basis for development of the interview questions and as a source of comparative data during the analysis of the interviews. The digital textual data and digital audio recording data were analyzed using qualitative software, ATLAS.ti.

Research Context

The informants were 2010 graduates of the Physician Assistant Program in the College of Health Professions at Rosalind Franklin University of Medicine and Science located in North Chicago, Illinois. At the time of the study RFUMS had about 3500 students, and was comprised of four colleges or schools: 1) The Chicago Medical School, 2) The College of Health Professions, 3) Dr. William M. Scholl College of Podiatric Medicine, and 4) The School of Graduate and Postdoctoral Studies. The College of Health Professions consisted of eight departments including Physician Assistant, Physical Therapy, Pathologists' Assistant, Medical Radiation Physics, Nutrition, Nurse Anesthetist, Psychology, and Interprofessional Healthcare Studies. The PA Class of 2010 consisted of 63 students, approximately three quarters of whom were female. This

master's level program attracted students primarily from the upper Midwest states of Illinois, Wisconsin, Minnesota and Michigan whose undergraduate majors were in the biological sciences. The ethnic and racial backgrounds of the students in the PA Class of 2010 were similar to other class cohorts—predominately Caucasian born in the United States. Upon matriculation the age range of students in this class were from 22 to 35 years old.

As described previously in the Introduction, the informants took part in several courses that included curricular content pertaining to interprofessionalism, service learning, cultural issues in health care, communicating with patients from diverse backgrounds, population medicine, public health, and psychosocial aspects of patient care. These interviewees were members of the first cohort of RFUMS students who participated in an interprofessional course that focused specifically on cultural issues in health care, *HMTD 501 Culture in Healthcare*. As first year PA students, the informants participated in clinical service learning activities: 1) one four-hour shift Kids First Health Fair in August 2008 filling a variety of roles from translation to registration, and 2) two four-hour shifts at Health Families Clinic between September, 2008 and May, 2009.

Researcher Identity

As both the researcher and the coordinator of the clinical service learning experiences that are under study, I am obliged to clarify my background and identity. During my 33 years as a practicing physician assistant, I have spent many years working with the medically underserved populations in a community health center, a migrant health center, school-based primary care clinics, and in private practice. My career path

has reflected the historical roots of the physician assistant profession to provide primary care in both rural and urban medically underserved areas. This contrasts to the present situation where physician assistants work in a wide variety of inpatient and outpatient settings, many of which do not necessarily provide medical care for medically underserved populations. The PA profession has gained wide-spread acceptance among by health care practitioners, patients, and the public compared to when I first started medical practice. Along with this change in acceptance and utilization of physician assistants has come the diversification of our society due to and increase in global and social mobility.

At the time of this study, I had been coordinator of the Healthy Families Clinic for about three years, and working at this clinic represented my only clinical practice. Primarily, I worked as a professor in the physician assistant program where the informants in this study were students. During my 11-year academic career in PA education, in addition to medical topics, I have developed and taught courses on population medicine and diversity in health care. The latter were informed by both my clinical practice and my background in cultural anthropology. I have created curricula that focused on disparities in the access to health care with an emphasis on the emic or patients' point of view.

My clinical work among people from diverse backgrounds, along with my formal education in anthropology, has led to an interest, as a PA educator, in the question of how PA students understand social and cultural dissimilarities between themselves and their patients. This led me to ask questions about how to present concepts of culture, diversity, and equity in the delivery of health care in both classroom and experiential settings. As

an anthropologist, I understood that to answers such questions, I would need to ask the students who had lived through the PA program in order to appreciate their perspectives on and reactions to the didactic and clinical experiences.

Informant Selection

The solicitation for volunteers occurred during the month before graduation of the RFUMS physician assistant class of 2010. A total of five students volunteered, but the interviews did not begin until after the informants completed their PA education and graduated from the program. One informant dropped out of the research after the first interview, because after multiple attempts we were unable to arrange subsequent interview appointments after the first session. Although each volunteer sent me a completed volunteer application (Appendix B) to provide personal background information, interviewees were selected in the order that they contacted me via an email response. This represents a purposive sampling, but not a typical case selection process. Because my research sought to explore the personal world views, beliefs, and perceptions underlying the informants' understanding of cultural competency , I required four volunteers that were selected from the members of the PA class of 2010 to develop an appropriate sample frame to provide thick descriptions. By interviewing the chosen number of informants, I hoped to create four cases that would be sufficiently diverse in terms of pre-matriculation experiences, age, and gender to address the research questions.

The following is an outline of the informant-selection process:

1. An email solicitation (Appendix A) for volunteers from the class of 2010 that included the volunteer application (Appendix B) as an attachment was conducted via RFUMS email until five volunteers were confirmed.
2. Exclusion criteria: Participants who as first-year PA students did not attend HFC at least once during the two required sessions.

   Rationale: A few students were not able to attend HFC for both mandatory clinical service learning (CSL) experiences due to cancellations of HFC on three occasions, due to inclement weather, and due to the closure of the building during an H1N1 influenza epidemic. These students were allowed to choose an alternative CSL experience.
3. The volunteers were contacted via email to confirm their interest in participation in the study, to request the volunteer application if not already returned, and to inquire about the best date and time to arrange the first interview.

Theoretical Considerations for Methods

Interview construction. Construction of the semi-structured interview process used in this research was informed by a social constructionist drive to "document the process by which social reality is constructed, managed and sustained" (Gubrium & Holstein, 2000, p. 487) and by an ethno-methodology driven by what Berger and Luckmann (1967) termed sociology of knowledge, which "must concern itself with the social construction of [everyday] reality" (p. 15). Using physician assistants as informants and delving into their perception of cultural competence in the clinical setting

allowed me, as the ethnographer, to "place specific encounters, events and understandings into a fuller, more meaningful context" (Tedlock, 2000, p. 455). This phenomenological study does not represent classic ethnographic research in which informants are observed and interviewed in their everyday home or work setting. The study does, however, yield the emic perspective of the informants, which is the ultimate goal of ethnographic research.

As Spradley (1980) noted, the formal ethnographic interview presents, in a predetermined time and place, an opportunity to explore in detail issues, questions, and topics of interest. A strictly structured interview format would not allow the spontaneity of individual interviewee reactions and interaction with the interviewer to respond to tangential or related topics generated during the sessions. However, an entirely unstructured format might allow participants to wander off topic and unnecessarily prolong the interview. Classifying the interview as primarily a qualitative research technique, Cresswell (2003) attributes the interview's usefulness to two factors: The interviewer has the ability to control the data gathering situation, and the interviewees can offer personal and historical background information during the interview session. Fontana and Frey (2000) also recognize that the ethnographic, semi-structured interview "can provide a greater breadth of data than other types, given its qualitative nature" (p. 653), which allows the informants' voices to be heard by the reader while recognizing the influence of the researcher "on what part of the data will be reported and how it will be reported" (p. 660).

The interview sessions were preset, somewhat directive, and guided by an outline of questions (Lofland & Lofland, 1995; Fontana and Frey, 2000) informed by the themes

and data that arise from my experiences as a physician assistant clinician and educator, as well as my being informed by a preliminary analysis of the aggregated ORF documents for the class of 2010. The list of questions used in the first interview was taken directly from the four research questions. The development of the interview outline for subsequent sessions followed a grounded theory approach by using "systematic inductive guidelines for collecting and analyzing data" (Charmaz, 2000, p. 509). Before Sessions 2, 3, and 4, I listened to the audio recording of the interviews, outlined their content, and noted questions to pose and issues to clarify based on interview content. Additionally, I searched the audio content for the cultural competency themes and terms (see below), references pertaining to the research questions, and new themes that arose during the conversations. In this manner, the research process was an emergently inductive activity, in which I went from "data, topics, and questions, on the one side, *to* answers or propositions, on the other, through intensive immersion in the data" (Lofland & Lofland, 1995, p. 184).

Additionally, I built the semi-structured interviews and developed the analytical framework based on the theoretical concepts derived from both the service learning and cultural competency literature that I had reviewed. Specifically, the interviews explored cultural competency themes such as ambiguity and uncertainty (Dogra et al., 2007; Dogra & Karnik, 2003), respectful curiosity (Dogra et al., 2007; Dogra & Karnik, 2003; Shaw, 2005; Taylor, 2003), social justice and democracy (Banks, 2001; Nieto & Bode, 2008), and the process of becoming culturally (and clinically) competent (Sullivan, 2001; Carlson, Tomkowiak, & Stilp, 2009). In addition, through the process of reflection on past experiences including, but not limited to, clinical service learning, the interviews

explored the importance of ethnic studies (Banks, 2001) and the clinical dyad or psychosocial aspects of patient care (Cauley et al., 2001).

Carrying out a series of four interview sessions of approximately 50–60 minutes with each informant allowed me an opportunity for in-depth interrogation of topics and for thick description based on the participants' opinions, descriptions, memories, and worldviews. Doing a series of interviews allowed me to return multiple times to themes and topics brought up in prior sessions to allow for elaboration and clarification.

Integration of the observational report forms (ORF). As an integral part of service learning, the reflection activity affords student an opportunity to critically reflect on their experiences in order to connect the actions with outcomes (Dewey, 1990). It serves a variety of functions for graduate-level students in the health professions: (a) to share experiences among participants, particularly those from different health care professions (Fahringer et al., 2000); (b) to consider ethical implications of the project (Saltmarsh, 1997); (c) to emphasize social responsibility and leadership in civic affairs (Knight et al., 2007); (d) to assess the impact and meaning of the experience (Elam et al., 2003); and (e) to express compassion and empathy toward patients (Knight et al., 2007).

The ORF was deliberately developed as a reflection instrument for CSL in order to introduce physician assistant students to the ethnographic skill of systematic observation in a social setting, specifically a health care clinic. They were asked to describe aspects of both the physical space and social interactions at HFC. The template (Appendix C), provided as a Word document for the students to fill in after completing the clinical service learning, is a hybrid of field notes and personal journals, which I

adapted from Spradley's (1980) descriptive analytical matrix with the intent to allow PA students to hone their observational skills while working at Healthy Families Clinic. Although derived from ethnographic research methods, the ORF did not expressly direct students to comment on specific ethnic or cultural topics.

The data set for this study contained two sets of ORFs (n=105) from each student in the PA class of 2010 with the exception of those who did not attend both required clinical service learning sessions. The analysis of the textual data was accomplished by techniques employed by anthropologists for ethnographic field notes (Spradley, 1980; Lofland & Lofland, 1995) and other qualitative researchers (Ryan & Bernard, 2000): creating codes and memos from the data using ATLAS.ti qualitative software.

Integration of the observed structured clinical examination (OSCE). Whether the acronym OSCE stands for objective structured clinical examination or for observed structured clinical examination, it represents a controlled simulation of the clinical encounter and has become an accepted evaluation instrument for assessing clinical skills and knowledge in physician and physician assistant education (Carlson et al., 2009; Duerson & Multak, 1999; Gregg & Dehn, 1999; Luce, 2001). The OSCE consists of a standardized patient (SP), sometimes called a professional patient, who has been coached and rehearsed to act as a patient with a defined medical condition and a consistent health history. The PA student is given instructions about the case, depending on what aspect of patient care is being evaluated (e.g., history taking, physical examination skills, and/or diagnostic abilities). There is a set amount of time for the encounter, and students may be

asked a series of questions about the history, physical examination, or diagnosis upon leaving the exam room.

In some institutions the SP grades the student, in others the exam is observed by faculty in real time through one-way glass or asynchronously via a video recording. OSCEs can be used to evaluate clinical readiness in the didactic year of PA education by offering a controlled simulation of the clinical encounter. It is also used in the clinical phase of PA education to evaluate the progress students are making during clinical rotations in their skills, knowledge, organization, and professionalism through observation of history taking and the physical examination, as well as testing of diagnostic acumen and abilities.

The OSCE is understood to be one tool in the PA education evaluation kit, along with tests, written case studies, faculty assessment of clinical and examination skills, and papers written on clinical topics (Gregg & Dehn, 1999). The OSCE provides a venue for faculty observation and evaluation of interpersonal skills, communication abilities, and cultural sensitivity in a controlled simulation of the clinical encounter. When appropriately trained, the SP can provide evaluations that represent a reliable and accurate assessment of students' performance (Carlson et al., 2009).

The OSCE scenario used in this research centered around a standardized patient who was presenting a history that contained culturally specific beliefs and behaviors (Nigerian immigrant living in Chicago) that influenced his use of medications, dietary intake, and commitment to adhering to the recommended treatment regimen. As with the ORF, the OSCE provided a focus for one or more of the interview sessions. I viewed the OSCE with each informant, who reflected on his or her cultural, psychosocial, and, to

some extent, clinical competencies during the exercise and what he or she thought he or she could have done differently, particularly in terms of cultural competency. I concentrated on how the informant reacted and interacted with the culturally specific worldview of the SP, and how his or her performance during the OSCE was consistent or inconsistent with other statements he or she had made during this and other interview sessions. In addition, each informant and I reviewed the SP's evaluation of the informant's OSCE.

Research Design

Interviews. Each informant participated in a series of four interviews of approximately 50–60 minutes in length. After the first interview, subsequent interviews were arranged at the end of the interview session based on mutually agreed on dates and times. As much as possible, I tried to accommodate the interviewee's schedule. As previously noted, each informant chose a conveniently located venue in which he or she felt comfortable talking with me.

The following is an outline of the method for organizing and performing the interviews.

1. Each volunteer was interviewed on four separate occasions.
2. Each volunteer completed and signed the RFUMS informed consent form at the first interview.
3. The interview sessions lasted 50–60 minutes.
4. The venue for the face-to-face interview was chosen by the informant. In a couple of instances, the first place we met was not suitable to record the interview due to

high levels of ambient noise. In those cases, I asked the volunteer to choose another place that was quieter and provided more privacy.

5. Each volunteer chose what name was to be used in the research documents.
6. The first interview covered the four research questions. We returned to these questions as appropriate throughout subsequent sessions:
    - During their CSL how do PA students understand the patients' and their families' experiences at HFC?
    - What do the PA students discover about people with backgrounds different from their own during their CSL?
    - What influence does the CSL experience have on the PA students' clinical practice during their clerkships?
    - How does this CSL experience impact the PA students' perception of their own cultural competency?
7. As appropriate, each interview explored the following cultural competency themes: ambiguity and uncertainty, humility, respect, curiosity, social justice, democracy, process of becoming competent, self-reflection, ethnic studies, clinical dyad (personal interactions, psychosocial aspects of care).

Data collection process.

1. For each informant, I followed a similar progression during interviews and from one interview session to the next: Each interview of 50-69 minutes was audio recorded using an Olympus digital recorder.

2. After each interview the Windows Media Audio (WMA) files were downloaded to a password-protected computer.
3. The WMA audio files were copied into the ATLAS.ti program, which was stored in the same password-protected computer.
4. All data files were backed up daily.
5. Before the subsequent interview, the audio was reviewed, notes taken, themes highlighted, and questions developed for clarification and expansion.

Interview 1.

1. Introductory activities: I outlined the research process for the informant, including use of the ORF and OSCE DVD during Sessions 2 and 3. I answered any questions about the consent form and the research project.
2. The informant read and signed the consent form. I offered the informant the options of either using his or her own first name or choosing a pseudonym to use in the research documentation. Semi-structured interview used during Interview 1:

- What surprised you during your first time at HFC?
- What surprised you during your second time at HFC?
- How do you think the patients (children) experienced their exam with you?
- What did you observe when patients were being care for by others?
- How do you think the adults experienced their visit with you?
- How did the CSL experience influence your choice of clinical rotations? What other factors influenced your choices?
- What are the factors that make a clinically competent PA?

- What is cultural competency and how does it apply to the clinical setting and competent medical care?
- How do your CSL experiences influence how you interact with your patients?

3. At the end of the session, I asked if the volunteer had anything to add to the interview.

Interview 2.

1. I investigated topics and themes derived from Interview 1.

2. I provided the informant with copies of the ORF from both CSL sessions at HFC. The informant was given time to read and review the documents.
3. We then discussed the ORF in light of our previous conversations and with the research questions and cultural competency themes in mind.
4. At the end of the session, I asked if the volunteer had anything to add to the interview.

Interview 3.

1. I investigated topics and themes derived from Interviews 1 and 2.

2. I used a laptop computer to play the DVD of the OSCE.
3. The informant and I watched the OSCE together.
5. We then discussed the OSCE in light of our previous conversations and with the research questions and cultural competency themes in mind.

6. At the end of the session, I asked if the volunteer had anything to add to the interview.

Interview 4.

1. I investigated topics and themes derived from Interviews 1, 2, and 3
2. I asked if the volunteer had anything to add to the interview.
3. At the end of the session, I thanked the informant for his or her time and effort. I then explained that if I had any questions or needed clarifications, I would contact him or her via phone or email.

Data analysis. I used the ALTAS.ti qualitative research software as a tool to organize, manage, and retrieve text and audio data generated by the ORFs and the interviews, respectively. The text and audio data were entered into the program, which had been uploaded onto my computer. The textual data set was entered as a single hermeneutic unit (the ATLAS.ti term for data set) in order to facilitate exploration of themes in all the OFRs. I could differentiate first ORF from second ORF by the number assigned to each primary document. I could also recognize an individual student's ORF using the initials that I had assigned to the primary documents (ORF 1 and ORF 2). In ATLAS.ti parlance, the primary document corresponded to one ORF uploaded from a Word document. Each informant's audio data (approximately 200 minutes) was uploaded as a single hermeneutic unit, so I ended up with four separate hermeneutic units, with one primary document for each interview session.

After populating ATLAS.ti as described above, I entered the four research questions as memos and the cultural themes as codes for both textual and audio hermeneutic units. Because my data analysis followed an inductive process, I also added memos and codes based on the content of the data set. This involved reading each ORF and listening to each interview multiple times and assigning codes or memos to segments of the data. I created discrete pieces of the text or audio by creating, in ALTAS.ti jargon, quotations. It was these quotations that were subjected to coding.

Interviews. The analysis of the approximately 800 minutes of audio from the conversations with the informants followed an inductive process, which started with listening to each interview session and marking quotations using the ATLAS.ti tools. During a second listen to each interview, I assigned the cultural competency themes as codes and the research questions as memos to each quotation. More than one code and more than one research question could be associated with each quotation. I also created new codes and memos as I listened to the conversation based on emerging topics and themes.

The following is an outline of the analytical process used for the interview data:

1. I analyzed one informant case at a time.
2. I listened to and analyzed each interview in the order in which they were completed.
3. I marked quotations into discrete snippets of each interview lasting 15–150 seconds in length.
4. I created codes and memos based on:
    - cultural competency themes;

- research questions;
- concepts that arose from the literature review, including those pertaining to service learning;
- themes generated during interview;
- topics that arose based on the informant's volunteer application;
- themes that arose from the analysis of other informants; and
- themes that arose from the ORF analysis.

5. Using the codes and memos, I was able to identify quotations that would appropriately support the narrative that constitutes the Results section of this study.
6. Transcription of audio recording:
   - I listened to the appropriate sections of the recording.
   - I hand-wrote the informant's words in a notebook.
   - From the handwritten transcript I typed the quotation into this document.
   - In transcribing the informants' audio recording, I have quoted each interviewee precisely, except to have taken the liberty to delete repetitive interjections and phrases such as "kinda," "sort of," or "you know."

Observational report forms. I submitted the ORFs (n=105) to text analysis using the ATLAS.ti software to provide an overall description of the PA class of 2010's attitudes, observations, reflections, and thoughts about their two required sessions at Healthy Families Clinic. This information was used in two ways: in the development of the guides for each semi-structured interview, and to link ORF quotations with similarly coded quotations from the informant's interview.

The following is an outline of the analytical process used for the textual data:

1. I analyzed all primary documents (i.e., observation report forms) in one data set.
2. I marked quotations using codes and memos based on cultural competency themes and research questions.
3. I marked quotations using additional codes and memos based on:
   - concepts that arose from the literature review, including those pertaining to service learning;
   - themes that arose from the primary documents; and
   - themes that arose from analysis of the interviews.
4. Using the codes and memos, I was able to identify quotations that would appropriately support the narrative that constitutes the Results section of this study.
5. I transcribed the text by cutting and pasting it from ATLAS.ti into this document.

Conclusion

Figure 1 illustrates the association among research activities and the data sets that I used to explore the informants' perception of cultural competence within the context of the clinical encounter, also taking into consideration other related competencies such as clinical and psychosocial. By using the construct of cultural competence within a particular clinical setting, i.e., Healthy Families Clinic, this research examined the informants' encounters with patients from diverse backgrounds (the "other") during clinical service learning sessions, both during other experiential learning settings and clinical encounters throughout their formal education, as well as into their nascent careers as physician assistants. Using the information gathered from the interviews and the data

from the ORFs, the next chapter will illustrate through case studies the ways that the four informants recognized and expressed their understanding of the intersections between cultural, psychosocial, and clinical competence as they responded to the research questions and wrestled with the cultural competency themes.

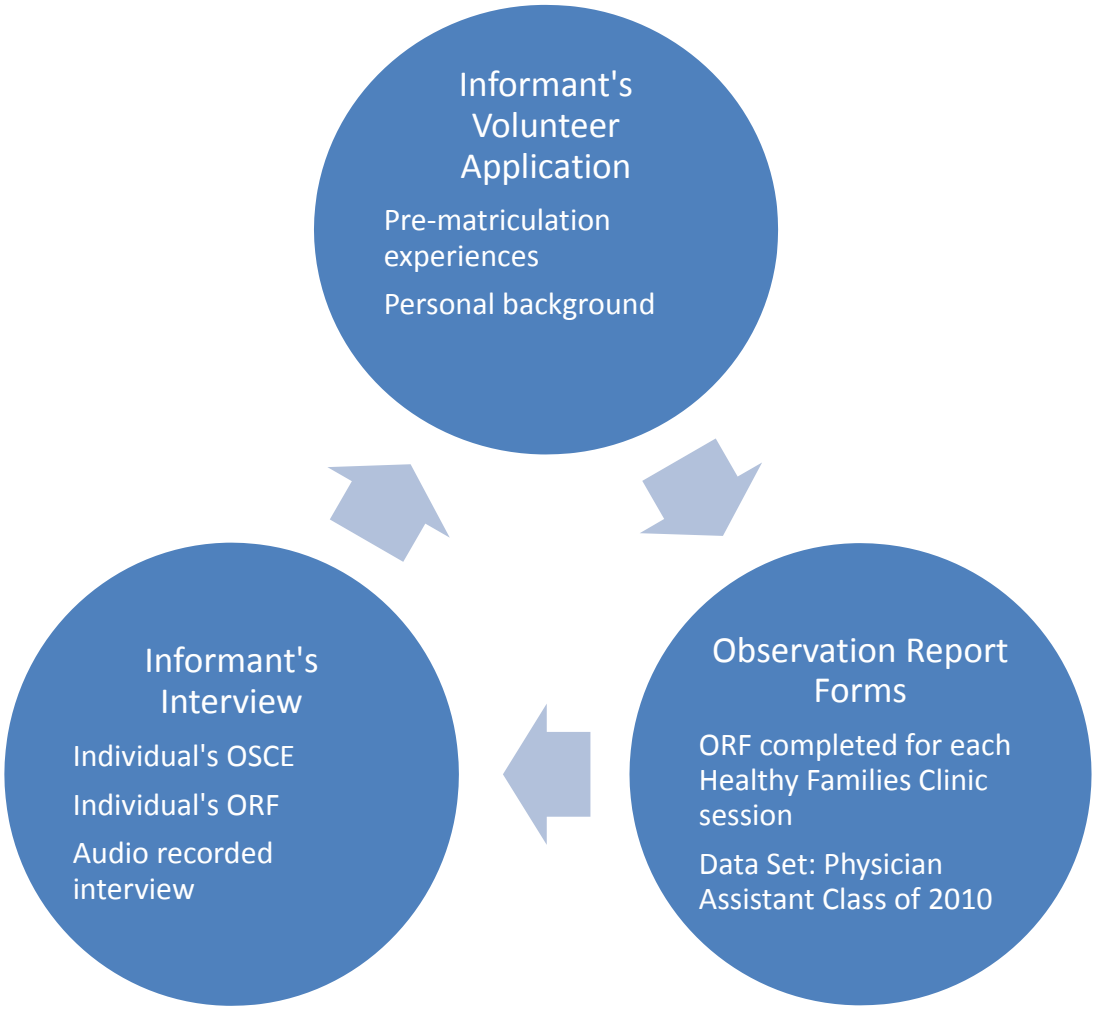

Figure 1. Elements of Data Collection.

Chapter IV. Results: Four Case Studies

Overview

This section lays out the contents of the interviews in a narrative format. It is organized by individual informants in order to provide a rich portrayal of each. During the interviews, the informant and I reviewed their observation report form and viewed a DVD of his or her OSCE session from the didactic year. In addition, comments from classmates' ORFs were woven into the narratives to connect the informant's statements to those of his or her peers.

In addressing the four research questions, the first round of interviews began with the students' initial reactions to Healthy Families Clinic and their memories of HFC patients, parents, and guardians, using questions from the semi-structured interview outline (see Methods section). I found that these straightforward questions about the informants' clinical service learning experiences and other aspects of their education laid a foundation for further exploration. In subsequent interviews, we revisited the questions but expanded their reach to include experiences before matriculation and after graduation from the PA program. We followed the themes and stories that emerged from the HFC experiences to explore how they played out during their clerkships, and, when appropriate, in their experiences working as physician assistants in clinical practice. With each informant, I explored his or her travel, educational, and health care experiences prior to PA school, focusing the discussion on how those might have influenced clinical and career decisions.

Because I had been the informants' instructor and the coordinator of clinical service learning during their two years in the PA Department, we shared knowledge of the curriculum and the workings of the Healthy Families Clinic. The Kids First Health Fair was their first clinical service learning requirement, so we frequently referred to their experiences at this community-staffed event, which provided free back-to-school services and items such as physical examinations, immunizations, nutrition counseling, backpacks, books, and dental screenings. With this common knowledge of the courses that the informants took as students, I was able to explore other influences on their perceptions of cultural, psychosocial, and clinical competence. In addition, we mutually understood the interprofessional nature of HFC, with both psychology and physician assistant students providing free services to the community, as well as the necessarily slower pace of a clinic where students are the health care providers.

Recalling the portions of the PA curricula that might have addressed topics of cultural competence, I interrogated the informants about whether it could be learned and, if so, how they might teach cultural competence. This was one technique that I used to explore the informants' perception of their encounter with the "other," i.e., patients whose backgrounds, ethnicity, or socioeconomic status are different from theirs. Another way of discovering the informants' ideas about their own cultural competence was to ask whether they had seen a clinician model cultural competence, as well as psychosocial and clinical competence.

To illustrate the advantages of the OSCE in guiding some of our conversations, a description of the scenario that they encountered would be useful. The standardized patient was an African-American actor who portrayed an adult patient of Nigerian origin.

The back story for this case, unbeknownst to the student, was that the patient immigrated from Nigeria as a young child along with his parents. They settled in the Chicago area; where they live together while the patient worked as a janitor for two different employers. The clinical case that this SP presented was that of a patient returning to a clinic for a follow-up visit after previously being diagnosed with type two diabetes mellitus and having been prescribed an oral medication to regulate his blood sugar. This was a scheduled visit in which the student was to take a focused medical history about how the patient was doing with his new medication. The SP evaluated each student after the session. The assessment consisted of check-offs for appropriate medical history, e.g., patient's symptoms, side effects from the medication, social history, barriers to taking the medication, dietary intake, exercise, and stress factors. The ways the students interacted with this patient provided fodder for rich discussions about cultural competence in the clinical setting.

Another source of prompting for the interviews was the ORFs. These reflections not only served as a focal point for discussion of cultural competence, but it also helped the informants recall events and observations about their time at HFC. Because the ORF was not designed to specifically describe patients' backgrounds, it provided more insight into the informants' and their classmates' understanding of cultural and social issues but did not consistently recall specific cross-cultural interactions. In the end, the ORF provided a way to connect the individual informant's experience at HFC with those of their peers in the class of 2010.

Case 1: Kristy

Background. Kristy described herself as a young Caucasian woman who grew up in a middle-class home in an ethnically integrated university town with elementary school classmates and friends who came from a variety of socioeconomic situations, ranging from those who lived in subsidized housing to others who were sons and daughters of university professors and physicians. Her experiences before matriculating into the physician assistant program included working as a medical assistant in several nursing homes and at student health services at a Big Ten state university. She also travelled extensively, including two trips to France and family vacations in the Caribbean, Mexico, and Canada, and around the USA. Kristy studied French in high school and college and has a working knowledge of medical Spanish.

The four interview sessions took place over a six-week span while Kristy was studying for and successfully completed the physician assistant certification examination. The interviews were conducted in her home with only her cats as onlookers. At the time of the interviews she was looking for her first position as a certified physician assistant in the specialty areas of general surgery or cardiovascular surgery.

To address the four research questions, my interviews with Kristy began with her initial reactions to Healthy Families Clinic and her remembrances of HFC patients and their parents. We then followed the themes and stories that emerged from her HFC experiences as they played out during her clerkships, as they reflected her past experiences, and as they informed and were informed by her worldview. These

reflections on clinical service-learning at a school-based pediatric free clinic offer alternative insights that both contrast and complement Kristy's account.

Interviews.

1. **During their CSL how do PA students understand the patients' and their families' experiences at HFC?**

When we explored Kristy's perception of the parents' and pediatric patients' experiences at Healthy Families Clinic, she remembered that the parents were impressed and grateful for the services they were receiving; she stated, however, whether they are grateful or not "doesn't affect the health care that I offer." Although she thought that it was hard to expect a lot from free care, she described the parents as being grateful that the health care "was free that they were getting health care and that they were getting access to it [health care]."

Kristy was appreciative of the parents and families who she saw as acting graciously while seeking and accepting health care from PA students who might not have a sufficient level of clinical knowledge or skills. She noted that HFC patients "did not take it [health care] for granted," compared to patients she encountered in "white suburban situations, where they just didn't want to interact with students." Kristy saw Healthy Families Clinic as a place where students could practice their cultural sensitivity and interpersonal skills by "getting to work with different people" in a real clinical setting while observing the clinical faculty set the example of how to interact "with cultural awareness."

These same two aspects of gratefulness were also reflected in the ORFs, as students reflected on the feelings and emotions of the patients and their parents/guardians. For example, one student noted, “The patients and family members were very patient and appeared appreciative of the services. The wait time was about 30–40 minutes . . . but the families did not appear annoyed.” Several students wrote about their own appreciation toward “cooperative patients and the opportunity to perform physicals and deliver vaccinations with the comfort and supervision of a PA, doctor, and resident.”

Focusing on the HFC pediatric patients that Kristy worked with during her first year in the PA program, she remembered them as generally accommodating during the intake and physical examination, but they were anxious about receiving immunizations. Kristy learned that although “we tried to sooth them, they just couldn’t get over it . . . . [So] eventually they just had to get calm enough for us to give it [the shot].” Having little exposure to taking care of children before beginning PA school, these clinical experiences helped prepare her for her pediatric clerkship at Intervention Arms (a PA-run private clinic serving the same medically underserved community in Waukegan and North Chicago).

Although Kristy understood that community members accessing free medical services at HFC might be medically underserved, this did not come up as a topic in any of the interviews, and I did not delve into this topic with her. She did note that families who had just moved to the area used HFC services in order to get into the school system as quickly as possible, sometimes even before Medicaid could be applied for or received. This perception was shared by her classmates, who understood that one goal of the HFC

project was to provide free, easily accessible health care: "[The clinic] provide[s] free health care to children with low economic status." Another student reflected that "This was a very rewarding experience because we were providing health care to people who otherwise could not afford it."

Kristy perceived that the parents at HFC were appreciative of the free school physical examinations and immunization that helped to get their children registered for school or keep them involved in school activities and sports. In turn, she was appreciative of the gracious manner by which the people accessing the HFC services accepted medical care from students.

2. What do the PA students discover about people with backgrounds different from their own during their CSL?

From Kristy's point of view, the most culturally distinct group of patients at HFC was Hispanic, although community members of African-American and European heritage also availed themselves of the free, accessible medical care. Although she recognized the diverse backgrounds of HFC patients and families, she did not "see any differences" between the behaviors, interpersonal relationships, or beliefs within these families and the relationships within her own family. She commented that many of the Hispanic families "had been in the United States for a long time, but they had just moved from some other area of the country." Among those families, she recognized different levels of acculturation. For example, she described differences within the same family, remembering one she had dealt with a lot: "They had moved from Colorado, but they had

been there a long time. The father still didn't speak very much English, but all the kids spoke perfect English and very good Spanish as well."

She felt that the children's reactions to the medical visit at HFC were not much different from those of any other pediatric patients, despite the atypical setting—holding a medical clinic in Head Start classrooms. The lack of private, dedicated spaces for medical activities such as physical examinations, immunization preparation and administration, and consultations with patients and their families did result in some of the children's being more scared about getting vaccinations as compared to her pediatric clerkship clinic, where "sometimes the parents did not tell them [about getting a shot] . . . [and they were] a room by themselves . . . [and they] don't usually see [other] people getting immunizations." She realized that this might be due to the HFC layout, where children could see the immunizations being prepared and could watch other children receiving them, which wouldn't be true in a regular medical office.

It was during her CSL experiences at Healthy Families Clinic that Kristy first realized the importance of speaking Spanish in clinical practice. She noted that although she only had one semester of college Spanish, she began practicing her medical Spanish at HFC, and by the end of her clinical year in the PA program she "could get through a history and physical in Spanish." She was called on in her pediatric clerkship "to do the best you can" speaking Spanish with the patients, because there were not enough translators. In addition, during her emergency medicine clerkship she was called on to translate for other clinicians when there was a need to get quick history in an emergent situation. In fact, language was the primary manifestation of ethnic diversity as she remembered it; within some family groups the "person who spoke English took the

lead . . . [while the] non English speaking would hold back." This also affected the parent–child dynamic, when "even if the English speaker [was] younger, sometimes they would let them answer all the questions in the history. If you wanted to get to know [the parents] you really had to coax them." In additional comments on children's translating for their parents, Kristy noted that the children would "simplify the language a lot of times. I could sometimes understand when they [were] not being translated perfectly." In that case she knew enough Spanish to "ask exactly what was that?" and to obtain a more accurate history or more precise answers to her questions.

Throughout our interview sessions, Kristy used language as a proxy for cultural differences, as did many students in their ORFs, who referenced language barriers and encountered the need for translation during their clinical service-learning experiences at HFC. For example, one student juxtaposed the inability to speak English with poverty: "In addition I got to practice my Spanish since the patient I saw was only Spanish speaking. The more I get a chance to work with lower income communities the more I enjoy it." Describing a second CSL session at HFC, another student noted, "This was my first time both doing a physical exam on a pediatric patient and on a patient that speaks little English. I thought that this was great experience. It has helped me learn how to interact with children during an exam and how to communicate with someone through a language barrier." Another student described the same phenomenon quite eloquently with a more self-reflective bent:

> Ironically, the patient's mother did not speak English and I was the only one in the room that spoke Spanish. I then became the official translator to the mom in order to help the resident do the exam. It made me realize how important knowing Spanish is going to be for my clinicals, as there seems to be quite a few providers that cannot speak it. While my Spanish is not perfect, I can get the point across

> and understand what they are saying. I found that to be a neat observation because there were close to seven of us in the room and none could translate for the mom.

Cultural, ethnic, and experiential differences were expressed often by students reflecting on their two CSL sessions at HFC. Unlike Kristy, her classmates were more explicit about the diversity of the patient population beyond just their language spoken. These students typically referred to people's ethnic background, country of heritage, immigration, and level of acculturations in the following ways:

- "I enjoyed this experience because I was able to interact with the diverse community."
- "I also decided that I need more exposure to Spanish speaking people so I can be more prepared for my rotations."
- ". . . about 8 families, mostly Hispanic and a couple African American. Some of the families did not speak English."
- "One family had just moved here from Puerto Rico a few days ago and all of the children needed to be caught up with their vaccines to start school."

As noted previously, Kristy's ability to communicate in Spanish was an asset at both the HFC session and during her second-year clinical rotations, but she expressed modesty in this ability:

> When I speak Spanish and when I do go through my history and physical exam, I tell them [the patient and parents] that I know my Spanish is not perfect and thank you very much for putting up with it. Very often times they are extremely nice about it. One person said 'no, no your Spanish is perfect.' [I thought] that I know that you are lying because my Spanish is awful.

In a number of responses during our first interview, Kristy addressed the importance of being curious and humble when the provider is confronted with people

from different ethnic groups, which may be greeted by encouragement and kindness from the patients:

> I know I definitely don't know all the intricacies of different culture. If I do know something about it, then I sometimes try to be aware of that [particular belief or custom] . . . . I just like to be very communicative with everybody and let them know that I am trying.

Following up on this theme in a subsequent interview, I asked Kristy to describe how she might learn about an unfamiliar ethnic background of one of her patients. She reached back to the process she went through learning French language and culture through classroom studies and two short trips to France. This provided an approach to understanding any culture: "As long as you've done it one way, you're aware of the different things [that] you should be attentive to—there are different foods, different ways of interacting." She went on to explain that she would appreciate the "sort of things to glean from other cultures when you are exposed to it [another ethnic group or culture]," even without much specific knowledge of beliefs, behaviors or customs. Kristy related that the appreciation and understanding of particular cultural details is a universal sign of respect.

One of her classmates reflected a similar humility and appreciation for the acceptance of medical care from students: "I had feelings of gratitude when the patients were patient and kind despite my obvious lack of knowledge." Both this student and Kristy understood the patients had a choice about accepting care from PA students and were grateful for their patience with and understanding of the slow pace of the medical care as students learned as they worked.

Again mentioning language as one important way to understand an ethnic group, Kristy explained that "if you can speak a person's language, you should go ahead and try. 'Cause then they know that you respect that part of [their background]." When confronted with the question about how she would show this type of respect for a patient whose culture she was not familiar with, Kristy stated that "you have to do the best you can, because you won't know if that [any given behavior, wording, etc. on the part of the clinician] is respectful to that culture."

Although the background of HFC patients and their families were ostensibly different from Kristy's, she said that familial interactions and expressed attitudes were similar to her own. She focused on language as the primary barrier to understanding and communicating with some segment of the people HFC served.

3. What influence does the CSL experience have on the PA students' clinical practice during their second year and beyond?

In exploring how working at Healthy Families Clinic impacted the abilities to practice as a physician assistant during the clinical year and beyond, Kristy identified three spheres of competence: clinical, cultural, and psychosocial. This section will address the intersection of clinical competence with both psychosocial and cultural competence in addressing the research question about clinical practice. Kristy and her fellow students understood the centrality of learning medicine and mastering clinical skills to their success in the PA program. This understanding formed the lens through which all educational experiences were viewed. Kristy understood that the process of becoming clinically competent included mastery of the didactic material as well as the

clinical application of that knowledge, stating the importance of repetition and patterns in "getting comfortable with the material, what your diagnosis is, and what you're looking at . . . finding a formula, honestly, to do things [diagnose and treat]." Later she admitted the complexities involved in the patient encounter describing the "skill [developed] over time to filter out what is important and your thinking about [the presenting complaints]":

> [There are] so many things to think about. You're trying to make the differential diagnosis in your mind, and at the same time you're trying to remember what questions to ask, and you are trying to listen to them [the patient] to really catch everything that they are saying. It's a lot to do at once.

In addition to HFC, Kristy felt that the OSCE also provided a venue to begin the process of attaining clinical competence by forcing her to "start doing what we're going to doing all the time":

> And it's not just sitting in a classroom. It's exactly what we do in our job. It's important to gain that [medical] knowledge, but hands-on is definitely the most challenging, but also the most pertinent to the job [of a clinician].

Although we focused most of our conversations on cultural matters and interpersonal abilities, Kristy's experience echoed what other students described about their experiences at HFC—that it was their first patient interaction as a PA student. The students' responses in their ORFs also reflected in what way the HFC provided the first opportunity to integrate medical knowledge and skills in an actual pediatric clinic setting. Typical comments were:

- "I also enjoyed learning to take blood pressures a little better and taking the height, weight, and temperatures of the students."
- "We began to learn more about the normals for a pediatric population."

- "I felt a bit clumsy with taking vital signs, as it was with pediatric cuffs and physical exam skills still feel so 'new,' but eventually I got the hang of it."

Although the focus of our interviews was not primarily on the process of becoming clinically competent, some examples of clinicians who modeled clinical competence did arise. Kristy discussed how she learned clinical skills and procedures by observing and being trained by PA faculty at HFC and, later, by her clerkship preceptors. One of the clinical skills that she observed was how a preceptor respectfully but firmly handled the situation in which a patient was questioning the medical treatment plan: "They'll lay down the law—[saying that] you can follow what we do here, but I'd be more than happy to refer you to somebody else. So they give them the options." This happened when a patient's spouse refused to allow medical residents to manage her husband's care in a teaching hospital where that was standard operating procedure.

Citing another instance when clinicians melded respect and curiosity in the face of uncertainty or ambiguity of a medical diagnosis, Kristy admired the manner in which her internal medicine preceptors tackled a tough clinical case. She noted that they "took a lot of time. It's a big process. They were definitely interested [in the process of sorting out a complex medical case] and definitely had different opinions about a tough case;" She said that they often consulted other clinicians for assistance. She acknowledged that uncertainty in the clinical encounter is particularly problematic "when you are trying to figure out a new differential [diagnosis] . . . when [the patient is] having new signs and symptoms."

Kristy considered the concept of developing professional distance integral to being clinically competent in the face of stressful, complex, and/or emergent situations,

sometimes necessitating ignoring the patient's social background (e.g., ethnicity, religion, socioeconomic status, gender, sexual orientation):

> I talked to this family in the ER [whose] young child was having an acute emergency. And they were very worried about him . . . . They said to us "I don't know how you can do this every day with children like this—having life-threatening moments." And that made me think about how we have these protocols to follow. And we're just trying to do our job—first to treat everything. There is an emotional aspect to it, but it usually doesn't seep in until later . . . . You're just doing the procedural things, step-by-step, and it's a formula. So it makes it easier, I suppose [to use this also] when dealing with patients . . . that are different than you. You follow that same professional formula [take a history, do a physical examination, develop a differential diagnosis, develop a working diagnosis, and develop a treatment plan].

Because interacting respectfully with patients is part of competent clinical care, we discussed how that is manifested during the clinical encounter. When I asked how a PA would show respect toward a patient during a medical visit, she stated that clinicians

> definitely need to listen to [patients] while they [the patients] are talking, and not cut them off. Or even sometimes we have busy schedules, but we don't want to make it seem like they [the patients] are not important. Taking social cues, you want to respect [the patient].

Then Kristy hesitated and exclaimed, "It's a hard question!" and continued:

> You can kind of tell if people want to talk more about something or less. Sometimes we have to ask very personal questions and to do that in a respectful manner you'd want to take your time with that, [and] be aware of the ways you ask questions.

She went on to explain that taking a thorough social history in the emergency department required her to ask patients about their use of illicit drugs, alcohol, and tobacco, which could cause confusion or seem discourteous. For example, elderly patients might answer the questions about drugs saying "Oh yeah, I take my medicine." Kristy explained:

> I would sometimes preface those more personal questions with [the statement that] these may sound like silly questions, but we have to ask everybody; and I really do need your truthful answers. So then I would go through all those questions, and sometimes give examples when they weren't too sure of what exactly I was talking about.

The social skills—the ability to put a patient at ease when asking personal questions and finding respectful ways to interact—that Kristy referred to are linked to clinical competence as a proficiency that can be learned and practiced along with the ability to diagnose and manage a patient's health care.

This emphasis on interpersonal skills was encapsulated by several classmates in their ORFs in describing their clinical service learning experiences. For example, one student wrote, "[HFC] helped me and my classmates with our physical exam skills, our patient communication skills, and our understanding of viral versus bacterial otitis media." Another student corroborated the opinion that HFC provided an opportunity to "practice my communicating skills with them [the patients and their parents]." Using good communication techniques also helped "to make the patient comfortable and at ease during the visit, especially when they needed a vaccination" according to another ORF.

Kristy equivocated about whether social skills could be learned or whether they were innate. On the one hand, she described some people as "better at following social cues or interacting with [other] people." On the other hand, when asked whether this is a skill that could be learned, she stated that she thought it might be possible to learn through "practicing and being forced into the situation—practicing interacting with people," as was done during Healthy Families Clinic. She volunteered that practicing with classmates might help future clinicians feel more comfortable. She thought that the

exercise where the students had to practice breaking bad news to one another "was a very eye-opening experience."

In addition, she felt that she learned appropriate interpersonal skills from the modeling of faculty and preceptors, but she did not see psychosocial abilities as central to the clinical encounter. Instead, from her observations during her clerkships, Kristy came to understand that the conversations with patients that included learning more about their social, cultural, and family situations occurred "when we have more time with patients—we talk about things that aren't completely necessary for them [the clinician] to know." When her surgical preceptor struck up a conversation with one post-operative patient during daily rounds, "He ended up talking about how he used to be a pilot and how he flew small planes . . . . He really seemed to enjoy talking about that." Kristy conceded without prompting that this interaction did provide part of the patient's social history—that of occupation. She also noted that these types of conversations "helps build rapport, and you [get to] know a little more about their [the patient's] life." It also "helps them [the patient] feel like not just a number to you [the clinician]. [The clinician] is not just asking the typical [medical history] questions." Kristy thought that this type of purely social interaction might fit best at the close of the clinical encounter, "when there is more time" and one does not need to hurry off to see the next patient.

Although her experience at HFC did not directly influence her clerkship choices, Kristy stated that the CSL experience provided an introductory clinical experience in a controlled, limited situation while working with "providers who are your professors; who you know and are comfortable with already." In addition, she noted that the HFC gave her "a little bit of an upper hand . . . to know what to expect" in the pediatric and family

practice clerkships. This was particularly true for her pediatric rotation, which, as noted earlier, was in the same community that is served by Healthy Families Clinic.

Because students completed the ORF assignments before they went out on rotations for their clinical years, they had a different perspective than Kristy had at the time of our interviews, which occurred after her graduation from the PA program. At that early vantage point in the educational process, the ORF comments reflected students' expectations for the upcoming clinical year and how HFC might improve their clinical competence and prepare them for interaction with patients. Typical comments were:

- "It prepared me for what I should expect when I go on my pediatric rotation."
- "I'm glad I had the chance to practice these skills without any time pressure and with several calm supervisors. I feel that it was a good experience and I feel better prepared for rotations because of it."
- "I was happy to be able to utilize my skills on 'real patients,' and it made me feel less anxious about going to rotations and participating in our EEC [OSCE] assignment."
- "I think that it put me a little more at ease before clinicals start in a few short weeks."

What Kristy took from her clinical experiences during the PA program, both at HFC and during the second-year clerkships, was the centrality of clinical competence, which for her meant making an accurate diagnosis and formulating an appropriate management plan that did not necessarily take into account the patient's ethnic or cultural background. Information gleaned about the patients' social and family background was

usually ancillary; their importance was mitigated by the clinical setting and time one could spend with the patient.

4. How does this CSL experience impact the PA students' perceptions of their own cultural competency?

To open the discussion about cultural competence and its intersection with psychosocial and clinical competence, I asked Kristy to define culture during our second interview. She replied, "Culture is the group of beliefs, ceremonies, daily things that a group of people has in common—not necessarily in common either." She seemed to understand ethnicity as immutable, saying, "culture is different from ethnicity. It [culture] is not based on genetic make-up, but a lot of times they [culture, ethnicity, and genetics] go together."

Kristy displayed a nuanced understanding of the place cultural (including ethnic background and socioeconomic) competence status has in the clinical encounter. From her perspective, the culturally competent clinician employs knowledge of specific ethnic beliefs, behaviors, and values to enhance the patient's management plan:

> It's good to have it [culture] as a sign and symptom on your radar; but not to stereotype either. Signs and symptoms . . . . are clues; they don't necessarily mean there is one diagnosis . . . . Sort of have in your mind [details specific to an ethnic group] as you're trying to work with that person and trying to figure out what is best for them. But it comes down to—you have to work with people individually. You can't stereotype based on culture or their ethnic background either. Some people have very different experiences [from] the same sort of ethnicity or [can] appear to be from the same ethnicity, but identify differently.

To further demonstrate the complexity of the society in which we live, Kristy looked to popular culture, such as theater, movies, and television, as supportive of positive notions of diversity. She used as an example the television series *Glee*:

> They really point out when people are in a minority or when people might feel like they are in a minority. Every character in it has differences about them. Even the white, middle-class person sometimes feels like she is in the minority, because of something [particular] about her.

In addition, during her upbringing in a diverse community during the 1980s, ethnic and cultural diversity was lauded by family and teachers as a "positive thing. People made that [differences a] positive thing—diversity is a great thing; you should learn from the people around you." Her experiences allowed Kristy to feel comfortable with people different from herself in the clinical setting.

Based on the societal emphasis on and her personal understanding of the importance of appreciating people from diverse backgrounds, Kristy had come to realize that she actually made more assumptions about people, including patients, who were more like herself in age, educational attainment, and social background. Some of those assumptions were "that they have the same priorities . . . the same beliefs about medical care, same lifestyle, same goals in life, same opinions about other people." She further explained that she feels more anxiety and stress in a clinical encounter with this cohort:

> To be honest, the group that I found I am the most nervous around is maybe late high school age to late college age. People might say that is pretty close to me . . . . It's interesting. I think I am nervous around them, because they are so much like me . . . . They will be very critical of me. I [have] noticed that pattern [of feeling most judged by people close to my age].

In contrast, when working with the elderly and with patients from different ethnic backgrounds, Kristy might make fewer assumptions about their beliefs and behaviors. However, she did admit that when a confronted with a patient with an unfamiliar social or ethnic background she might feel anxious, "because I feel there are more areas culturally or socially to make mistakes. You don't have as many tools in your toolbox to find

common ground, if you don't know a lot about that type of person or their culture." Her experiences in navigating the French culture as a teenager, and her more recent experience in mastering medical Spanish may have provided her with insight into the intricacies of relating to people with backgrounds different from her own.

For Kristy, the notion of finding common ground was key to a successful connection during the clinical encounter. She used the term frequently during the interview sessions because finding commonalities between herself and her patient in important to her:

> Any sort of social interactions is a kind of big deal for me. I want to do very well at it . . . . I do take things very personally. It's a big motivator when I feel like I've really helped people that day . . . . [When I have] had a really good interaction, I feel the best.

Her search for commonalities between her and her patients might include the areas of food, travel, and, as discussed elsewhere, language. Apparently, finding common ground afforded both her and her patient a modicum of comfort during the clinical encounter and is a tool to better understand the patient's background, thus becoming culturally competent.

However, as we viewed the DVD of the OSCE together, we agreed that this stress on finding common ground may have backfired in the case in which cultural components were entwined with an issue of medication adherence. The standardized patient, acting as a first-generation Nigerian, stated that he drinks tea daily prepared by his mother to treat his hypertension and takes the prescribed anti-hypertensive medication only when he has a headache. In this way the SP was providing the student with a hint about a particular viewpoint about his illness and allopathic medication, including the fact that he took his

medication only when he had a headache and that his mother gave him a special tea to lower his blood pressure. Kristy realized that she did not pick up on the allusions that the SP made to an alternative worldview for at least two reasons: She also drinks tea regularly, and her mother takes her own daily medications with a cup of tea. In recognizing the SP's background to be different from her own, Kristy opted to view the behavior of tea drinking as common ground, hoping that

> it would make both the patient and myself feel better when we find some commonalities. I thought of that [drinking tea] as a similarity, not a difference. There we so many differences [between us] with his socio-economic level and his job . . . . He worked very hard at a low-paying job.

She further explained her process of finding common ground by latching on to what she believed was a commonality between her and her patient:

> I think maybe with somebody who is appearing to be from a different background than you or [is] ethnically different, maybe you're looking for those similarities too. And, maybe you might brush over them [the differences] or try to not make them stand out as different . . . . I just didn't really go there because I thought "OK that's something we have in common—we both drink tea." And I really didn't think about shining light on another difference between us.

By not exploring the patient's use of tea as a substitute for the prescribed anti-hypertensive medication that was to be taken daily, Kristy missed the reasoning behind the patient's non-compliance and did not determine whether the tea itself could affect his hypertension.

Kristy related another patient encounter during her clerkship at a community health center, which again reflected her desire to make the patient comfortable. She tried not to focus on the difference in his ethnicity, despite the fact that she had to "listen very hard [because] he did have somewhat of an accent." She described how, toward the end of the office visit,

> we started talking about culture a little bit. I had some background in studying the language [French] and culture [West African] . . . . I asked where he was from, finally, and it wasn't part of the [medical interview] and [I said] "I was just wondering [where you were from, because] you have an accent."

Perhaps because Kristy believed that one of her greatest challenges was interacting professionally, respectfully, and amicably with her patients, she consistently linked and, at times, interchanged concepts of cultural and psychosocial competence, explaining, "I think they are intertwined just because culture is a constructed human thing. It is based on interactions between people." A successful clinical encounter demanded good interpersonal skills, as when trying to derive a focused medical history from what she perceived as a patient (the SP) who acted as if "he didn't want to be there" during the OSCE. She was more thrown off by his taciturn personality than by his apparent ethnic differences. It seemed her inability to connect on a personal level with the standardized patient interfered with her ability to complete a focused history for a patient with an atypical ethnic background.

In relating another anecdote from her clinical year, Kristy described what she believed was an appropriate modeling of clinical, cultural, and psychosocial competence by the physician preceptor during her Women's Health Clerkship. The Spanish-speaking patient was seeking fertility treatment to conceive a second child. The young, never-married woman had previously experienced medical management in her country of origin, which led to a successful pregnancy. This resulted in a dilemma for Kristy and her preceptor on a cultural level, where there "are assumptions about what makes a family; about when children should, ideally, be brought into the family." However, Kristy believed that the crux of this situation was an ethical dilemma:

> I think the provider had to think about "well, is this the best thing for the unborn child and the best thing for this patient?" Does she [the physician] even have a say in . . . whether she [the physician] should help her [the patient] with her fertility in this situation where she felt like she didn't really want to, ethnically or culturally. It was against her culture so she didn't think it was right.

This request posed several clinical, cultural, and ethical conundrums. The clinical problem was that the case fell outside the customary manner in which female infertility is medically managed, so the "physician fell back on medical protocol. She did talk about, 'Are you sure you really want to have a child with this person [the patient's boyfriend],'" although she did not raise her concern that the patient's presentation of a sexually transmitted infection might be a sign of the boyfriend's infidelity. Variations in how medicine is practiced from country to country created part of the clinical challenge that included a

> cultural aspect . . . [that] had implications on the whole situation, because she had gotten those pills [Clomid] in the past and had the first child that way. That gave her an expectation that "I can just have these pills and get pregnant and have a kid whenever I want to." She did didn't understand that here [in the United States] we follow a [particular medical] protocol, and try to figure out what is actually wrong [with the patient].

Even though the preceptor did not directly address the patient's ethnic background or the differences in the practice of medicine between the two countries with the patient, Kristy judged that her preceptor modeled appropriate clinical decision-making skills, adequate interpersonal skills, and cultural competence abilities, as well as good ethical practices, by agreeing to treat the patient's immediate health concerns. She did this by ordering the customary panel of fertility diagnostic studies and asking the patient to make an appointment to discuss the results several weeks hence. This bought

time to consider this challenging case by not guaranteeing during the first office visit that she would prescribe the patient the requested medication at a future time.

Kristy recognized the uncertainty under which her preceptor labored in deciding what the best course of action would be to provide medical care for the patient that conformed to accepted fertility management protocols yet acknowledged the patient's personal preferences. She accepted that the physician's ethical quandary was based more on medical than cultural issues. However, in Kristy's opinion this lack of focus on the patient's particular ethnic background and the culture of her country of origin were congruous with her conviction that "medical practice is set up to be good for all cultures."

Kristy admitted that she made more unverified assumptions with patients who were similar to herself in age and background than she would with patients who were obviously of a different demographic. Her strategy to create a respectful and open clinical dyad with a patient less like herself would be to find some commonality in beliefs or behaviors between herself and that individual.

Summary. Kristy brought to the interviews a sense of what steps needed to be taken to learn about another culture, which focused on the ability to communicate. This included tackling a foreign language as well as acting respectfully toward the patient. Although she knew that making assumptions about any aspect of a person's background was not good clinical practice, Kristy consistently described the tangential nature of cultural and psychosocial competence.

Kristy's worldview took into account the diversity reflected in popular culture and was indicative of the acceptance of difference in our society. Therefore, she concentrated

on finding common ground with her patients, whether it was through a common language, shared traditions, or similar dietary habits. Recalling the actions of her preceptors, Kristy appreciated that the practitioner might have to juggle clinical, psychosocial, and cultural competencies but acceded that the need for professionalism meant focusing on the accepted process of diagnosing and managing a medical problem.

If anything, the cultural and social contents of a patient's life were deemed one aspect of the medical conundrum that might or might not be relevant. Although she enjoyed social interactions with her patients, she admitted that it was sometimes a challenge to conduct a medical interview, so she used informal conversation to make both herself and her patient more comfortable. In general, however, information gained from this chitchat was not viewed as relevant or important to the patient's treatment regimen.

Case 2: Tom

Background. Tom described his ethnic background as Caucasian of German and Scottish heritage. He was raised in a Catholic family in Michigan. Prior to matriculation into the PA program he worked as a patient technician in an inpatient hospital setting. In addition, he spent a total of two and a half years working as a medical assistant in a rural family practice clinic—first as a volunteer, and then as an employee. This clinic primarily served people without health insurance or covered by Medicaid, as well as other patients that he considered to be of low socioeconomic status. Tom provided health education to the patients on such topics as diabetes, hypertension, and appropriate hygiene practices. In both these positions, he performed nursing duties such as taking patients' blood

pressures, temperatures, and pulse and respiratory rates, as well as doing injections, cleaning surgical dressings and changing linens.

Tom minored in Spanish as an undergraduate and is able to speak, write, and read the Spanish language. He also understands basic German vocabulary. Travel outside the United States was limited to one leisure trip to Mexico that included a visit to Chichen-Itza, an important Mayan archeological site.

The four interviews took place over a five-week period while Tom was working as a certified physician assistant at an urban family practice clinic. As of the first interview, Tom had been working at his first job as a PA for about one month. We conducted the interviews in a private office at the family practice clinic, where the only interruption was a ringing phone that we let go to voice mail.

Because Tom was working as a PA throughout the time that I interviewed him, he brought many of his clinical experiences into the conversation to illustrate and reinforce reflections he made about his time in the PA program. These anecdotes and observations are liberally sprinkled throughout this section, as they offer an additional dimension to Tom's narrative.

An additional note of explanation about the content of Tom's interviews: The ORF assignments were lost to both him and me. He reminded me that he submitted the assignment to me after the due date via e-mail (instead of the D2L drop box), and neither he nor I could find a copy in our computer files. This means that we were not able to review the observation forms and his ORF was not analyzed in the aggregate.

Interviews.

1. **During their CSL how do PA students understand the patients' and their families' experiences at HFC?**

As we discussed what Tom noticed about the parents' attitudes toward the HFC experience, he reflected:

> As far as the parents, it was nice because they were grateful. They were pleased with the fact that they could bring their kids there. Never a bad experience with parents; no complaints about how long they had to wait . . . really no complaints at all. That aspect was nice, because working at a normal job now and going through clinic [clinical year], and now working here, that's not always the case.

He explained that some of the patients at his present clinic would complain about having to wait or spending too much time in the clinic waiting for test results. The most disgruntled patients sometimes didn't return for future visits.

When I delved further, asking whether he was surprised that the parents at HFC were appreciative, he understood their attitude and their patience to be rooted in their ethnicity.

> I don't think so. Basically, what I have seen out of the Hispanic culture, Hispanic families, from working at my job presently and now looking back, I really see a sense of family in the Hispanic culture. When I have Hispanic children come in [to the clinic he presently works at], it's usually both parents who come in. I just feel that the families themselves are happy to come [and] get everything taken care of. I don't really have problems with complaining. I don't get a lot of complaints as far as how long they have to wait.

Blending his present work experience with children and what he recalled from his HFC experiences, Tom described the children's reaction to being in a health care setting, whether in a classroom or clinic:

> This is coming into my experience even here—[children] are hesitant, not knowing what to expect. But it really just depends on the kids . . . . Some kids

> were fine with it and took to the atmosphere and were able to act normally, [as] I can imagine they would at home—running around. But other kids were a little more hesitant about this new atmosphere—people in white coats.

Specifically at HFC he remembered the "younger kids were clinging to their parents and the older kids were more relaxed."

Perhaps because the HFC experience was familiar to Tom, his reply to my repeated questions about how the patients and family members perceived the student-run clinic housed in a school centered around his own comfort with the surroundings and patient population. He understood that, compared to some of his classmates, he had more familiarity with both the clinical and cultural aspects of patient care:

> Healthy Families Clinic and Kids First Health Fair would be more beneficial for PA students who didn't have a background prior to coming to PA school. But some of the experiences I had prior to Healthy Families that were similar to Healthy Families—that's why it's so hard to say whether it was Healthy Families that taught me that [cultural competence, social interactions, respect for patients, humility]. I didn't feel that Healthy Families was out of the ordinary to things I had done in the past.

While Tom felt comfortable in the setting and with the patients, one of his classmates reflected in an ORF that the clinical service learning at HFC provided an opportunity to apply medical knowledge learned in the classroom and to gain a perspective on the complexities of a clinical setting:

> Sometimes, with school, I feel very overwhelmed. Going to Healthy Families just gave me that final push to keep going, and [reminded me] that all the stress from school will all be worth it in the end. I was also surprised at how much I had already learned and that I was able to keep up with everything.

For Tom HFC offered no surprises, but rather was a familiar health care setting in which he felt comfortable due to his experiences as a nurse's aide and patient care technician before matriculation into PA school. Even the fact that the HFC was set up in

a school building did not faze him: “The first moment you walk in, it’s a school. But once you get started, then I feel like I get so focused on the patients and the interaction with them that you lose your surroundings.”

2. What do the PA students discover about people with backgrounds different from their own during their CSL?

Tom recognized similarities in providing health care services to the medically underserved patients at HFC, who were primarily of Latino and African-American heritage, and providing health care services to the population of patients that he had previously worked with in rural Michigan, who were primarily of northern European heritage: “I didn’t think it was anything out of the ordinary.” He went on to explain,

> The hardest part of that first time at Healthy Families was learning how Healthy Families worked. Where am I supposed to be at this time? Where am I supposed to go? I really didn’t feel any pressure, any kind of difficulty with the medical or social part of it—interacting with the patients.

Tom said his comfort level with the HFC patient population, including medically underserved patients of primarily Hispanic and African American backgrounds, was due to two factors—previous experiences and his ability to speak Spanish. First he stated, “As an MA in an underserved clinic that was rural . . . [I worked with a] population that was a little different to Healthy Families Clinic . . . . It was primarily Caucasian. Healthy Families was predominately Hispanic.” Then he elaborated, “A couple months prior [to my first HFC session] we did Kids First Health Fair, and I volunteered as a translator there.” He had explained earlier in that first interview:

> I am pretty fluent in Spanish, so it wasn’t a problem or big shock to have to worry about a language barrier. A lot of other people [i.e., fellow students] would have

> had that problem. At that time I actually hadn't used my Spanish a lot over the past year. So it was rusty—so maybe the biggest challenge was actually using the Spanish again. But it was not overwhelming.

Tom concluded that, "If anything, Healthy Families or Kids First Health Fair exposed me to . . . being able to apply the language [Spanish] that I know or that I had learned."

One of Tom's classmates also expressed satisfaction in being able to effectively communicate with HFC patients in Spanish, linking the ability to communicate with a positive clinical experience for clinician, the patient, and the parents:

> Also, the appreciation that was shown by the parents of the children was much more than I had expected. Lastly, it was striking the happiness seen in parents' faces when they saw that I spoke Spanish. It further demonstrated the importance of understandable communication and the satisfaction patients/parents have when they feel as if they are being totally involved and understood.

When pressed to describe particular HFC patients, Tom referred briefly to their ethnic background, but detailed the clinical picture:

> I just remember there were a brother and sister that came in . . . . I remember the little boy having a flow murmur—a Hispanic male having a flow murmur. I just remember the pediatrician talking to us about it. Having us listen a couple of times and just running us through that.

It should be noted that he reworded his response to include the child's ethnic background in the manner in which he had been taught to present clinical findings (e.g., "This is a 4 y.o. Hispanic male who presents with . . .").

When asked about his view on access to health care, Tom addressed the topic as both a social justice issue and in terms of how the inequity affects his practice of medicine. He declared, "First of all, I think everyone deserves access to health care. I don't know if it necessarily should be free for everyone, but [perhaps] everyone should pay the same percentage [toward medical services]."

In a similar vein a PA student called attention to the issue of access to medical services in an ORF entry:

> The goal of this activity was to have children get sports physical examinations for school. One family had just immigrated from another country and needed immunizations in order to enroll in school. This event is free of charge and allows equal access of medical care to everyone that was there.

Tom compared this population, which is medically underserved because of limited access to a variety of societal resources, with the patient population of generally higher educational attainment and more financial resources that he encountered during clinical rotations in affluent suburbs of Chicago:

> [The patients in Chicago are] people you can teach the most or that will listen the most [to medical advice]. [So I will have the] most influence [with them]. I don't think this population is any different [in their level and expression of] appreciation . . . . The need is there. There is not a lot of access. It's really tough when you deal a lot with public aid patients, Medicaid patients, because their resources are not there, too. So you really have to know what to do. I feel it's a really good start. [I] can learn so much working with this population.

Through their ORFs, other students also highlighted the importance of working and/or volunteering in medically underserved areas as a result of their clinical service-learning experiences. One PA student wrote, "I definitely want to get involved with a service opportunity similar to this once I am a PA. As a PA, I am able to help others with preventative medication and decrease the illnesses and lost-school-days." This same student reflected in the second ORF on the clinicians working at HFC: "All who were there as providers were glad to be there and serve the community." Another student noted, "This was a positive experience. It was one of the special volunteering opportunities that leaves one feeling as if they have accomplished something."

Finally, Tom viewed the clinical service learning sessions as opportunities to get to know his classmates better:

> I was surprised at how good a lot of them were with interacting with kids. [It was a revelation] because a lot of them didn't have kids themselves. I didn't know their backgrounds or what they had done before . . . . They were really good as far as interacting with the kids, making them comfortable and relating to them.

One of his classmates echoed this sentiment about HFC being a place to interact with peers outside the classroom, writing in the ORF:

> One thing I noticed was how all of us were more relaxed and talkative than when we are in class. Outside those four walls, we all let our guard down and talked about our interests and goals. It was a nice way to get to know classmates I don't normally talk to.

In summary, Tom felt comfortable with the people served by HFC (and Kids First Health Fair), seeing no novelty in speaking Spanish or working with people having few resources. The challenges that he faced were primarily clinical—recognizing physical findings, filling out forms, remembering how to give immunizations to children.

3. What influence does the CSL experience have on the PA students' clinical practice during their clerkships and job?

Tom recalled HFC as a place where he could further the process of becoming clinically competent in the field of pediatrics. The pediatrician volunteering during his second HFC session supervised the first-year PA students as well as the medical residents:

> We could actually do immunizations and physicals [examinations] at that point. I do remember a little more clearly. I worked with a couple of other students. And I worked with a pediatrician. We helped with some of the physicals. He talked to us a lot about pediatric heart murmurs and flow murmurs. And we did a lot of listening to pediatric hearts, a lot of cardiac exams. So that was really interesting. And the interesting thing about it—what I remember—he was asking us questions

> and wanting us to answer his questions. I remember feeling, "This is kind of nice, because it's preparing us for what we are going to expect in a month or so when we venture out on rotations."

Other students also underlined the centrality of clinical education during the clinical service learning at HFC through appropriate modeling by the physician, as well as being able to correlate the physical examination findings with pediatric anatomy and physiology. One student recalled in the ORF:

> One little girl had an innocent flow murmur, and as observing students the mother gave us permission to listen to the child's chest also. It was helpful to learn how to determine whether the murmur was systolic or diastolic on such a fast pediatric heart beat. The physician was very willing to share his knowledge about circulatory anatomy and physiology of a child. This knowledge will be valuable when approaching my pediatric rotation later this year.

Another ORF reflected that the history-taking and physical examination skills used on real patients at HFC rather than on fellow classmates in class improved the student's abilities to synthesize didactic and clinical material, as well as to garner the student a modicum of confidence:

> This opportunity allowed me to test my physical exam skills and try them on patients that didn't know what was coming. In addition, I was allowed to complete more activities and apply these to the things that I have learned since the last time. The pediatrician teaching made more sense and connected the dots for me as well.

When asked, Tom offered a lengthy definition of clinical competence based on his present position that centered on the psychosocial expertise within the clinical dyad. He relied on advice from a family practice PA he shadowed before entering the physician assistant program, who told him that the patients will diagnose themselves with time:

> Clinical competence is the ability to walk into a room [and] to be able to interact with your patient professionally. And just be able to listen to them, because I really feel like your patients will tell you what's wrong with them if you listen. You just really have to be open-minded and not feel rushed as we always do . . . .

> I feel like you just need to put everything else aside. And you really need to hone in on what's the patient is there for—just for the medical part of it. But then you really have to take a look at the whole picture; really take into consideration everything that is going on. Observations are really important—that plays a strong [part] in your competence.

He continued by outlining an idealized patient encounter and concluding with an example from a recent day at work:

> From the moment of walking in—your first observation of what a patient is like. How are they acting? How [do] they feel? It can tell you so much. So I would put in the social part of it—the interaction with your patient. Being able to listen to them fully and then doing the best that you can do as far their exams—taking a full history, doing a full physical, and then finishing the problem that they are there for today—just looking at the whole patient. I had a patient yesterday who came in for a rash, and a facial rash turns into a talk on depression. So you can really pick up on a lot of things, if you pay attention to everything that they have to tell you.

At the final interview session I asked Tom to revisit his definition of becoming clinically competent, and he re-emphasized that it included both didactic and experiential components, including medical and psychosocial knowledge and skills:

> First thing is to create the atmosphere for your patient to feel comfortable and telling you information. So you have the social things to consider, and you have the medical things to consider. And we talked about this over the past few meetings, how we can learn those things.

Tom did not deliberately choose rotations with Spanish-speaking patients, but he noted that at least half of his second-year preceptorships included predominately Spanish-speaking patient populations. Because the ability to effectively communicate was key for Tom, he reflected that other students

> had a really hard time, especially not having the second language to communicate with your patients. Sometimes some people [students] may have had a bad experience with it and a good experience with it. If you are not able to communicate with your patient and take a good history, well, how are you even going to do the task you are supposed to do?

His choice of specialty and practice setting was more deliberate, taking into account factors gleaned from experiences both before and during PA school. Initially, Tom couldn't pinpoint any influence that clinical service learning might have had on the decision saying, "Did it push me toward working with the underserved or with other populations? I don't really think it had any kind of decision-making in that process." But with further questioning he recognized that there might have been two minor influences: "Through Healthy Families and through Kids First Health Fair, maybe learning the community at hand influenced it [job decision] a little bit," and "I really enjoyed being able to apply all the Spanish I had learned. So that may [have] helped solidify the fact that I might want to work with, at least, a small Spanish-speaking population.

Significant factors in his decision to work at a family practice clinic located in a medically underserved, poor-to-working-class urban area of northern Illinois were his experiences prior to entering the PA program. Tom chronicled his decision-making process that resulted in his searching and finding his present position by first reiterating that he had decided on primary care based on pre-matriculation activities:

> I had a mindset before I came to PA school just based on my prior experiences, as what I thought I may have liked and may not have liked. So I don't really feel that Healthy Families or Kids First Fair changed my decision much. I was really geared toward primary care anyway.

He goes on to detail how he came to this conclusion about his career choice:

> Prior to working as an MA, I was really, really surgically based. And I really enjoyed surgery. I had shadowed PAs in surgery. And I really liked the OR [operating room] atmosphere. And then, to get a little more well-rounded experience, I began volunteering at a rural clinic . . . . What I really enjoyed about the office [was], we would see everything. It really just seemed to me like [this was the] bread and butter of medicine, because you deal with everything. You're basically the first person they see. You are doing everything. That probably is

> what set up my intention in going into primary care. I liked and still like seeing a variety of things.

This intrigue with the multiplicity of presentations and diagnoses was reinforced during his first rotation of the clinical year, which was general surgery, where he remembered, "I loved it. I loved being in the OR, but I absolutely loathed going to surgical clinic, because it was the same thing—abdominal exams all day. There was no variety."

Searching the ORF documents for comments about student preferences for particular medical specialties disclosed only one comment about how HFC clinical service learning sessions did broaden the student's views on her career choices: "I previously volunteered in an adult free clinic and I enjoyed this more b/c the population was children. This experience made me think more about specializing in pediatrics."

Tom was firmly in the camp of those who considered the primary benefit of working at HFC as the opportunity to apply the clinical knowledge and skills absorbed during hours in the classroom and more hours reading and studying. The clinical service learning experiences merely reinforced Tom's decision to work in family practice in a medically underserved area and introduced him to the diversity of the Waukegan community.

4. How does this CSL experience impact the PA students' perceptions of their own cultural competency?

Despite Tom's own limited travel, he acknowledged that cultural competence is best accomplished as experiential learning: "The best way to learn it is to go places and

travel. Because that's the way you learn it. Basically, what I've learned has all been formal, has all been institutionalized and taught educationally."

His paradigm for learning about specific ethnic practices and beliefs was to study via class work or book learning, ask questions of his colleagues, and then to come into contact with that particular community or ethnic group. He explained that he learned about aspects of culture such as diet "in school and living in the area, going to the restaurants myself and just seeing personal evidence of what you see." As we delved deeper into how Tom was becoming culturally competent when most of his exposure to other cultures was through academic coursework, he explained:

> You just learn things in class; you hear it. It's just like applying what you learn to practice medicine. It's much the same way. You learn something; you apply it. You remember back to something someone said at one point or another. And you do it or you always have it in the back of your head.

Tom's approach to becoming culturally competent relied heavily on learning about such details as social norms, behaviors, customs, health care practices, family constellations, and dietary practices of specific ethnic groups. Although he had looked forward to the new interprofessional course, Culture in Healthcare (HMTD501), offered during his first year in the program, Tom was disappointed with the course's content:

> I was really excited for it and was pretty disappointed because I thought it was going to be pretty applied . . . . I thought we were going to learn things that we could use every day [in clinical practice]. I thought we would take a look at certain areas of the world . . . [exploring] views on how these people view Western medicine or . . . [about their] social norms. More or less like another sociology class or something that was geared toward medicine.

To more fully appreciate Tom's perspective on becoming culturally competent, I asked him in a later session to detail how he might teach cultural competencies to PA students. Throughout the interview sessions he consistently insisted that cultural

competency could be taught and learned in much the same manner as clinical competence—through research and reading, listening and observing, and experiencing and practicing:

> Language can be taught. Ways of life can be taught. The difference with being taught is there is being taught formally, and there is applying [what you have learned formally]. And I think they are two different things . . . . Language is one example. You can formally learn a language, but if you don't apply it, you can lose it . . . . That can [apply to] ways of life—cultural competence, [which include] all those things [ethnically specific customs, behaviors, beliefs]. If you haven't experienced them firsthand, I think, that is more of the thing that opens your eyes.

At the final interview session I asked Tom to revisit his definition of becoming culturally competent, which he insisted follows the same process as becoming clinically competent, including good interpersonal skills:

> You create an atmosphere where a person is comfortable talking about their background with you. We talked [in previous interview sessions] about how culture can be learned, and it can be experienced. I feel that both of these make you a more [culturally] competent person.

When pressed to describe particular curricular components to teach cultural competence in medical education, he outlined classroom and experiential classes that would include an assessment of the patient population or community in which the students might be working during their clinical preceptorships. He would then offer a series of speakers who

> have had experiences as medical practitioners working with people with different beliefs and habits and everyday life. Bring [members of] the community [into the University] and have them discuss what they feel may be dilemmas or issues with health care [through] their eyes and [with] their thoughts . . . . The best thing would be to have health care providers who identify themselves with [a particular] culture, beliefs, or practices . . . . That would be your best case scenario: you have an individual very familiar with the medical as well as the cultural part of [an ethnic or cultural group].

Following this didactic phase, using stories from community-based lay people and ethnically diverse clinicians, he would develop a way to apply this information while on clinical rotations, although he admitted this might be difficult to do, since it would mean extensive use of faculty time. He suggested that clinical-year students be "sent to places that are culturally diverse," and that they keep a diary of clinical situations in which they were able to apply "what they had learned" in the didactic year.

As students begin their careers as PAs, he would encourage them to use research as a tool to become culturally competent:

> Just knowing the percentages of [ethnic] populations in your area. What their socio-economic status is. [As well as, encouraging] volunteer activities. The biggest thing that Kids First and Healthy Families showed me was to introduce me to the populations [in the Waukegan area]. I think research and involvement in the community [are key to being culturally competent].

When confronted with a patient from an unfamiliar ethnic background in a medical setting, Tom described how he used available personnel resources to provide care:

> When I did my ER [emergency medicine] rotation, I worked predominately with Russian immigrants. And I know nothing about that subset of the culture in that area [of Chicago]. I don't speak the language. It's tough. It's really tough, because you really don't know a lot. I think the way that I dealt with that is that we had an employee of the ER that was actually from Russian . . . . I guess what I would say is that, if you have questions or concerns about things, one way [to learn about an ethnic group] is to take advantage of having people who are familiar with that culture. One way to be competent is to ask those people if you have a specific question about things: Can you fill me in on this? Is this normal? Is this not normal?

He summarized this aspect of becoming cultural competent by saying, "To be competent is to take advantage of your resources around you."

He then re-emphasized the centrality of communication and, particularly, of speaking a common language with his patients, as well as appreciating specific ethnic behaviors and habits:

> The biggest part for me is to actually communicate. I may not know too much about what the [cultural] norms are as far as everyday life. But what helps me and what makes me culturally competent here [in his present position], with the patients here, [is] I know a lot about the cuisine, the diet of a lot of the Hispanic populations. And that plays a big part in a lot of the disease states—diabetes, hypertension. A lot of their foods are carb heavy. So just knowing the basics can help you. How I feel you ultimately learn things better [is] by going places, traveling, experiencing those things.

At another point in the interview sessions he lamented losing the ability to care for a patient during clinical rotations without the ability to communicate either directly or through a translator:

> How are you even going to do the task that you are supposed to do? At certain places, without having an interpreter or people to help you, that's a patient that you can't see. You have to let another provider who knows the language step in. And that, in turn, decreases your experience.

When we explored the clinical encounter as a psychosocial phenomenon, Tom wrestled with the balance between what could be considered innate personality traits and what skills could be learned. His bottom line was that "everything can be taught; everything can be learned." First he noted that becoming comfortable with medical and diagnostic knowledge and skills would allow a newer PA to relax during the clinical encounter and improve his or her interpersonal skills:

> The social part of it depends on your personality and how interactive [you are]—if you are introverted or extroverted. Then, I also think a part of that, the social part, can also be learned. I feel like, as a new student or someone with not a lot of experience, it's so hard. You're so focused on the medical part of it . . . . Maybe you're not so up on the social part of it with your patient in establishing a rapport. But as you become more familiar with the medical aspect, you're less focused on

> the getting that down, [and then] you are able to relax a little bit and establish the social part of it [the clinical encounter].

Tom reiterated that the key to building psychosocial skills is experiential, i.e., working with patients, and interpersonal abilities can be mastered:

> It depends on your personality, [which] plays a huge role in it, but I think that [social skills needed to build rapport with a patient] can be learned. Just by experiences, working with it every day, becoming more comfortable with what you're doing.

He proposed that a clinician cannot rely solely on good social skills to build a professional relationship with a patient. Both cultural and clinical competence are key to this process:

> I think it would be helpful to understand a little bit about them [through social interaction by] using culture competence and clinical competence. Being a nice person—that's definitely helpful. But you could be a nice person and not be competent. Establishing the fact that your patient wants to come back to you and establishing rapport isn't just based on being a nice person.

However, at a later time he did stress the connectedness between interpersonal and cultural competence:

> I definitely think that the cultural competency plays into the social aspect. Because, as I mentioned before, different body language and things like that really ties into their culture. [Making eye contact or not as a sign of respect] is just one example of how it might be hard to have a good social interaction, if you're not really familiar with that cultural practice or the ethnicity [of the patient] . . . There could be things that you are totally missing in your interaction.

When weighing the importance of cultural competence during the clinical encounter, Tom took into consideration the clinical setting in which he was seeing the patient. For example, contradicting his previous description of Russian patients he cared for in the emergency room, he argued:

> I don't feel like a lot of the times culture was a problem, because there were such acute [medical problems] that they needed taken care of. When the patient is

> coming in with a heart attack, you don't have the time to discuss culture. [The patients were provided with appropriate], standardized care.

In contrast, during his obstetrics and gynecology (ob/gyn) rotation in a predominately Spanish-speaking area with a male physician preceptor fluent in Spanish, Tom observed the importance of sensitivity toward the patient due to language, gender, and cultural differences between him and his patients, despite his facility with Spanish:

> And that's a rotation where the language you use is really important. And the terms you use are really important. And I found it so difficult to be able to communicate with my patients, because I hadn't had a lot of expertise in that area of medicine, where terminology is really important. The words you use can make or break you (for lack of a better phrase). And it was difficult.

Tom found a good role model in his preceptor, who studied medicine in Mexico and was thus conversant both in language and culture, as well as being a specialist in the field: "I would speak slowly [in Spanish] and really think about what I wanted to say before I said it. Also, [I would ask] my preceptor about the proper terminology, because he was fluent in Spanish.

Tom surmised that the Hispanic women that he cared for in this practice setting were similar to many other women, who

> don't want a male provider for their women's health care. I think a lot of patients were taken aback by the fact that I was male. And not only male, but I was—probably I walked into the room they had the image that language was going to be a problem.

In circumstances described above Tom was imagining that his patients were making assumptions about him, so we also explored the notion of making assumptions about patients. Tom understood that generalizing about patients, both medically and culturally, might be a necessary evil in medicine: "Assuming is always going to be [your]

downfall. There are times when assumptions are correct. And there are times when assumptions are false. They can be a pitfall."

He differentiated between generalizations and assumptions in clinical reasoning and in cultural competency:

> Medical assumptions are based on facts. Medicine is more a science than an art. The scientific facts of medicine [are why you can make] scientific assumptions. You have that factual base . . . whereas, cultural [competence means that you are] basically just looking at someone and interacting [with them]. It's a little trickier.

Prior to making this statement Tom had elaborated on the specific problems with making assumptions about the ethnic backgrounds of patients. He noted that falling back on the customary medical history format helped him to get the information necessary to provide appropriate medical care:

> If you assume that someone who walks in and looks Hispanic goes with the culture, they may not. They may have a totally different experience . . . . They could have grown up in a very different part of the area or not be from the area or be adopted. You don't know anything. That's why you always have to ask questions. It's pretty standardized . . . asking the same questions [with each patient]. What is difficult is when you don't know much about the culture at all.

We then explored the issue of making assumptions about people who seemed to be more like him. For example when defending why he didn't ask the standardized patient during the OSCE session more about his ethnic background, Tom explained that there was not anything obviously different about the actor portraying a Nigerian-born patient: "There was nothing that would have told me that he wasn't an African American who grew up in the United States . . . . He could have been my neighbor."

When I proposed that sometimes we make more assumptions about those who appear to be more like us, Tom readily agreed:

> If someone is more like me, I'd have a harder time getting the differences out of them, because I would identify with them. If you can identify a lot with someone, you may not realize that they are different from you, if they seem so like you.

During the first interview session, Tom noted that in his limited clinical experiences throughout the second year of PA school and his short employment tenure, he found no incidences of conflicts between allopathic medicine and patient beliefs:

> I never experienced any problems with medicines or any clashes between Western medicine and belief systems. Maybe the populations I was working with had grown accustomed or been here for a while, so they also had taken on the norms of our society.

However, by the third interview, he had had just such an encounter with an East Indian patient who was observing the month-long daytime fast of Ramadan. Tom's second office visit with this patient included follow-up of his blood sugar levels. He described how admitting to his patient that he didn't know much about his religion and ethnic background "led to a whole learning experience . . . . So you can learn from your patients" about their culture:

> It was evident on that [first visit] that [the diabetes] was very uncontrolled. I did labs and what I was suspecting came true—it was very uncontrolled. When he came back, I was asking him about his medicines and how he was taking them. And then—I actually thought of [this study] at this point—I was asking him, "Well, you said you were taking [the medications] this way last time. Are you still doing that?" He said, "Well, no. Because it's my hold month now—Ramadan." Then I said, "Well, I'm not too familiar with it."

Tom explained that he opened the door for further discussion by admitting that he didn't know much about Ramadan:

> So he explained that he doesn't eat from early in the morning until after the sun goes down. All day he is going without food. And that's a big thing when you are diabetic, and you are taking certain diabetic medications. If you are not getting any kind of carbohydrate and you are giving them medicines to lower their blood sugar, it can lower the blood sugar too much. So that was a dilemma. That was a learning experience, as well.

Tom then elaborated further about how he worked with the patient in developing a management plan:

> I stressed to him that it was important to take care of the diabetes and that I would work with him around Ramadan. [I said,] "I can give you these medicines to take with your evening meal, but when your hold month is over, and you go back to your normal dietary habits, you come back in so we can adjust all these things [medications and diet]." And I left the room and came back. He flat out told me, "Maybe I should skip Ramadan and really get this taken care of." I said, "I know this [Ramadan] is important to you. I don't want you to have to give it up. We can work around it for now." He was very adamant that health was his main priority and that he really wanted to get it [diabetes] taken care of.

Tom used the same open-ended questioning technique that included an admission of ignorance when addressing the patient's usual diet: "We talked about diet, as well. I said, 'I'm not too familiar with the Indian diet, but I know it is full of carbohydrates and rice and curry.' He [subsequently began] explaining what he ate."

When we revisited this patient encounter during a later interview session, Tom insisted that asking the questions about the patient's religious and dietary practices fell within the usual way he would conduct a patient interview. He asked the patient to elaborate "so I could understand it a little better;" but it was just like a normal interaction with a patient, "just getting to know him better." Tom agreed that cultural humility was a good interviewing technique to use:

> If I am not familiar with something, I [say something like], "I'm sorry, forgive me. I'm not familiar with [for example] the diet. I know a few things; can you give me an idea of the foods you eat?" Or getting back to Ramadan, [I might ask], "So you don't eat from when to when?" Unless you have a really good concept about what goes on . . . I would use a little humility.

Exploring how Tom might gain clues about what to ask a patient, we discussed the concept of curiosity during the clinical interaction. He felt that within the bounds of

something being pertinent to managing a patient's disease or caring for a patient, inquisitiveness was justified.

> If you're just curious about something [in the process of] establishing rapport with your patient to know a little bit about where they are from, [that is OK]. Is it curiosity or pertinence? Is it something you need to know? Or is it something you just want to know? And if it's something you just want to know, but it's within the boundaries of being in the patient's comfort zone . . . then curiosity is fine. But you have to be careful about curiosity.

He admitted that curiosity might improve the medical-history-taking process by "opening things up" to develop questions that might prove to be appropriate and relevant to the patient's health care status or medical situation, such as with the Muslim patient who had poorly controlled diabetes mellitus. Tom relied on strict adherence to the medical model of history-taking, performing a physical examination and ordering appropriate diagnostic studies along with listening to the patient to provide culturally, clinically, and psychosocially appropriate health care.

Summary. Throughout the interviews, Tom displayed confidence in his ability to create an atmosphere during a clinical encounter that would ensure the provision of appropriate medical care. His pre-matriculation experiences had a significant impact on his approach to patient care as well as his career choice to work in family practice with a predominately medically uninsured population. Although Tom felt that the CSL played only a minor part in his formation as a PA, he admitted that for other PA students with less clinical experience working at HFC and Kids First Health Fair might have revealed the complexities of clinical practice with medically underserved populations.

Tom asserted the hazards of making assumptions about either medical or cultural issues and admitted that if he believed someone to be similar to him, he might delve into

their beliefs, customs, and values. When considering encounters with patients whose backgrounds were different from his own, Tom relied on past experience, knowledge about a particular ethnic group, or the ability to ask the right questions. He found a good role model in the male preceptor caring for women not culturally similar to himself, who was able to communicate in the patients' language and effectively and compassionately interact with them.

Tom explicated a path to cultural competence that included didactic study backed up by experience. His facility with Spanish only enhances his ability to allow his patients to fully tell their stories.

Case 3: Laura

Background. Laura described herself as a Caucasian woman who grew up in a small town in Wisconsin. She is married and does not have children. For about a year prior to matriculation into the PA program, Laura lived and worked in Minneapolis, MN. As a high school student, Laura was an exchange student in Venezuela, where she lived with a local family and went to school for four and a half months. She also made several shorter (1–3 weeks) trips to Europe and Mexico. During the clinical year in the PA program, Laura, accompanied by her husband, worked on a medical mission in Guatemala sanctioned by the University. She described herself as fluent in Spanish.

Before studying to become a physician assistant, Laura worked in two paid positions in the health care field. The first was a two-year part-time position during her undergraduate years as clinic coordinator for the MEDIC clinic in Madison, WI, which provided medical care to the local uninsured population. Medical care was provided by

University of Wisconsin faculty physicians and medical students. After completing her bachelor's degree, Laura worked for one year as the Latino Outreach Coordinator at a state-funded insurance company for those receiving Minnesota state aid. Her duties included teaching individuals preventive health and safety practices. Laura also volunteered for Habitat for Humanity.

The four interview sessions took place in pairs. The first two sessions were recorded on consecutive days, followed by the second set of interview sessions on consecutive days about six weeks later. Laura had taken the physician assistant certification examination just prior to the first interview and was in the process of interviewing for full-time positions in Minneapolis. By the first interview she had already secured a part-time, on-call physician assistant position at a community health center. She already had attended an orientation session but had not yet been called to work a shift. By the time of the second set of interviews, Laura had begun a new, full-time position as a family-practice physician assistant in a suburban clinic, where she was the first PA who had been hired by that physician group. She had been working about two weeks in this job and had still not been called to work at the community health center by the time we concluded our interviews.

We met for the first interview at a coffee shop of her choice. Although it proved to be a pleasant atmosphere, it was a bit noisy for purposes of recording the session. At my request she suggested meeting at a local library, where we reserved a private room that was small and quiet. Three subsequent sessions were held in this setting, where the conversation and the quality of the audio recording improved.

Interviews.

1. **During their CSL how do PA students understand the patients' and their families' experiences at HFC?**

When we explored how Laura perceived the parents' and pediatric patients' experiences at Healthy Families Clinic, she recalled specific patients' reactions, ranging from indifference to severe unease. One teenage boy was very uncomfortable with the experience, and she believed this was not due to his culture, but rather more related to his age:

> Those poor children—you can feel their discomfort with [the situation]. Especially [with me] being a female working with them, and [they] being younger [than I]. They are uncomfortable and [probably are thinking] "I don't want to talk to you. And I don't want you to put your stethoscope under my shirt." They are, of course, cooperative. But it is tangible, [the feeling of] "I am not comfortable with myself, much less with you being here."

She also remembered a family group consisting of several sisters and cousins who seemed uncomfortable with medical procedures perhaps due to social pressures or cultural influences:

> The teenage girls did not want to get weighed. [There were a group of African American] girls who came in together to get a physical. And they were asking if they had to get weighed. [Society] put on them that they have to be thin. But I think that medicine is a little bit more about that [thinness] too.

On the other hand, Laura reflected that the children's parents were generally tolerant and appreciative of the somewhat novel and disorganized process of a weekly clinic set up in a school building, staffed by PA students and medical residents:

> People seemed pretty happy, pretty grateful that we were there to help out. They were definitely patient with students and new people, with [our] trying to figure

> out how to work a blood pressure cuff. Just that little stuff that come with the first time you touch a patient. But I thought, for the most part, we were well received.

However, she did observe limitations to their patience when it came to multiple visits for subsequent immunizations in a series or having to make a separate appointment at the health department for tuberculosis or lead tests:

> They wanted it to be wrapped up in one visit. And they were willing to wait that one visit for everything to be done. But coming back was a problem for multiple reasons; they had to work or they just didn't want to [return or go elsewhere].

She continued by contrasting parental insights about the unusual clinical setting and the student-run nature of HFC to the reaction of the children as well as reflecting her own unease in her new role as a clinician:

> I think that sometimes [they showed] a little bit more annoyance with the time that they were spending waiting. And I think, because they [the parents] had more experiences with practitioners, they were more aware that we were students. The kids didn't know any better, whereas the parents clearly did . . . . It might have been just me feeling more self-conscious and feeling like they knew.

When pressed to explore the notion of gratefulness and appreciation of patients toward health care providers, she stated, "I don't think they have to thank you over and over. [They] don't have to go above and beyond. As much as I want to respect them [the patients], I want to be respected as well."

Laura elaborated on an area not remarked on in any of her fellow classmates' ORFs in comparing the U.S. health care system to that of the country of origin for an HFC patient who had a family history of early death from cardiac disease:

> [He] had relatives [in] Mexico who [might have] had this happen [e.g., an illness, injury, or medical problem] or went to the hospital and had it taken care of . . . . [That's an] interesting distinction—had this child had some sort of cardiology

> issue, there wasn't much we could do for him at Healthy Families Clinic. Obviously we could refer him out.

As we discussed this further, Laura clarified that this particular patient, who did not have insurance to cover that type of specialist care, would have had access to a cardiologist in Mexico. We did not delve into a discussion of the relative quality of medical care in each country, touching only on this issue of access.

She sympathized with the medically underserved patients who had to use HFC services:

> It's striking – the kids without health insurance. You take it for granted that everyone goes to the doctor for their yearly check-up. And to see little kids that had to wait a few months. They couldn't participate in something [e.g., sports] because they weren't able to get in.

An ORF entry summarized the impact of clinical service learning at HFC for both clients and students:

> Healthy Families is a great way for students to get [the chance to provide] hands-on care and to practice their skills. Healthy Families is also a great entity that provides health care to families that don't have access to other means of adequate health care providers.

Laura considered the HFC clinic as a necessary stopgap measure for patients who had limited access to primary care services due to income, language, immigration status, or family circumstances, which also provided an opportunity for PA students to practice skills of their chosen profession. Her interactions with HFC patients focused on the individual variations based on age and developmental stage rather than on ethnic background.

2. What do the PA students discover about people with backgrounds different from their own during their CSL?

Laura had significant contact with people from cultures and socioeconomic backgrounds different from her own prior to entering the PA program but still felt that the clinical service learning experience at HFC was an important part of the first year:

> [It was] a good exposure to have that be your first experience working with underserved populations that otherwise wouldn't be able to have health care. I know for a lot of people in the class it was a big eye-opener. Because I had other experiences, I wasn't as surprised, but a lot of people were. And it's always good to remember that not everybody has health insurance. Not everybody is taking it [medical care] for granted.

Despite her ability to communicate in Spanish and her relative comfort with Hispanic culture, Laura understood that sharing a common language with a patient is not sufficient. She worried that because she had primarily learned conversational Spanish that she might not come across as professional and respectful as she does in English.

> I imagine that I might come across a little differently [in Spanish compared to English]. And I know that I don't speak perfectly; so I might be interpreted [as having] a different educational level. I know that because of the way I learned Spanish, which I learned by just listening to people and not actually studying. When I was there [Venezuela] I was 16 . . . so some of the words that I would use—like, gosh, "I hope that is not slang for this or that." I spoke fluently by the time I got home [from Venezuela], but you wonder "is that appropriate in this formal environment [clinic or hospital] or is this just how I learned it?"

During her clinical year, she had checked with several professional interpreters about this issue of appropriate language usage in the clinical setting and was reassured that speaking this conversational, informal Spanish "didn't matter, because that's how your patients talk." Laura then went on, "But sometimes you're a little self-conscious. Like, did I say that right? I hope I didn't offend them."

Recalling one particular patient at HFC, Laura spoke with empathy, sympathy, and respect for family and individual resilience in the face of personal tragedy. Despite her comfort with interacting with people from diverse backgrounds, including low socioeconomic status, she described:

> The girls that I was talking about yesterday: The mother was addicted to drugs. I forgot about that. We were in charge of vitals that day and filling out the [school physical examination] form, which wasn't huge. But we had her take her shoes off to get weighed and get her height. And she was wearing her father's socks, and had tucked the top underneath, because they were too long. She had folded them under and tucked them under. And it was—She didn't have [her own] socks! And it was just one of those heartbreaking things to see in a kid . . . . She just had one of those uncomfortable airs about her. And I wasn't sure if it was because she was a teenager or what was going on. But it was [a] kind of shame [on the girl's part] having come into this setting, seeing these people who were nicely dressed and doing well and older.

The memory of caring for this 13-year-old girl during interviews 1 and 2 echoed Laura's ORF reflection about this same encounter, which had occurred during her first HFC session. On the ORF form Laura wrote, "In my work in free clinics in the past, I've seen a lot of clothing sharing, but there's something about seeing a 13-year-old girl wear her father's socks that breaks your heart." The incident impacted her deeply, as witnessed by Laura's ability to clearly recall it for our interview 18 months after it had occurred. She did this without reading her ORF and without any prompting from me. Over the course of her encounter with this patient, Laura learned some of the family history from the girl and her father, who had brought her to the clinic for a school physical examination:

> They left her mother in Puerto Rico, who was addicted to drugs. She [the patient] had taken care of her younger siblings in Puerto Rico. They were staying with family, so they didn't have a home [in the area]. They had just moved here . . . .

> She wasn't really giving a lot of information. And [I] didn't want to ask Dad, at that point, what happened. It was not really essential to getting her height and weight. And I don't know if the pediatrician talked more about it or not [during the physical examination].

Laura apparently felt it would have been disrespectful and inappropriate to delve further into this patient's social history in her role as a student whose tasks included taking vital signs. But she did recognize the impact that separation, moving to an ethnically different part of the country, and poor parenting might have had on the patient's self-esteem, as well as on her physical and mental well-being.

Laura recognized the centrality of the interaction between the individual's narrative and his or her familial, cultural, and social milieu in the clinical encounter. She found that she could still be surprised by the complexity of peoples' lives no matter their age.

3. What influence does the CSL experience have on the PA students' clinical practice during their clerkships and beyond?

As a new practitioner, Laura's concept of social justice focused on the health care system. This position was not addressed in any of her classmates' ORF forms. Consequently, her critique of the existing delivery of health care in the U.S. formed the basis for her desire to work with medically underserved patients:

> I do think that health care is a right not a privilege. In our society, sometimes it's backwards. People look at it more as a privilege. That plays into why I like to work in underserved communities, because I don't think that they should get substandard health care or anything else. I think that everybody deserves equal time and service. It usually comes down to money. If you want to pay more, that's fine. But everybody deserves to have a least basic health needs met.

When asked whether the HFC experience influenced her clinical or career decisions, she remarked, “Did it change anything for me? No. But it helped me to realize this is really what I want to do.”

Understanding that HFC allowed students the opportunity to interact with patients while providing needed health care, we discussed how this clinical service learning experience contributed to her clinical competence. Laura defined clinical competence as a merger of three skills sets:

> . . . intellectual skills, procedural skills and social skills to somehow manage all the patients that will come into your office. [Intellectual skills] are probably diagnostic: What are they [patients] here for? What would that [signs and symptoms] be? What questions would I have to ask to get the right diagnosis? what lab test do I have to do? [This would be the] book learning aspect of it [clinical competence]. Procedural skills is kind of obvious: You have to be able to do what you need to do [e.g., physical examination, suturing, inserting an IV]. And then the gray area of social skills: You have to be able to make your patient feel comfortable enough to actually tell you why they are here . . . . You have to be pleasant enough that they want to come back to see you next time. You have to have social skills to handle difficult diagnoses or sensitive questions, the ability to talk about private matters in an open way that makes people trust you.

Laura appreciated learning to be clinically competent, particularly with the pediatric patient population, through observing and interacting with clinicians during both sessions at HFC. She learned the importance of taking a thorough medical history:

> That time we had a kid—13 or 14 years old—come in for a sports physical. You think, “kid, healthy, not that much to do.” But as I presented to the pediatrician, she [asked], “Did you ask family history?” And I was like, “Well he’s 13 . . .” And she asked [the patient’s parents], “[Have] any of your relatives dropped dead or died at an early age?” It turns out he had an uncle that died at thirty. So all of a sudden we’re talking about more of a cardiology work-up than I was even thinking about.

In addition she gained skills in the age-appropriate approach to patients by observing how more experienced practitioners interacted with pediatric patients:

> The practitioners that were there—you definitely watched them and got clues or tricks . . . they would use. [I would think,] "Oh, that's a great idea." I wouldn't have thought to say "I'm going to look for an elbow in your ear" when talking to a little kid [before inserting the otoscope]. But all of a sudden she is laughing, where she was screaming with me.

As described in their ORF reflections, Laura's classmates also seemed to have appreciated that the patient contact afforded them at HFC represented the beginning of the process of becoming clinically competent. Some excerpts from the ORFs for the first clinical service learning session reflect this:

- "My job was to listen and practice questions in my mind to gain experience."
- "This was a good opportunity for me to practice extracting information from children and their parents and a learning experience for how to interact with pediatric patients."
- "As a student my goal was to provide quality support to the other staff members and to help make the patient and their family leave with a sense of being well provided for. Another goal of mine was to become familiar myself with physical exams, vaccine series, intake, and other useful information that will help me succeed as a PA."

Experiential learning brought depth to Laura's classroom-acquired knowledge of the signs of diabetes mellitus type two when she, along with other PA students, were called into an HFC exam room by the faculty physician assistant to observe acanthosis nigrans on a patient's neck. This is just one example of specific medical knowledge and

clinical skills that were enhanced through the HFC experience. Other advances in becoming clinically competent are also reflected in the ORFs completed after students' second session at HFC:

- "It was very educational to be able to practice everything we have learned in class and lab on actual patients."
- "I felt more efficient and was proud that I successfully gave four immunizations."
- "I definitely feel more confident in my ability to do some of the things revolving around the pediatrics exam, such as the entrance info [height, weight, body mass index, vaccination history] and the vaccinations portion. Until this night I had never given anyone a shot before, except for in clinical procedures, and I was able to do it successfully. It was actually quite confidence boosting."

Gaining clinical competence resulted from observing the patient as well as learning from the preceptor. Laura described a physician during one of her preceptorships:

> [He] was very knowledgeable. And I try to glean the benefits of working with him. [For example] my physical exam skills definitely improved. I mean, literally, we would sit there and stare at a patient for five minutes before we started [the history and examination]. To me that's really awkward, but you do learn a certain amount of information [from observation].

Laura elaborated on her process of gaining clinical skills and knowledge, which allow her to be more comfortable and professional with her patients. First she described learning medical procedures such as suturing, performing an incision and drainage, removing sutures, placing a chest tube, etc.:

> [As students, we follow the maxim] "see one, do one, teach one." For the most part I feel like it was expected that if you watched it one time, then you would be

> able to do it. And usually I would ask to do it under supervision. And then after I had supervision one time and would do it one time well, then I would feel a little more comfortable doing it without them [the preceptor] directly there watching me . . . . Even if we weren't allowed to do it then [in training], after watching a certain number of people doing an activity, I would be able to do it now.

At another point in a later interview, Laura described that her path to clinical competence involved repetition, which in turn improved her interpersonal skills with patients:

> The more patients you see with the same problem—at least for me, you get less nervous after you've seen the same thing 17 times than when you saw it the first time. So that probably makes you more calm. If you're nervous or uncomfortable, it comes off right away and the patient will probably sense that. I think I heard in surgery "fake it 'til you make it." [That is] pretend you know what you're doing until you actually know what you are doing. Just because you need to have that confidence to make people believe in you.

This concept of developing a professional, confident demeanor alongside, and perhaps even fostering, clinical competence was a frequent theme that Laura explored during the interviews. When describing doing an invasive procedure such as giving immunizations at HFC, she touched on the issue of trust:

> Parents know what you are going to do. Parents know how their child is going to react. So, at that point you really have to get them to trust you. It was a whole other level having somebody new [a student] examine their kid with a stethoscope, [which] isn't very invasive. But now they are having someone new inject something into their child. So I think, for me, you really did have to have a more confident air.

This professional face extends to taking the medical history, as well as performing procedures and doing a physical examination to show respect toward her patients:

> I try not to be shocked or appear shocked in any sort of interview, but I know sometimes you hear something [and you think,] "Wow, I really can't believe that you did that," in your head. But you don't want to make the person feel they did

> something wrong, especially [with] parenting skills. [You don't want to give the message] that they are bad parents for doing this . . . . You do have to learn some cultural things. Like, OK, this is what they really thought it [some behavior] is, so let's just act like that's normal and maybe guide them in a certain way. That will get them to realize they need to do something different without insulting or disrespecting the patient's beliefs or behaviors.

Like Laura, other students reflected on how they developed their professional personae as physician assistants. They described their first clinical encounters as student clinicians at HFC in their ORFs with awe and pride as they begin to understand the intersection of a professional demeanor and clinical competence:

- "I was able to be the medical consult . . . to sit in on a psychology session, which was very rewarding. I felt honored that I . . . was trusted enough to be the only person in the room with medical knowledge to catch any part of this patient's history, etc. that may be the manifestation of a medical condition."
- "It was interesting to have one of my first experiences as the authority figure in this sort of situation. It was slightly stressful because all of the paperwork was unfamiliar to me and so I was worried about missing something or doing something incorrectly."
- "I felt very much like a student, but also like the patients were respecting the white coat!"

When comparing clinical and social capabilities, Laura appreciated that clinical competency was a challenging process, while the psychosocial skills came more easily to her:

> The learning curve on that end is pretty steep—learning medicine in one year, and then trying to apply it in one year is difficult. So I think that was definitely, for me, much more difficult to grasp—the intellectual, the procedural [skills]—

> whereas the social skills came a little bit more naturally [to me] . . . . You're either a people person or you are not; or you are introverted and don't feel as comfortable with other people. There are some things that you just can't [learn].

Laura could clearly outline what it would take to become a clinically competent physician assistant and appreciated the challenges of the process. She felt most comfortable with navigating cultural and psychosocial competencies but understood that all three abilities constituted good clinical practice.

4. How does this CSL experience impact the PA students' perceptions of their own cultural competency?

Laura described the components of culture as specific, learnable factoids that in total define a group of people:

> All those unwritten rules that form a subset of the population—it's the food that they eat, the music they listen to, the holidays they celebrate, the way they interact with each other—all the rules that dictate the life of a subset of the population. Because it's so broad, it's hard to become fluent in someone else's culture, because there is always something that perhaps you didn't know.

These rules can be learned a variety of ways, but Laura differentiated memorizing factoids from understanding complex social interactions:

> Knowledge that you can read about or see visually for yourself or you can hear about . . . before [you see the patient], someone could just tell you. [For example] "at Christmas we have this special bread"—that's just a fact. That's just what they do; that's learning about their culture but is on a fact-based level. Whereas the social aspect isn't a fact. It's hard to explain the demeanor of [people] in a society, where you have to experience it and see what is normal and how you are supposed to interact the right way.

Her notion of cultural identity came down to self-identification through specific ethnic customs, beliefs, or behaviors and through incorporation of elements of popular

culture such as music and entertainment into one's life. In answer to my question about how she would define culture, she spoke to issues of uncertainty and ambiguity in the clinical encounter, because one could not be certain what part of a patient's background would take precedence in his or her identity:

> The easiest definition is ethnic group . . . . [But] you have a religious identification that is part of your culture that perhaps forms more of your culture than your ethnic identification. Especially with youth, nowadays, even the type of music you listen to. Maybe that's a really important part of your self-identity. Or, [perhaps it is] your sexuality [i.e., sexual preference] really defines who you are. I think there are so many things that can define one's culture. It really comes down to how you self-identify . . . . That's going to define more of what clothes you wear, how you interact with people, or what clubs you go to, or what you do on a Saturday night.

Despite the difficulty involved in understanding and working with people from diverse backgrounds, it is important to continually strive to understand through repetition and familiarity augmented by reading, observing others, and asking questions:

> There are things you have to learn if you didn't grow up in that culture. Those are the rules of the culture . . . . [If] you work in the culture long enough or you live within the culture, they do become second nature. I think you do have to be taught the rules to begin with and practice them and work them into your routine with patients. The rules of culture [include] the speech, the body language [that becomes] routine.

Laura felt, that, at the very least, if a culturally competent clinician is not able to completely master and integrate those culturally specific behaviors, at least that person should learn to not behave in an offensive manner.

Laura's notion of clinical competence was intimately tied to cultural competence, but she acknowledged that it was hard to become fluent in another culture. Unfortunately,

she lamented, “You don’t know what you don’t know.” She summed up her process of gaining cultural knowledge and becoming culturally competent:

> What makes you culturally competent is to understand a culture that isn’t yours or maybe [is] your second [culture]. And the ability to be humble enough to ask questions when you don’t [know], to not assume anything when it comes to a culture that you are not familiar with. And to try to keep learning about the culture that your patients are coming from.

As she continued, Laura made it very clear that even with adequate psychosocial abilities, a clinically competent health care provider needed also to be culturally competent:

> You can be the best clinician in all the three ways that I said you could be clinically competent [intellectual, procedural, and knowledge skills], but if you overlook the cultural aspect, especially in certain cultures, you’re really not going anywhere. You can be very socially appropriate and have social skills for your own culture, but if it doesn’t apply to someone else’s, you don’t really have those skills.

When asked how she would interact with patients from an unfamiliar ethnic or social background, Laura explained:

> You just have to be humble. This isn’t your area of expertise, so you go in there acknowledging that and keeping an open line of communication. [For example saying], “If I do anything to offend you, I apologize in advance. Please tell me so I don’t do it again.” That’s generally my rule when I go into a strange situation. I think it’s important to say because you don’t want to go through the whole day saying [something like], “Gosh I worked with 25 Hmong patients and I didn’t know you weren’t supposed to shake the male’s hand. I’m sorry. Oh, crap. How come no one told me in the beginning?” So I always try to get them [the patients] on my side, to understand that I am really trying.

Although most students did not comment on the HFC clinicians’ modeling cultural competence in their patient interactions, one student observed, “The physician is explaining to the mother about the potential danger of having an overweight child. He is

doing his best to explain healthy eating options that would fit within their cultural norms."

Several times throughout the interviews we discussed a preceptor who "definitely in my opinion was not culturally competent at all and had questionable social skills—but intellectually, procedurally, those skills were amazing." This allopathic clinician had trained in Britain but had lived and worked in the United States for most of his long career. From Laura's point of view, he was well acculturated as an American despite being born in East Asia. This preceptor exemplified a clinician who was clinically competent but culturally (and socially) incompetent:

> He read the *New England Journal of Medicine* every month that it came, from front to back. He would make copies of articles for all the other physicians. He knew his stuff. He was one of the bigger "pimpers" [the person who singles out a student to answer a question] of the docs that were there—always asking questions, [such as] "Give me all the differentials for being tired." You got raked over the coals with him. But on multiple occasions, he would ask them [Latino patients], "How long have you lived in this country?" [They would answer, for example], "15 years," and it would be through an interpreter. [He would ask], "Why don't you speak English?"

Laura reacted with exasperation when recalling these incidences, commenting, "You would want to ask him—'how long have you worked at this clinic? Why don't you speak Spanish?" This case emphasized the inter-relatedness of social and cultural abilities:

> Beyond just cultural [issues], he didn't have social skills . . . . [For example] even with an English speaking patient, we would walk in [to the exam room] and he would say, "What's the first thing you notice?" As a student, I don't want to say [out loud in front of the patient], "The patient is overweight," because it's not socially appropriate. So I know myself and other students would try to say, "They have a high BMI [body mass index]," Or something like this, that would answer his question, but not in an offensive way [to the patient].

Notwithstanding the centrality of cultural competence in a clinician's clinical competence, Laura related how she collected the family, social, and cultural information as her way of developing a rapport with a patient not particularly central to developing a differential diagnosis or a management plan. She could recognize the significance of the information:

> From a medical standpoint it [personal, familial, and cultural information] is important. [For example] food during the holidays will affect things like diabetes mellitus and BMI. So that goes into the clinical category. You also learn, do they spend [the holidays] with their family or relatives in one house? Is the family unit always together? Do they spend it with the nuclear family? You garner that information on the side—the part that all goes in the social history [part of the medical history] . . . . As I am starting to work [at a suburban, family practice clinic], I rarely take a [formal] social history, but it's just the questions you ask: What are you doing this summer? What work are you doing? How are the kids? that extra stuff that you don't think is important to ask about that just come up . . . . Occasionally, if I don't get anything [in this informal way], I'll think to use [a formal social history].

Reiterating the innateness of communicative abilities, Laura concludes, "If you have the social skills to ask about someone's life, that kind of thing just naturally come out."

When discussing her interaction with the standardized patient with the Nigerian background during the OSCE, Laura remembered that she felt constrained to delve into the patient's ethnic background "because I wouldn't want him to think that I think that they [Nigerians] are all that different, that they don't fit in somehow or that there is something to be studied." In the previous interview session, she had also emphasized her desire to respect the patient by keeping the clinical encounter nonthreatening:

> [If I ask], "Do you eat that or not," it insinuates that they are different than you. I have to ask what you do, because I don't understand you. I think it [diet and other ethnic customs] has to be asked rather tactfully. But it would have been good

> information to have. [For example], asking, "Why do you live with your Mom?" I think that would have been a strange question [to ask a 30-year-old male].

She also indicated that the reason for the patient's visit might have moderated the types of pointed questions she asked about both the patient's family dynamics, which she labeled as psychosocial, and ethnic practices, such as diet: "You know, for a blood pressure check, probably not [ask about these topics]. If he was coming in for depression or anxiety or something like that, then I feel it's more appropriate to enter more of the psychosocial history."

Further defending her reasoning for not delving into the details of his diet, she noted:

> But a lot of what he said—vegetables, fruit, fish—that doesn't strike me as all that strange of a diet. So if it had been a bunch of food that I didn't recognize, that would have been a cue to [ask more specific questions], if didn't know what he was talking about. I guess it didn't strike me as that strange.

For Laura, the cues that might have sparked her to delve deeper into this SP's background were things such as differences in language and attire, which were not present in this situation. She described her decision-making process for when to include a more detailed cultural history, including both relevance and time constraints:

> I just get a feeling by reading people. If I just get a feeling like it's going to be necessary information, then I don't have a problem asking about it. But if I don't think it will pertain to what I will do [clinically] . . . . Looking back [at the situation during the OSCE], if I was going to just change his blood pressure medication, I'm not sure it would have changed the [amount of] increase that I would have done. I think it also comes down to, especially at this point [as a clinically practicing PA], you only have so much time to get it all in. That's something to think about—prioritizing.

Laura found in the clinical service learning experiences a confirmation of her previously held perceptions about the centrality of culture in her patient's life. Taking on her new

role of clinician, however, made her reconsider when and how to apply her well-developed sense of cultural competence.

Summary. Laura brought to the interviews a firm understanding of what it was like to be an outsider within a culture and what it had taken for her to become comfortable and accepted as a high school exchange student. From this initial encounter with the "other," she developed an interest in working with people from diverse backgrounds, including those from lower socioeconomic status, which affects their ability to access medical services. Laura employed humility and curiosity to understand patients from unfamiliar cultures, whether they represented specific ethnicities, sexual preferences, religions, or age-related cohorts.

With the goal of clinical competence, Laura brought her people skills to the clinical encounter by creating a respectful atmosphere where patients would feel cared for. On the other hand, she might consider employing cultural competence in different ways depending on the setting and the patient's medical condition or health concerns. In the end, Laura appreciated that the practitioner might have to juggle these competencies—clinical, psychosocial, and cultural—to provide appropriate health care.

In exploring whether cultural competence can be taught and can be learned, Laura laid out several ways to do so: (a) living in another country or among people from a different culture; (b) quizzing people who live and work with a particular group and members of the group; and (c) researching using books or the Internet to find out about specific beliefs, customs, behaviors, and values. She was less certain about whether psychosocial competence could be taught or learned and viewed this realm as more of an

innate ability. In the end, as a physician assistant student and new graduate, Laura was able to admire a clinician with superb clinical skills and knowledge as a good diagnostician: but without concomitant social and cultural abilities, Laura said that clinician was not one she would recommend for herself, her family, or friends.

Case 4: Kari

Background. Kari described herself as an Italian-American who worked for 12 years as a registered dietician before applying to the physician assistant program. During the last several years of her career she worked primarily with hospitalized patients on ventilators who needed parenteral nutrition via feeding tubes. She described this as involving primarily calculations of nutritional needs based on a patient's medical condition but not requiring the extensive clinical interaction with the patient that a PA might have.

Kari described her international travel opportunities as limited to short vacations in the Bahamas, Cancun, Antigua, and Jamaica. She does not speak a foreign language, although she took two semesters of high school Spanish more than 20 years ago. As part of her dietetic internship, Kari provided nutrition counseling for women receiving Women, Infants, and Children, a federal assistance program for low income families, known more commonly as WIC. Additional contact with people from a lower socioeconomic class occurred when Kari volunteered on food and nutrition projects over the last 12 years. She listed her volunteer activities: (a) nutrition counseling as a registered dietitian at multiple health fairs; (b) participating as a member of her

community's Hunger Task Force, organizing fundraisers and collections for food pantries; and (c) serving food at Salvation Army meal sites.

Our interviews took place over a span of four months after Kari had passed her physician assistant certification examination, and while she was working as a physician assistant in an urban emergency department (ED). The first interview occurred as Kari was in the process of being hired for this first job as a PA, and at the last interview she revealed that she had given notice at the ED, having found a new position working in gastroenterology. She explained that as a PA in this internal medicine subspecialty, she would be expected to apply her dietetics skills and knowledge along with her medical capabilities. We held the first interview in a restaurant near Kari's home, but the ambient noise created a poor quality audio recording. Subsequently, we met a nearby public library, where we reserved a private room, which both facilitated the interview process and created a better quality recording.

Throughout the interview sessions, Kari would often allude to clinical situations that she encountered in her work in the emergency department. She used these encounters and, to some extent, her background as a registered dietician, to elucidate, to illustrate, and to reinforce reflections and ideas about the topics we covered in our conversations. Anecdotes and observations based on her work experiences are liberally scattered throughout this section, as they offer an additional dimension to Kari's narrative.

Interviews.

1. **During their CSL how do PA students understand the patients' and their families' experiences at HFC?**

During Kari's first session at HFC she spent the entire time observing a mental health intake session run by a graduate psychology student. Observing a counseling session was provided as an option for the PA students working at HFC, especially if few patients came for medical services, as was the case on this date. Kari volunteered for this activity, although, as we will discuss later, she regretted this decision because of what happened during her second HFC session: She felt disoriented and anxious because she had not had the opportunity to practice performing an intake history or vital signs for the medical patients as her classmates had. Despite this frustration, Kari valued the opportunity to observe the interaction among the psychology student, the client (a teenage boy), and the boy's father. She recalled how the teenager's discomfort was contrasted by his father's determination to get help. The boy was having behavioral problems in school and at home, and his father was taking advantage of HFC's free psychological services to help his son understand his mother's suicide, which is what had prompted the boy's move less than a year prior from Puerto Rico. The boy's father had moved to the area from Puerto Rico many years before. The boy now lived in the United States with his father, his father's wife, and their children, and Kari explained that there seemed to be cultural differences within this family configuration.

> Fifteen plus years [ago, the dad] was married to an American. So he, I believe, was in a different place culturally than his son. He was all for the whole process of getting his son help and working with the school and [the] psychologist.

Kari was convinced that part of the son's discomfort was also a reflection of his developmental stage, noting the complexity of the case: "Again, what 15-year-old boy wants to be in that situation [counseling session]? [However, additionally], there very well may have been cultural elements."

As Kari observed the interaction between the psychology student conducting the intake interview and the patient, she reflected, "I was trying to read the kid's face and body language a little to see what he was feeling about his dad telling all this stuff to these strange women. He was clearly uncomfortable." The interview took place in English, which was perfectly comfortable for the father. However the "son probably needed some work [on his English], but was clearly able to communicate." This prolonged exposure to HFC patients during a 45–60 minute counseling session stands in contrast to the medical side of HFC, where students interact with patients for only 15–30 minutes during medical intake. The length of the counseling session allowed time for Kari to formulate a clear picture of how the patient and his father experienced HFC. She remembered the adolescent seeming self-conscious and distracted, as he was "checking his phone every few minutes and wanting to be elsewhere." At one a point in the session, the psychology student asked the father to leave the room in a manner that Kari described as respectful and professional:

> She said, "I gathered all the data I need now. The next part of the session is one-on-one. Is that OK with you [the father]?" He [the father] said, "Absolutely." I thought, "Good move." [The father] meant well. He was passionate about helping his son, and would do absolutely anything to help him. But I think he was overwhelmed and embarrassing his son [by being in the room].

Kari also left the room at that point and did not know what transpired, as she left the building before she could talk to the psychology student.

Looking back on that first HFC session from the vantage point of a graduated and certified physician assistant who was struggling to master the many clinical procedures necessary to succeed in the emergency setting, Kari related:

> It was not disappointing, because it was a good experience. But going into [the clinical year, I missed that] hands-on experience. When I was a dietician, I was always a thinker, thinker, thinker, calculator. So I was desperate to do things—even blood pressures . . . . So I was disappointed that I wasn't hands-on [during that session] just to get better.

During her second clinical service-learning session at HFC, Kari worked on the medical side but remembered feeling disoriented and inept, because she had not previously done medical intake:

> I didn't know what was going on. My classmates knew exactly what to do, where to go, what the plan was, how to use the sheets [forms]. So I felt even worse. I was even more clueless than I realized.

During this clinic evening, Kari cared for three patients, a 17-year-old boy and two elementary-aged sisters needing physical examinations and immunizations. She described the teenage boy as being impatient: "He didn't want to be there; was aggravated with his grandmother. Rolled his eyes. Gave me a real hard time. It was awkward and uncomfortable given that I wasn't very great at what I was doing."

She observed that the child's grandmother was intent on completing the visit so that she could enroll her grandson in high school:

> The grandmother was mostly just aggravated with her grandson. I think she appreciated that we were there to get done what she needed to get done—to get the kid in school . . . . It took a while for the 17-year-old to get through, and he wanted to leave. She [the grandmother] wasn't having it.

This was the only time during our interview sessions that Kari reflected that patients expressed or gave the impression of being grateful for access to free health care provided at HFC or at Kids First Health Fair.

The two girls that Kari cared for acted very differently from the boy. They "were fine, happy, no problems. [They] seemed to just go with the flow. They were patient [and] didn't care that I was taking a little longer." She didn't have a clear picture of their mother's reaction to the medical care at HFC but recalled, "She didn't speak English, [but] seemed patient." Kari completed her first physical examination outside of the classroom for one of the girls and remembered the pediatrician demonstrating the appropriate way to determine the Tanner stage (i.e., stage of puberty) a 12-year-old female patient. Her comments reflected the lack of privacy that the makeshift exam rooms afforded the patient, which could potentially have added to the patient's embarrassment, but the pediatrician professionally and competently performed an inspection of the external genitalia on the fully clothed girl:

> I don't know if she [the pediatrician] should have done that there, but when doing those types of exams, whether it be there [HFC], where I think it wasn't appropriate or in an office—go with that. Don't build up to it and make it a really nervous thing that is about to happen. [Make it] just part of [the exam]: look in your ears, look here [at genitalia]. It was very smooth.

Mirroring Kari's concern for a patient's privacy, another student also expressed dismay at how inhospitable the physical setup of Healthy Families Clinic was for patients. This student adamantly wrote about the lack of privacy afforded in the classrooms that had been turned into examination rooms with mobile dividers. This student understood that the situation was disrespectful toward the patients:

> I was shocked by the atmosphere that the "clinic" gave. There was a major lack of privacy that made me question whether or not the patients that did come answered honestly. Perhaps if there were walls they would be more comfortable or maybe they don't care since it's free.

Kari was quite sensitive to the feelings and reactions of the HFC patients to their visit to the student-run clinic. She empathized with the discomforts faced by the children, whether the probing was psychological or physical. However, she also recognized the parents' roles as caretakers who gratefully accessed the services to keep their children well both psychologically and physically.

2. What do the PA students discover about people with backgrounds different from their own during their CSL?

When considering the socioeconomic and cultural backgrounds of the patients she encountered during clinical service learning and subsequent clinical experiences, Kari focused on language and food to signify differences between her and the patients. Kari became so frustrated with her inability to speak Spanish and needing to use an interpreter first at HFC, later in some of her clinical rotations, and finally at her job in the emergency department, she admitted,

> I did buy a $200–$300 [piece of] software, that, of course, I haven't used yet, to learn Spanish. And I would definitely like to take a class to get up to speed. I do not like using interpreters . . . . [I now work with a] heavily Hispanic population. There are Spanish interpreters always, and they do a beautiful job. I think it's very different [to talk through an interpreter versus directly to the patient].

Kari's classmates also understood the importance of speaking Spanish in the clinical setting. After the second HFC experience, one student noted, "I also decided that I need more exposure to Spanish-speaking people so I can be more prepared for my rotations." Another student lamented his or her lack of ability to speak Spanish: "I also

felt a bit helpless because the community is so predominately Hispanic and I could not communicate with the parents as much as I would have liked to."

During a later interview Kari differentiated language barriers with other aspects of culture, when I asked how she might interact with a patient whose socio-cultural background was unfamiliar to her:

> If I am honest, I would just try to pick up on the cues from the patient. I listen the best I can through an interpreter, if needed. Or if it's just a cultural issue, not a language barrier, it [might] be realistic to look it [the information] up quick or see what's unique about this [patient's background].

Kari relied heavily on her interpersonal abilities to empathize and to read a patient's body language to help her interact with people from different cultural backgrounds. As we will see in subsequent sections, she also used these skills to provide both clinically competent and psychosocially appropriate care.

Throughout the four interviews, Kari struggled with the concept of cultural competence and its impact on patient care. When grappling for an example, she often returned to dietary differences:

> Nutrition is the example I keep giving. But it's certainly relevant for [the social history]: "Who do you cook for? What types of meals do you eat? [Do you eat] ethnic foods?" It's all part of the planning. I'm not sure I would ask necessarily directly, if it weren't [applicable]. But I suppose it could be pertinent, if they [the patient] did not believe in taking medications or those types of things.

Upon contemplating the question about the place of cultural topics in the clinical encounter, she conceded that dietary habits and other behaviors and beliefs would be important in "making sure you have an understanding of what needs to be done for follow-up."

While relating how she and a classmate, who was also a registered dietician, carried out nutrition counseling at Kids First Health Fair, Kari easily honed in on the need to integrate culturally appropriate values and customs with patient care. In this case, it was in the dietary guidance that they offered:

> That's where I think that [we] worked in cultural competence now that I think of it. I wasn't used to educating nutritionally the Hispanic population. So I had to rethink how to make a plate [in order] to make it as simple as you can. The typical foods were a little bit different. We had to think about it a little bit . . . . We hadn't counseled that population before, so actually, I think we did a pretty good job.

Kari went on to clarify the process by which they modified their presentation and interaction based on the information they got directly from their patients about their particular values, beliefs, and behaviors, which they often explicitly expressed during the short counseling sessions. Kari and her classmate not only had to adjust specific foods and meal schedules, but they also addressed

> the fact that it was different—the concept of obesity or overweight. Wanting to feed the child to show love. It really was quite different than I was used to . . . . If it was the grandma or if it was the dad [accompanying] the child or the mom, they liked feeding the child even though the child was overweight and bordering on diabetic. And it [feeding the child] was showing love—giving them seconds, giving them junk food. So you can't disregard that emotional part, so we just tried to give them ideas to work within that framework. You know they weren't going to give it up.
>
> [They] weren't going to think of food as they should. Well, I don't know if I should say, "how" they should, but how to be healthy, more balanced. Just not using it as reward, not using it as love. We weren't going to get into all that right there and then for 20 minutes. So we tried to focus on little things that would fit into their culture, their lifestyle. [Something] that would work for that person.

When I inquired how they prepared themselves for this intercultural encounter, Kari remembered:

> We did not prepare. We winged it. We talked to the patient and to the mom [or guardian or other adult]. We would take a diet history and get a sense of what they were doing. And then we were [thinking], "Oh, OK, this is different than

> what we're used to. We need to revamp how we educate. We're not going to just do our usual." We figured it out as we went. But it was definitely different. It was interesting.

Despite these insights into this process of providing culturally appropriate dietary counseling, Kari continued to struggle with transferring that ability to her role as a physician assistant: "It's just a little different. [Dietetics] is just more straightforward in that area. I just haven't done much with it as a PA—the cultural part." She recalled routinely exploring the particular ethnic dietary customs with her patients, and feeling culturally competent throughout her career as a registered dietician. When I asked how this was taught in the dietetics curriculum, she recollected, "Maybe we had a chapter or unit. It was probably just built into one of our clinical nutrition classes."

As for Kari, other PA students also found dietary habits and language the most basic way to discuss cultural differences. For example, one student observed, in the ORF, how diet was embedded in cultural norms, while empathizing with the HFC patient and family based on having a similar ethnic background:

> The physician is explaining to the mother about the potential danger of having an overweight child. He is doing his best to explain healthy eating options that would fit within their cultural norms . . . . The doctor seems to genuinely care about the norms of the patient's culture (which includes her diet and how her culture looks upon children of this body habitus). The mother seems scared for her child's health and is concerned. I am concerned for the child's health and social well-being, but I am also understanding of the cultural constraints that are attached to the dieting issue, as I am like this family, Mexican American.

Kari focused on language and dietary differences when considering the backgrounds of the patients she encountered during her clinical service learning experiences at both Healthy Families Clinic and at Kids First Health Fair. Otherwise, she found the variations in patients' backgrounds and interactions with the health care system

had more to do with individual, idiosyncratic characteristics that could be appreciated through verbal and nonverbal cues.

3. What influence does the CSL experience have on the PA students' clinical practice during their clerkships?

Throughout our interview sessions, Kari repeatedly expressed lacking confidence in her clinical competence and having that feeling reinforced every day during her shifts in the ED, where she was expected to perform various clinical procedures (e.g., suturing, casting, suture removal) and learn a wide range of clinical routines to care for the wide variety of patients who presented in the emergency room. She explained that the feeling of ineptitude was particularly difficult for her, because she had spent 12 years working as a competent, confident registered dietician: "It's just such a contrast, because I felt perfectly competent as a register dietician." When I asked why the confidence did not transfer to her clinical work as a PA, she noted that the expectations and skill sets were so different that, except for an ease in her psychosocial capability, nothing else seemed to apply to her new career: "It's [dietetics] just different. It's simpler. You take a diet history. You find out what they eat; so you know their cultural [preferences]; really their individual and cultural [dietary habits]. And they give it to you straight up." In a previous session she had lamented:

> It's just such a contrast, because I felt clinically competent as a dietician. And to go from that to not . . . It's almost shame [that I feel]. I don't know if that is too harsh of a word, but it is hard. I want to do the right thing, and I don't have a strong sense of clinical judgment. Two people do things differently, and I don't have an opinion of which way to go.

When I asked Kari to provide a definition for the concept of clinical competence, she exclaimed, "Something I am lacking right now!" She admitted to being challenged by the process of becoming clinically competent, both during her clinical year in PA school and in her new position, and came up with this definition of clinical competence:

> The ability to simply care for the patient appropriately: to diagnose, treat, provide proper follow-up. To do a good physical exam that covers everything, that doesn't miss anything. Take an adequate history. To know when to defer, when it's above you—get your attending [physician]. If there are procedures, do them well. Not create problems or harm [the patient]. Don't over-treat or under-treat . . . . [Also] interpreting labs, x-rays. The whole entire thing.

When I probed about patient interaction as part of clinical competence she explained that clinical competence includes maintaining professionalism by "speaking to them [the patients] at whatever level they are at appropriately. Using interpreters when needed. Education at whatever level they are at. Handouts. Really everything about it is part of clinical competence. "

The arena of psychosocial competence is where Kari felt strongest as a result of her years of patient care as a registered dietician and her capacity for empathy honed over the years. She viewed her skill in forming responsive, professional interpersonal relationships with patients as part of being clinically competent. She explained:

> It helps me to get the trust of the patient. To get them to open up more. To cry if they need to. You can just see that whatever it is they will let go. Just be honest with whatever is really going on . . . . Just talk about what I am sensing [and] get them to expand on it.

Kari provided an example of how she fostered trust with a patient's mother who initially was angry and distrustful based what she believed was mistreatment at another hospital:

> I have literal empathy—you can see that the mom is really concerned about the child. I had an African American mother who came in [to the emergency room] with her 17-year-old, who had a liver laceration from a car accident. She felt she wasn't treated well [at another hospital]. The chief complaint [written on her chart] said, "Pain medication refill." And so I just said, "You're here for pain medication refill." And she got very offended, very upset, and I apologized. I said, "Let's start over." By the end of it [the visit] she said, "Thanks so much for listening to me" and "I really appreciate it." I did what I thought I should do for her [child].

She understood that there may have been some stereotyping by another employee making the assumption that an African American adolescent would be inappropriately seeking drugs, and that attitude might have interfered with appropriate medical care for this patient. Kari put herself in the mother's place and said, "Well, I'd be offended too, if that's not what my complaint was. And that's what they put down [in the chart]. And it may be an assumption, so that's not fair."

However, she recognized that being overly empathetic with the patient could interfere with patient care. For example, Kari commented that the pediatrician at HFC modeled clinical competence while performing a thorough physical examination:

> I guess I learned [that] even though I felt awkward and the girl felt awkward, the key was that the pediatrician wasn't. [She] didn't make a big deal out of it [the genital examination]. Did what she needed to do. Moved on. Talked about it. Did some education about getting her period soon. Trying to not make a big deal out of it. It was the right thing to do.

Despite completing a supervised physical examination on the patient described above, Kari did not express in any of the interview sessions that the second HFC experience represented a first step to building her clinical competence through direct interaction with real patients. One of her fellow classmates, however, did reflect such sentiment:

> It was helpful to follow one patient through the entire process at Healthy Families and complete one entire physical along with all paperwork. The reality that we know enough to perform everything needed at the clinic was surreal. It was very informative speaking with the resident and attending physician to gather tips, advice, and medical knowledge that will continue to help me as I endeavor into rotations.

When I asked what advice Kari had for new graduates about the process of becoming clinically competent, she used her current experience in the workforce along with her experiences during the clinical rotations to emphasize humility in the face of the vastness of medical knowledge:

> You have to look it up if you don't know, [and] you won't know. I would tell them you need to realize there will be a huge amount you won't know after the PA program. One think I'm realizing is that is expected. I think that they have to train us on the job, and that's accepted and expected. So there will be a lot that you will need to look up and continue to review nightly, and make notes, like in rotations on things you aren't 100% sure on. Ask when you don't know. Definitely don't want to harm the patient. [Make sure] your ego is not in the way.

Following this description, Kari spontaneously addressed the issue of becoming culturally competent, albeit, with less surety:

> The same clearly applies for cultural competence. I just don't know where I would send them to use resources. [Hesitating she continued]…there are books out there, and people. And one resource I didn't think about could be [consulting with the] interpreters.

When pressed as to whether clinical competence and cultural competence were connected she stated, "No, they are not related. I could be totally clinically competent and culturally incompetent at the same time." She then immediately contradicted herself saying, "It's all about quality of care," in which both competencies are important factors. She went on to explain that the clinical setting dictates which competency takes precedence. In the emergency department, culture issues were put aside "with what we're doing—trying to make sure no one is going to die."

Frustration in overcoming the hurdles of becoming clinically competent in the emergency department entailed accepting uncertainty, vagueness, and multiple approaches to the same clinical quandary. She related the time in the ED when she was trying to determine which of two management plans to follow for a particular patient and asked both a PA and MD working with her:

> I did ask the doctor, and she did something differently too. The doctor [was correct], but the [answer] was somewhere in between, too. I could do two different things. That is the truth, although it is preferable to do "so and so."

Kari purposefully chose a position as an emergency PA in order to develop her clinical and procedural skills. She wanted to focus on skills other than those she had honed as a registered dietician, e.g., patient education, creating long-term care plans. She stated that the only skill sets that transferred from one profession to another were understanding laboratory values and interpersonal skills:

> It helped me be familiar with labs. That's mainly what I did with tube feedings and TPNs. But beyond that, [it didn't help] much with clinical competence. Just patient interaction skill set and labs would be the two skill sets [that apply to both dietetics and PA clinical practice]. But in terms of being a dietician, it's all calculations and thinking and analytical—in your brain. [There is] no hands-on whatsoever.

She went on to explain why she originally decided to challenge herself with emergency medicine, which did not use the skills she had developed as a dietician:

> In IM [internal medicine], the clinical competence [developed previously] helped, because there was a lot of diabetes, high blood pressure, CHF [congestive heart failure requiring] long-term management. Just talking with patients and educating them. Those are skills I feel OK with, [however] . . . surgery, hands-on—that's rough for me.

When I asked whether the clinical service learning experiences during the first year of PA school influenced either her choice of rotations or her job search, she

answered emphatically, “No! At Kids First Health Fair I volunteered at the nutrition booth. It just confirmed that I didn’t want to do that anymore.” Kari went on to explain, “The only thing it made me realize is that I hope to volunteer to do those kinds of clinics. It’s not something I would do full time. But, for sure, I like the concept and being available to help.”

Her disinterest in working full time in a situation like HFC apparently did not have to do with working with a medically underserved population, as she described enjoying her rotation at a family practice clinic that catered to low income people, many of whom were Latino, noting, “I would take [the physician assistant preceptor’s] job—I told him, ‘You have something good here.’” Despite having worked as a dietician in pediatric and neonatal intensive care units, Kari did not want to work exclusively with children as a physician assistant. She explained her decision-making process:

> One of the things I did when approaching the clinical year was just tell myself to be wide open—“You have no idea what you are going to love” . . . but I did not care overly for pediatrics. I did not. I’ll be honest . . . but that had nothing specifically to do with the fair (Kids First Health Fair) or Healthy Families Clinic.

Instead she opted to test herself as a PA by choosing a particularly challenging first position in an urban hospital’s emergency department that used few skills she had perfected as a dietician. Although her original job choice did not build on her strengths and even her stated preference for a family practice position, by the last interview she had secured a new position in gastroenterology that did promise to use all her clinical and psychosocial abilities.

4. How does this CSL experience impact the PA students' perceptions of their own cultural competency?

Kari struggled throughout the interviews to articulate a definition of cultural competence and the role that it played in the clinical encounter. By Interview 4, she expressed the following definition after pondering the topic for several moments:

> Cultural competence means being educated or having access to the information about a person's culture/ethnic group and belief system that they grow up with or that they live by. That affects how they perceive health, how they live, how, for example, they take medication. That affects everything about their lives and helps the clinician figure out how to best educate them and manage their health.

Referring to the OSCE with the standardized patient acting as a Nigerian-born American, she continued:

> I don't think that every culture would want the same approach. Nor would it be effective to have the same approach. This example [the OSCE] was interesting, because he perceived [that] because I didn't ask [directly about Nigerian health beliefs] that I didn't address it. Perhaps another culture might take offense or might react negatively to the more direct approach.

Kari purposely didn't ask about specific customs and beliefs during the OSCE, because she felt calling out differences between herself and the patient might embarrass him. She did acknowledge that because he didn't have an accent and dressed in typical American clothing, "I might have not thought of it [cultural issues] with this guy." She admitted that if he had looked more exotic or spoken with an accent, she "would have been more alert to ask those questions [about specific ethnic behaviors, beliefs, customs, etc.]."

Kari recalled a couple of incidences in which clinicians generalized about Hispanic female patients, and to Kari's way of thinking the generalizations bordered on stereotyping. During her surgery rotation, Kari asked her preceptor, who was Latino

himself, about a particularly distraught patient whom they were seeing for a post-operative visit. She noted that he would not have brought the subject up if she had not asked him directly and was surprised by his response: "What my Hispanic surgeon said about [Latina female patients]—how he worded it, 'Overly dramatic, borderline hysterical, post-op, post-appendectomy'" She noted that he relayed this observation in a matter-of-fact tone, and he did not manage this patient population any differently than any other in terms of post-operative medications or instructions, except that he may "give them a few extra days off work." Yet, she contrasted the surgeon's matter-of-fact tone with comments she overheard during a shift in the emergency room, when a health care provider (ethnic background unknown) said something similar "with a little bit of an eye roll [about the patient's] over-dramatization." Despite Kari's obvious disdain of their stereotyping, she believed that even that clinician would provide clinically competent emergency medical care.

In contrast, a PA student who was less cynical than Kari and the clinicians she had encountered, described the positive aspects of Latino culture that she observed at HFC:

> Many of the families that came to the clinic were Hispanic and their entire family came with for the visit, which was pleasant to see. Many times the children were translating for their parents. In this aspect, I saw many families working together for their children to receive the services they need for school.

As discussed previously, Kari had mixed feelings and opinions about the need to use interpreters. As she recounted a recent case in the emergency department, she reiterated her impression of interpreters as indispensible professionals and her frustration in having to rely on them:

> I had a patient the other day, Spanish-speaking—this is awful—who was supposed to be, I can't remember how many weeks pregnant. It was a blighted ovum. I had to tell her through a male interpreter. He was really good, too. It was awful! I felt just sick.

She tried to remember how she phrased the news: "It was hard, really hard. It was so awkward. I said to her, I literally said, 'I'm sorry I have to tell you.' God, I can't remember the words I used. It's so hard to do in another language through a guy sitting across [the bed]." She went on to relate that this was a confusing diagnosis to explain to a woman who believed she was pregnant and then was told she actually was not pregnant. Instead the patient had an odd sounding condition that mimicked pregnancy. Kari imagined that the patient was thinking, "Did I lose the baby? Was there a baby at one point? What do you mean?" Kari's level of empathy and anxiety were heightened

> because of the language barrier. [I would have been] less tortured by my inability to covey or be sure I was getting through. It was just a terrible time to not be able to communicate . . . . It's a terrible situation. No matter what, I would have felt bad. I felt worse that I could not speak to her directly. . . . I did my best to make sure she understood, but how do I know she really understood? I asked [if she understood the diagnosis] and she said, "Yes," to him [the interpreter].

Together we imagined the hypothetical situation of a Spanish-speaking clinician caring for this patient. Kari stated, "For the sake of the patient I would have switched [with a Spanish-speaking provider] because it would have been better for the patient." She thought for a few seconds and then said, "But maybe it just would have been better for me." For this woman in the emergency room, Kari agreed that having a clinician who could be speaking the same language as the patient, but was not necessarily of the same ethnic background, might have improved the cultural competence of the encounter. A discussion followed as we further explored the idea as to whether having a similar

background as your patient would result in more culturally competent care. Kari harked back to the Hispanic surgeon's comments and said that was not necessarily the case.

The interplay of respect, empathy and curiosity factored into Kari's description of another preceptor who worked as a hospitalist in an urban, tertiary care medical center. This East Asian, internal medicine physician "modeled for me how to interact with patients regardless [of their background]." She observed:

> He was just amazing with every patient. He was not different no matter what language or what [ethnic background]. He was my favorite person to observe interact with patients. They loved him. He was so good with them. He'd sit on their bed, and he'd chitchat about anything and everything. And he'd say things like, "We'd be very good friends, if we met in a different place."

When I pressed Kari to dissect this physician's clinical style, she emphasized his psychosocial abilities rather than his cultural competence. Although she observed that he was facile in his ability to interact with patients of many ethnic backgrounds, she related most to his empathetic skills and his apparent respect for each of his patients: "He very much can read people and relate to people regardless of culture. So that's not culturally specific. [He was] very respectful of an individual." Rather than displaying curiosity specifically about a person's ethnic or cultural background, Kari described his focus on the individual:

> More than he [was curious] about culture, he wanted to know about the individual. [For example], an African American woman with multiple sclerosis—I remember, we were about to go in [to her hospital room] as a group [during rounds]. And [he asked], "Is she depressed?" And the resident said, "No." And he's like, "Are you sure? Every MS patient I know is depressed." And he sat on her bed. And he talked to her. And he had her bawling within, literally, thirty seconds. He's like, "All of you just leave. I'm just going to talk to her a minute by myself."

This preceptor's manner and personality created a warm, respectful clinical dyad, which could, according to Kari, also be culturally appropriate "if it would absolutely matter. No question he would have been totally respectful."

In a later interview session she described this same physician's clinical and psychosocial competence succinctly without including the attributes of cultural competence:

> He was getting to know them [the patients] as people, and chatting about non-medical stuff first. [He was] so relaxed and so interested and focused and listening. [For example, he would say], "Tell me about your farm," and five minutes later, "So this is where we're at [with the medical treatment]"—very much including the patient and asking, "Are you good with the plan?"

Probing the intersection of psychosocial competence and cultural competence in the clinical interaction, Kari clarified that one didn't preclude the other. For Kari, cultural competence meant addressing specific topics of ethnically based beliefs, behaviors, customs, etc., and she insisted that she did not witness this type of interaction between this physician and his patients, despite the fact that he had emigrated from India and many of his patients were African American.

> Certainly some people wouldn't want him sitting on their bed and interacting in the manner that he did . . . . [However] they all loved it . . . . I think he's absolutely smart enough and would not do that [sit on the bed, if it were culturally inappropriate]. I just didn't see any specific cultural issues come up with him. I just think he's an astute guy, in tune with his patient, sensitive to the situation, aware. I think, he actually was culturally competent, in general. I just didn't observe any specific incidences.

Over the months that our interview sessions occurred, Kari's negative self-assessment of her clinical skills, coupled with her confidence in her interpersonal skills, contrasted with her confusion about what constituted cultural competence. Toward the end of the last interview, after we had completed viewing the DVD of Kari's OSCE

session with the standardized patient portraying a Nigerian man, she turned to me with exasperation and asked, “What am I repeatedly missing with this that I cannot answer?”

Although Kari could recognize both culturally competent and incompetent health care, she continued to express an uncertain perception of her own cultural competence as a clinician. Instead, she emphasized the importance of psychosocial competence through empathy and good communication skills in her assessment of her own and others’ ability to deliver competent medical care.

Summary. My conversations with Kari were marked by her overriding anxiety about her work situation, where she struggled with her abilities to adequately master and execute the various procedures and tasks required to succeed as an emergency physician assistant. Transitioning from one health care profession, dietetics, to another presented challenges that were first played out at Healthy Families Clinic and later at her job in an urban ED. She felt comfortable interacting with patients from various ethnic and socioeconomic backgrounds as a dietician, PA student, and a physician assistant but found clinical competence within the medical framework an arduous aspiration and cultural competence an elusive concept.

When considering encounters with patients whose backgrounds were different from her own she focused on respecting and empathizing with the individual’s needs and wishes. She relied on her ability to read a patient’s body language and her ability to imagine walking in her patient’s shoes to develop empathy for and understanding of any given individual patient.

Whenever we discussed the role of cultural competence in the clinical encounter, Kari focused on cultural competence as being savvy to particularity, e.g., particular behaviors, customs, and beliefs held by individuals from a specific ethnic group, such as language, diet, and ways of addressing others. Kari felt that clinical competence was integral to every patient encounter, whereas cultural competence was only sometimes necessary or applicable, depending on the clinical setting and the patient's medical concern. If there were no obvious cultural differences between the clinician and the patient, then cultural competency seemed to play a very minimal role in the patient's care. This was particularly apparent when she described practicing medicine in an ED, where tending to medical needs was paramount. Even when there were obvious differences in the backgrounds of the clinician and the patient, as we saw with her internal medicine preceptor and his patients, she did not recognize any part of the clinical interaction as pertaining to culture. On the other hand, Kari recognized that stereotyping patients based on race, ethnicity, or background could interfere or influence their medical care. In the end she had a difficult time delineating the nuanced differences between cultural competence and interpersonal skills (i.e., psychosocial competence) in a patient encounter.

Conclusion

This section has offered the reader an opportunity to hear from the informants through the medium of this interviewer's using ample descriptions of the context and situations in which the interviews took place, as well as insight into my role in the conversations as "an active participant in interactions with respondents" (Fontana & Frey,

2000, p. 663). Through the informants' voices we have explored the four research questions and moved beyond the clinical service learning experiences to explore a range of clinical encounters in the light of three competencies: cultural, clinical, and psychosocial. Chapter Five includes an explanation of the informants' comments, ideas, opinions, and points of view in light of the themes that emerged from the interviews and the concepts covered in the pertinent literature, while also proposing pedagogical and curricular recommendations.

Chapter V. Conclusion

Discussion

Overview. As happens with inductive research, the research questions that I posed at the beginning of my investigation and used to organize the Results section served as useful frameworks for conducting the interviews with the informants and for organizing the data to discover emerging themes. However, because the results of the conversations went beyond the specifics of clinical service learning to an emic understanding of cultural competence, the research questions were less useful as a framework for discussing overarching concepts and for formulating mid-level theories based on the data as a whole. Some of these themes related directly to the cultural competency themes derived from the review of literature , but some themes related only indirectly, growing organically from the conversations held on four occasions with each informant. Instead of directly addressing each research question in this discussion section as was done in the results section, I will explicate several themes that have emerged from the data, and link them to the corresponding cultural competency themes , to the appropriate extant literature, and to relevant concepts embedded in the research questions.

Two of the cultural competency themes, social justice and democracy, did not seem to be significant to the informants of this study. Neither of these topics arose spontaneously during the interviews, and when I posed questions about disparities in health care or the import of public policies relating to health care, these were not topics about which they did not have much to say. When analyzing the interviews , I looked for

phrases and concepts in the informants' narratives that were similar to those found in the teacher education literature, such as ameliorating social inequities or addressing power differentials. When asked, two informants, Tom and Laura, did briefly address public policy, noting that they believed that health care was a universal right that has have not yet been achieved in the United States; but they did not have much more to say on the topic of social justice or democracy. Perhaps these themes were not central to the informants' conceptualization of cultural competence because they were not emphasized during their PA education. Although health care disparities were associated with cultural competence in several courses (e.g. Culture in Healthcare and Population Medicine), the curriculum failed to foster critical analysis of the socio-political factors that impact America's health care system and the delivery of medical care to individuals. In addition, the four informants did not seem to be exposed to the terms or concepts of social justice and democracy, as they apply to health care, prior to matriculation, and did not seem to understand exactly how they might apply to a critique of the health care system or to their own clinical practice.

Clinical service learning is less influential than pre-matriculation experiences. The interviews revealed the significant impact of the informants' pre-matriculation volunteer and work experiences in health care settings on several areas. For example, prior to starting their PA education, both Tom and Laura worked in medically underserved areas, rural and urban, respectively. Both referred to those experiences as crucial to their desire to work with the medically underserved as physician assistants. Tom was working in a private clinic that served a culturally diverse, low-income

community, while Laura balanced her full-time position as a PA in a middle class, suburban community with on-call shifts at an urban community health center. Tom explicitly stated that the sessions at Healthy Families Clinic did not influence his choice to work with a medically underserved patient population, but remarked that the clinical service learning experiences might have been more influential for students who lacked his pre-matriculation experiences with a similar patient population. Unlike medical students, who were found in some cases to be influenced by their service learning and community service experiences (Elam et al., 2003; Davidson, 2002), these physician assistants did not view the Healthy Families Clinic as instrumental in their career choice; rather, they relayed that their pre-matriculation experiences were more influential on their career choices.

Because the historical roots of PA education lay in retraining people who already have had extensive health care experiences, such as Army medics, most PA programs require applicants to have some direct patient care experience. These experiences range from students who spend briefer periods working full- or part-time in such occupations as emergency medical technician (EMT), certified nursing assistant (CNA) in a nursing home, or personal care assistant (PCA) in a hospital, as well as those who are turning to PA education to prepare for a second career in health care after years working in professions such as athletic trainer, registered nurse, or medical technologist. The informants for this study represent a similar range of pre-matriculation health care experiences, ranging from Kari's twelve years as a dietician to Kristy's short stint as a CNA in a nursing home. Tom was also a CNA, but worked in a rural, primary care clinic, while Laura's health care experience included volunteering in a free clinic and working

as a Spanish-speaking case manager for an insurance company. No matter the length of these pre-matriculation health care experiences, the informants all noted that the limitations of these experiences provided the motivation to apply to PA school.

In addition, Tom, Kari and Laura all claimed that their clinical service learning experiences did not influence their choice of rotation sites during their second year in the PA program. Other issues served as their motivation. Kristy was more intent on finding rotations close to her home, while Tom was motivated to get a broad range of clinical experiences to apply to his goal to go into family practice.

Perhaps because of the brief nature of physician assistant training, other life experiences have a greater impact on a PA's choice of specialties and patient population as compared to the few clinical service learning experiences that occur during the first year of the program. Rotations in the clinical, second year offer familiarity with various medical specialties, which may have more influence on career choice for new graduates. Since the service learning experiences constitute a very small part of the informants' education, the impact may have been commensurate with the limited time spent at Kids First Health Fair and Healthy Families Clinic, and later eclipsed by twelve months of clinical experiences during their second year.

The clinical setting matters. During each of the four interviews in the series, I asked the informant to revisit the concept of cultural competence. Interestingly, each informant felt that cultural competence might be applied differently depending upon the clinical setting. Referencing her work in the emergency department, Kari insisted that the skills of cultural competence (e.g. taking a thorough social history that might include

uncovering specific culturally-based beliefs, values and behaviors) would not be appropriate in this setting. However, when she described several patients that she saw, she recanted this declaration as she recalled the language barrier that she encountered when talking to the woman with the blighted ovum. But in subsequent interviews, Kari continued to insist that when you were trying to save a person's life, culture did not play a part.

This points to the notion, expressed by several of the informants, that cultural competence is separate from other clinical competencies, such as procedural skills, the ability to do a focused physical examination or the ability to come to a correct diagnosis. However, even in a community health center that serves a diverse population—where Kristy admitted that ethnic background might influence health-related practices—she described as incidental the identification of a patient's country of origin and language preferences. Other informants expressed the same perspective by explaining that portions of the patient's social history were sometimes discovered only through what they deemed as purely social interactions with the patients. For example, Tom and Kari, even upon repeated questioning, would insist that much of the patient's social and cultural background was ancillary to the clinical encounter.

Institutions like Rosalind Franklin University of Medicine and Science and the accrediting body, ARC-PA, bolster this concept of cultural competency as ancillary to other clinical skills; the former by creating a separate course to address the issue, and the latter by not including cultural competency in the general description of central physician assistant competencies. Additionally, ARC-PA does not provide the same consistent standards for a cultural competency core curriculum as it does for a biomedical core

curriculum (Chang, 2004; Jacques, 2004). The message to these informants as physician assistant student appeared to have been that the biomedical subjects superseded all other curricular content in its significance to the practice of medicine. Throughout the interviews, Kristy, Kari, Laura and Tom reflected by their answers to my inquiries that the didactic year of the PA program's stress on learning a large body of biomedical information in a short amount of time reinforced the secondary nature of cultural competence. During the clinical year, the inconsistent modeling of culturally competent clinical encounters, as we have heard in the informants' reports. The informants' sentiments regarding Health Families Clinic, corroborated by many statements by their classmates contained in the Observational Report Forms, reinforced this perspective, as they understood the central importance of their clinical service learning experience at Healthy Families Clinic as acquiring clinical skills such as history taking, physical examination, and giving injections (i.e., immunizations).

Language serves as a proxy for culture. In one way or another, the informants all used the ability to communicate in the patient's preferred language as a proxy for cultural competence. Laura and Tom were fluent in Spanish before entering the physician assistant program and felt that their ability to communicate effectively with Spanish-speaking patients both at Healthy Families Clinic and in their clinical rotations allowed them not only to effectively communicate, but also to provide insight into their patients' lives, behaviors and beliefs. Although the language barrier in the clinical setting is a focus of five out of 14 Culturally and Linguistically Appropriate Services (CLAS) standards promulgated by the government's Office of Minority Health ("National Standards for Culturally and Linguistically Appropriate Services in Health Care (Final

Report)," 2001) that address appropriate use of translators, signage, and written patient education materials, language is not as much an emphasis in the cultural competency literature of nursing and medicine. In contrast, the informants referred often to the ability to speak the patient's preferred language as a key to showing respect, communicating effectively, and providing culturally appropriate health care, even if the language proficiency was not up to the "National Standards for Culturally and Linguistically Appropriate Services in Health Care" (Final Report, 2001) recommended for practitioners and health care facilities. Although this standard of language fluency is often not met in the clinical setting, the goal is that clinicians

> who communicate directly with patients/consumers in their preferred language must demonstrate a command of both English and the target language that includes knowledge and facility with the terms and concepts relevant to the type of encounter. Ideally, this should be verified by formal testing. Research has shown that individuals with exposure to a second language, even those raised in bilingual homes, frequently overestimate their ability to communicate in that language, and make errors that could affect complete and accurate communication and comprehension. (p. 12)

This indicates a discrepancy between the value that the informants place on their language facility, ranging from fluent to halting, and the caution embedded in the CLAS standards to not rely solely on professional medical translators. One explanation for this discrepancy might be that although the standard focuses on the medical necessity of exact translation, the informants were focused on building relationships with their patients based on demonstrating culturally sensitive communication skills.

Furthermore, as outlined in the review of literature, theories and models for cultural competency from education, nursing and medicine generally do not position the ability to communicate in the preferred language of the patient as the basis for cultural

competence. For example, in *Purnell's Model for Cultural Competence* (Purnell & Paulanka, 1998) the area of communication, which includes consideration of the patient's dominant language, dialect spoken, and non-verbal communication attributes, represents only one out of twelve domains that are "interconnected with each other and have implications for health" (p. 9). It is interesting, then, that the informants often returned to the ability to speak the preferred language of their patients as a marker of culturally competent communication. And further they were not sensitive to possible ethnic differences that might impact the patient's compliance when there was no apparent language barrier or any indication that English was not the person's native language. The informants appeared to be focused on language to the exclusion of most other cultural artifacts; when confronted with the standardized patient who spoke English without an accent, they did not explore other differences that might have been key to his non-compliance with his medications, such as customs, behaviors and beliefs.

Labeling patients as "other" is problematic. The underlying impetus for cultural competency education for students in the health professions is the fact that their patients will be different from them in one way or another and those differences must be taken into account in order to learn to provide accessible, acceptable and appropriate medical care. The most common distinctions recognized by the informants were language and ethnic differences, substantiating the scholarship on cultural competency in health care, which generally embraces ethnicity and race as markers of diversity and culture, but tends to ignore differences that result in marginalization and under-representation such as sexual orientation, educational attainment, mental illness, homelessness and socio-

economic status (Kumaş-Tan, et al., 2007). For example, Tom and Kari struggled with the concept of "otherness," which revealed that defining the "other" is not a simple matter. Tom assumed that the Nigerian OSCE patient was more like him than not, despite differences in race, ethnicity, and occupation. Kari struggled with deep empathy for all her patients, which seemed to make her blind to the impact of their cultural history on their health and medical care.

All of the informants mentioned their reluctance to embarrass their patients by calling out differences between the patient and themselves or between the patient and general social norms. This could be a reflection of the informants' relative inexperience with patient care and reluctance to confront the patient with concerns that might arise from these different belief systems or life style choices. The informants weren't able to integrate the recognition of differences with their responsibility to create an appropriate medical management plan. Integration into the clinical encounter of these three components, showing respect for the patient, empathizing with patient, and understanding when culturally-based values, beliefs and behaviors might impact patient care, represents the process of becoming a culturally competent health care provider.

Although I will argue later that cultural competency is integral to each patient encounter and should be emphasized equally with the biomedical knowledge in physician assistant education, the results of the study revealed an understanding of cultural competency as knowledge-base or skill that might be selectively applied depending upon the clinical situation. It seems from the variability in the informants' capacity to recognize essential differences between themselves and their patients, that cultural competence for them is predicated on the ability to be aware of differences in a given

individual's background that may affect their health care status or access to medical care. The anthropological literature on the "othering," the study of foreignness, is rooted in the divide between Western and non-Western, modern and pre-modern, scientific and proto-scientific. For example, Rottenberg, et al. (2006) argue that understanding the "other" means that "we take alienity into account not as reality but as irrefutable possibility" (p. 38) while holding "otherness" as "true enigma that no [social] science could ever resolve" (p. 38). Perhaps the informants' uncertainty, about the extent to which the patient's differences should be explored and utilized in patient care, points to an acceptance of diversity and difference as a positive and expected part of practicing medicine in America.

Alternatively, the informants' inability to recognize the "other" could hinder them in acknowledging differences when they are relevant to the health care assessment and medical management. As the informants indicated in our conversations, too much emphasis on cultural differences, fueled by stereotyping and prejudice, could lead to incomplete health care. On the other hand, without being open to the idea that cultural characteristics could have an impact on a patient's health status, they may miss important factors in the patient's diagnosis and management. In contrast to Shapiro's (2008) observations about medical students whose empathy diminishes during their education, Kari exhibited high levels of empathy as she described patient encounters at Healthy Families Clinic, during her clinical rotations, and at her job in the emergency department. Instead of creating distance due to fear of emotionality, Kari's responses to her patients were filled with compassion for their plights, which at times got in the way of her ability

to take a comprehensive history, work with cultural differences, and create an appropriate treatment plan.

Like medical students who may gradually take on the shield of professionalism to protect themselves in the face of suffering, pain, disease and death, the informants agreed that professionalism served a useful purpose. Both Laura and Kristy described professionalism as a way to overcome uncertainty in the clinical encounter around issues of both cultural differences and clinical diagnosis. Tom insisted that he obtained the pertinent cultural and social history from his Muslim, East Asian patient, because he simply took a thorough medical history and allowed the patient to tell his story. With less time in school resulting in less time to be acculturated into the biomedical model, physician assistants may start out their careers with more compassion and empathy for their patients; but, perhaps, over time as practicing clinicians, they too will become jaded and create distance from their patients rather than retain that empathy and compassion as their careers progress.

Clinical, cultural and psychosocial competencies overlap. The final theme that emerged from the interviews with all four informants is the overlap of clinical, cultural and psychosocial competencies in the clinical setting. During our conversations, we explored the ways in which these three competencies are manifested in the clinical encounter. Laura described general clinical competence as proficient skills and adequate knowledge in medical, cultural and interpersonal arenas. She labeled psychosocial skills, the ability to communicate with and personally relate to patients, as a “gray area,” by which she meant a difficult skill set to define, to recognize, to learn or even to teach. Kari

and Kristy also considered interpersonal skills to be inborn or instinctive talents, while Tom was adamant that even this skill could be learned.

When remembering a particular preceptor, Laura stated that a practitioner could be clinically competent and culturally incompetent and still be an effective clinician, but that the converse was not true. Kristy focused on the combination of medical knowledge and the ability to communicate effectively when explaining how she carefully listened to each patient's concerns, but didn't always recognize when she should probe more deeply into the patient's cultural background. Kari provided an example of when cultural stereotyping might interfere with appropriate medical care, describing the African-American teenager who was triaged as a possible drug seeker when he had a legitimate medical condition. At another time Kari stated that cultural and clinical competence are not related, but she then immediately revised her remarks by saying that quality of care depends upon both. These examples suggest the complexities and nuances entailed in a clinical encounter that relies on adequate communication abilities to obtain appropriate information from a patient by employing curiosity, respect and patience combined with medical knowledge and diagnostic skills. The informants reacted to my questions about the overlapping of clinical, cultural competency and psychosocial skills with confusion, indicating that this level of understanding seemed to be a tall order for physician assistant students to master during their education. Instead the priority was to master clinical skills and medical knowledge over psychosocial (e.g. communication) and cultural competencies.

During the course of the interviews with each informant, I became curious as to what recommendations they had as to how to more effectively teach cultural competency

skills to physician assistant students. I hoped their recommendations would give insight into what each informant understood as constituting cultural competence, how best to communicate the concept to others, and how to recognize cultural competence modeled in the clinical setting. The informants suggested some concrete ways to teach cultural competence, but all also expressed exasperation because of the difficulty of outlining this process for me. Tom suggested that members of the community speak with physician assistant students about their traditional practices and the issues they might have in accessing the U.S. health care system. In addition, Tom felt that he would have benefited from presentations by practitioners from diverse ethnic groups or with particular backgrounds, e.g. homosexuals, immigrants, people living with HIV/AIDS, or those who have worked extensively with those particular groups. Laura, Kari and Kristy focused on learning from role models either in a service learning setting like Healthy Families Clinic or during the clinical year in hospitals and medical offices where second year physician assistant students can work with and observe seasoned health care professionals.

According to the informants, cultural competence is intimately tied to psychosocial competence through the abilities to communicate respectfully and effectively with each patient. Kari emphasized the ability to communicate her empathy with her patients as the key to overcoming cultural misunderstandings. Laura understood that appropriate communication included cultural humility, as she repeatedly told me that "you don't know what you don't know," and she emphasized the importance of apologizing to the patient if there was an inadvertent breach of culturally specific decorum. Some of the informants agreed that speaking the same language did not assure culturally competent health care, as they sometimes witnessed clinicians during their

clinical rotations who modeled insensitivity toward their patients by stereotyping based on experience, despite sharing a common language or ethnic background.

Summary. The informants' descriptions of the physician assistant responsibilities supports the merger of components from both critical analysis in educational scholarship and social relationships in nursing scholarship in order to interconnect cultural, clinical and psychosocial competencies in physician assistant education. The integration of these three competencies offers an opportunity to develop curricular elements that address their application and relevance in specific clinical setting, with specific patient populations, and with specific disease states and conditions. Addressing the place of cultural competence in physician assistant education must go beyond linguistic ability still while finding ways to encourage pre-matriculation foreign language preparation. Although the informants did not credit clinical service learning for influencing their choice of medical specialty or to work with medically underserved populations, the informants did view clinical service learning as a positive, first "real" clinical experience that gave them a realistic taste of what their future career held for them. Finally, physician assistant educators must recognize how their students recognize the "other," in order to facilitate appropriate communication skills that allow them to take a thorough medical history from any patient from any background. In the last section, I will make curricular and pedagogical recommendations based on this discussion of the study results, as well as offer suggestions for future research.

Recommendations

Overview. The results of this investigation give rise to curricular, pedagogical and further research recommendations to improve physician assistant education. These recommendations address several of the themes that arose in Chapter Four and which were discussed earlier in this chapter, as they apply to the role of cultural competency training and clinical service learning in the preparation of physician assistant students to become competent, compassionate, and well-informed health care practitioners who will endeavor to provide accessible, acceptable, and appropriate medical care to a diverse patient population throughout their careers.

The results of this study raised the basic question about who is the "other." This question begs for research into the emic understanding of culture, alienity, and shared values for students who matriculate into physician assistant programs. Further research is needed on this topic to move the discussion of cultural competence curricular development toward the present and future reality of a multifaceted, globally influenced American society in which pervasive images of diversity in the media and popular culture (including advertisements, movies, television shows, and sports) are more common than they were even 20 years ago. PA students and new graduates have grown up with diversity as a norm, and discrimination and prejudice a more subtle social phenomenon. Therefore, the approach to cultural competence in health care and PA education must encompass a broader framework that goes beyond superficial descriptions of various racial and ethnic groups. The context of cultural competence education for physician assistants must also include discussions and critiques of systemic issues such as power

differentials between clinicians and their patients, disparities in health status and access, and social injustice in both the health care and socio-political systems (Ogbu & Simons, 1998; Kumaş-Tan et al., 2007).

In addition, PA educators might need to rethink the definition of culture as applied to the concept of cultural competence. Rather than focusing on the specifics of language, diet, and health beliefs (Culhane-Pera, et al., 1997; Crandall, George, Marion, & Davis, 2003; Crosson, et al., 2004), physician assistant educators can turn to the disciplines of education, anthropology and sociology to broaden the theoretical underpinnings of the curriculum. For example, rather than indentifying specific ethnic differences that could be addressed in the clinical encounter, the students may be introduced to the concept of marginalized populations that often have to navigate more than one cultural realm (Delpit, 1995). The community-responsive physician assistant would be one that recognizes the individual patient as situated within a network of family, community, ethnic, religious, social and political affiliations and loyalties (Purnell & Paulanka, 1998; Brill, Ohly, & Stearns, 2002). This would contrast with what passes for culture in much of the current cultural competence education and training—an exotic notion of an individual or group who dresses, speaks or acts significantly outside the general societal norms (American Medical Association, 1999; Anand, 1999; Jacques, 2004; Morton-Rias, 2006). Addressing culture as the fluid, multifaceted, complex phenomenon that it is would provide physician assistant students a more accurate and functional framework in which to apply appropriate interviewing techniques to take a thorough medical history and provide comprehensive medical care.

In developing the following pedagogical and curricular recommendations, I rely in part, on my experiences in as a clinician and educator along with the informants' insights featured in this study and the relevant scholarship. My suggestions for future research are tied to the discussion of the recommendations.

Recommendations to create parity between biomedical and cultural curricula. The misunderstanding and confusion related by several of the informants as to the importance of cultural competence to accessible, acceptable and appropriate medical care argues for the complete integration of cultural competency awareness, knowledge and skills into the physician assistant biomedical curriculum, so that students appreciate the place and value of the patient's ethnic, cultural and racial background in the diagnosis and management of diseases and in the maintenance of health. I contend that the introduction of cultural competence education represents the shift from disease-based medicine to a patient-centered, contextual perspective of illness and disease that calls upon the clinician to "optimize outcomes that work within the patient's world" (Nunez and Robertson, 2006, p. 371). The principles of population medicine might apply to physician assistant curriculum development as it takes into account group characteristics, epidemiological data, and sociopolitical issues that apply to cohorts of the population variously based on age, gender, ethnicity, socioeconomic status, educational attainment, immigration status, residences, and other shared factors. The natural and social science-based disciplines of public health, epidemiology, anthropology, and sociology would inform the development of didactic year core cultural competencies that focus on awareness and knowledge. Subsequently, the clinical year curriculum would focus on the

skills needed to master the core cultural competencies directly applicable to the clinician-patient relationship, such as respectful curiosity and communication skills (Dogra & Karnik, 2003).

Didactic year curricula often represent a blend of instructive strategies including lectures, case-based learning, simulations, and workshops. I suggest that cultural elements be included in each of these teaching modalities and be afforded a place of prominence along with the biomedical knowledge and skills through consistent presentation and grading of both components. To maintain this parity between cultural and biomedical topics, socio-cultural issues can be divided into 1) population medicine that focuses on prevention, public health, health education, epidemiology, and health care disparities, and 2) clinical medicine that focuses on interpersonal skills, psychosocial competence, and taking a complete social history.

To further emphasize the parity between cultural and biomedical topics in physician assistant education, educators must help students gather and analyze both cultural and medical data in a consistent manner. Acceptable medical practice already includes two organizing tools that might be useful in the pursuit of parity: 1) the differential diagnosis in which the clinician lists out all likely diagnoses and provides the basis for ordering diagnostic testing and other interventions; and 2) the problem list which is a compilation of the patient's past medical history, present health issues that might not be included in the differential diagnosis, along with any personal habits (e.g. smoking, coffee drinking) and social issues that might be pertinent to patient care. By coupling the development of the differential diagnosis with the development of the problem list for each patient, students would learn to routinely include all salient issues in

the patient's background that might influence the treatment plan (e.g. living situation, preferred language, insurance status, ethnicity, gender identity, etc.).

Both the differential diagnosis and the problem list represent important but temporary statements about the patient's condition that will be verified over time by the results of diagnostic studies, further physical assessments, and in the course that the patient's illness takes. These modalities, the differential diagnosis and problem list, are currently widely used in medical practice. The educator helps the physician assistant student handle the uncertainty inherent in the process of creating a treatment plan to care for the patient with the need to proceed with concrete steps like ordering diagnostic studies, treating empirically, and providing palliative care until a definitive diagnosis is formed.

Another way to address parity of the cultural and psychosocial competencies with the clinical and biomedical competencies in the physician assistant curriculum is to create a heuristic method to guide obtaining a complete medical history. Combining Jonsen's (2002) "Four-box Method" created to help analyze a biomedical ethics dilemmas with elements within the cultural competence literature that addressed the clinical encounter (Culhane-Pera et al., 1997; Campinha-Bacote, 1999; Jacques, 2004), I have developed the *Diversity Paradigm*. This is a template from which PA students can learn to take a complete social and cultural history for patients from any background. Students would be instructed to use all or portions of the *Diversity Paradigm* in all situations, obviating the need to determine if cultural competency "applies" to a particular patient in a particular setting. The *Diversity Paradigm* integrates pertinent medical information with social and

cultural factors in a format familiar to a medical practitioner. There are four categories of information to elicit from the patient:

1. ***Medical Considerations***: subjective and objective medical information that is pertinent to culturally competent care such as the past, social, and family histories, use of medications (e.g. prescriptions, over-the-counter, herbs, and vitamins), physical examination findings, diagnostic study results, diagnoses, problem list, treatment plan, and prognosis.
2. ***Primary Factors:*** permanent individual features, some of which can be derived from the patient's chart, such as age, gender, sexual orientation and level of disability.
3. ***Individual Secondary Factors:*** numerous personal, social, and cultural topics and resources, such as socio-economic status (e.g. income, occupation, and type of housing), marital status, family constellation, education attainment, living situation, acculturation level, immigrant status, preferred language, transportation use, health insurance coverage, and religion.
4. ***Societal Secondary Factors:*** infrastructure and community issues that apply to the individual patient's case, such as health care accessibility (e.g. insurance, emergency transportation, and medical facilities), public health services and infrastructure, social infrastructure (e.g. transportation, housing, and food resources), and social services availability.

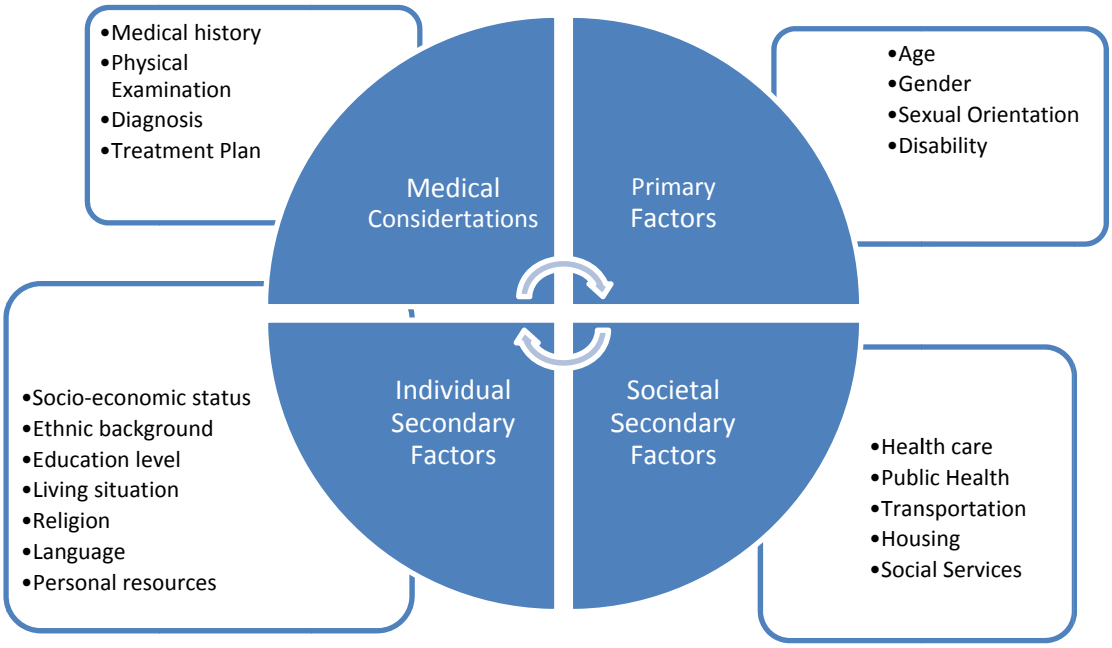

Figure 2: Diversity Paradigm
(Note: Only the key factors in each category are displayed.)

Using the *Diversity Paradigm*, physician assistant educators can consistently emphasize the centrality of taking a thorough and methodical cultural and social history with every patient, no matter their presenting medical complaint or the clinical setting. Students are challenged to assess the individual patient's case to determine which categories and issues would be pertinent. The *Diversity Paradigm* invites critical analysis of systemic, political and institutional dynamics that affect an individual patient's access to health care and their health status, forming the basis for discussions both in the classroom and in the clinic. Implementation of the *Diversity Paradigm* by PA faculty in the didactic curriculum and clinical preceptors in the clinical year might be the subject for future research.

Recommendations for addressing uncertainty in the clinical encounter. In the process of the clinical encounter, physician assistant students are taught that while eliciting a history, performing a physical examination, and ordering diagnostics there will be uncertainty and ambiguity as to the final diagnosis and management plan. To manage the ambiguity, students are taught how to develop a differential diagnosis and a problem list to organize all salient factors in the patient's case. The ability to manage contradictory or inconclusive information as one works through to diagnose and develop a treatment plan can also be applied to understanding and incorporating the patient's cultural and social background into the diagnosis process and treatment plan. For example, physician assistant educators should consistently emphasize the centrality of taking a thorough social history with every patient no matter their presenting medical complaint, background or race, or clinical setting. To this end, various aspects of the social history would be emphasized depending on the type of patient visit.

Addressing the ambiguity and uncertainty in the biomedical and cultural competencies links these two aspects of patient care as equally important. In addition, physician assistant educators can model humility in the process of caring for patients by admitting when they do not know certain medical or cultural facts and modeling how to professionally and systematically find out the answers to questions. Using scholarship from the medical and social sciences, the physician assistant curricula can emphasize the development of critical thinking skills applied to both population and clinical medicine. For example, this might include integrating epidemiological information, i.e., the pattern of disease, considering factors such as gender, race, and socioeconomic status, about each

disease studied, with individual social factors that might influence medical management (e.g. homelessness, ethnic background, immigration status, educational level, etc.).

Managing expectations and offering techniques to obtain a patient's complete and relevant cultural history in physician assistant education might mitigate the anxiety and confusion expressed by the informants over how and when to apply cultural competence skills during the clinical encounter. Integrating the methodology of critical analysis into the curriculum could enhance the ability of physician assistant students and practitioners to successfully address cross-cultural interactions. This already occurs in research courses where physician assistant students are taught to critically evaluate the funding, process and outcome of clinical research. To guide the extension of this skill into other areas of the curriculum, we can turn to the educational scholarship that examines educational multiculturalism. Here we find that critical analysis of cultural competence in the education setting encompasses a critique of larger social and political factors that influence that particular institution (Banks, 2001; Nieto & Bode, 2008; May & Sleeter, 2010). Integrating a similar critical analysis of social and political factors that impact disparities in the delivery of health care, as well as in health status for various populations, would provide cognitive tools for physician assistants as students and later as clinicians to use in appraising health issues in communities in which they work as well as in evaluating cultural competency in individual practitioners and in health care institutions. In her critique of cultural competency in medical education, Wear (2003) eloquently described the application of educational scholarship in the cultural competency education of health professionals by invoking Giroux's concept of "insurgent

multiculturalism" as a bridge that moves from a focus on medically underserved populations to an analysis of power relationships that allow some

> but not others to acquire and keep resources, including the rituals, policies, attitudes, and protocols of medical institutions. This approach includes not only the doctor–patient relationship but also the social causes of inequalities and dominance. Linked to professional development efforts, insurgent multiculturalism can provide students with more opportunities to look at their biases, challenge their assumptions, know people beyond labels, confront the effects of power and privilege, and develop a far greater capacity for compassion and respect. (p. 549)

Recommendations for reimagining experiential learning. Since one half of a physician assistant's formal education consists of experiential, apprenticeship-like activities that occur primarily during clinical rotations, PA educators rely heavily on community-based preceptors to model all three competencies discussed in this research: clinical, psychosocial and cultural. This presents a challenge for PA educators as most clinical preceptors are volunteers, have little or no formal training in being a preceptor for physician assistant students, are primarily focused on their own medical practice, and are not screened for their cultural or psychosocial competence. Due to competition for sites from other physician assistant programs, medical schools and residencies, only the most basic criteria are used to screen clinical sites and preceptors: Are they willing take students? Do they have a busy enough medical practice to afford students the opportunity to engage in direct patient care? And finally, are they licensed, board certified practitioners?

Although the informants focused on Healthy Families Clinic as a first opportunity to provide medical services in a real-life setting, rather than valuing it as a place to learn cultural competence, the clinical service learning experience could be a place to

intentionally integrate the clinical, psychosocial and cultural competencies. I have coined the term *respectful curiosity* to denote the professional, thoughtful, and confidential inquiry into all aspects of a patient's life constitutes the valued privilege of the physician assistant acting as a competent clinician. Within the clinical service learning milieu, the application of respectful curiosity can be appreciated by students where members of the clinic staff act as instructors. The physician assistant students have the opportunity to interview medical, nursing and ancillary staff who live in the community or have extensive experience working in the community, and with guidance from the PA faculty members gather information about such things as community assets, ethnic groups who access health services, and perceived barriers to adequate health services. In asking questions of the staff, the students practice respectful curiosity and gain a deeper understanding of the community that they are serving at the clinical service learning site. Highlighting the importance of this skill might empower physician assistant students to ask questions of the patients with respectful curiosity in a situation where they may initially be shy or unsure of themselves. In addition, PA faculty model the provision of culturally appropriate and respectful health care by using the skills of cultural humility (Tervalon & Murray-Garcia, 1998) to take an appropriate social and cultural history, and demonstrating the implementation of the *Diversity Paradigm* as part of the complete medical work-up.

Clinical service learning offers a real-life situation that can provide experiential education for physician assistant students to become proficient in clinical, cultural, and psychosocial competencies. But it also offers a forum for the appreciation and the critical analysis of broader societal and social justice issues such as those addressed in the fields

of public health and population medicine, such as health care disparities, barriers to access of health care, resource allocation and distribution of resources, and health care reform. These types of issues could be addressed in the reflection component, which is a fundamental part of service learning, where physician assistant students are encouraged to describe their clinical experiences with individual patients in light of the broader sociopolitical and cultural issues.

Therefore, a clinical service learning site that is coordinated and staffed by the PA program faculty can provide the clinical setting where PA faculty can model clinical, psychosocial, and cultural competence (Flannery & Ward, 1999) and where physician assistant students can learn from community members in an organized, intentional manner. This requires a systematic integration of medical and ancillary staff from the collaborating clinic or health care agency in the direct education of the physician assistant students at the clinical service learning site. As stated by more than one study informant, clinic staff members often have roots in the community and can be good resources of information about the community and about specific social or ethnic groups that seek services at the clinical service learning site. This would be an excellent subject for a community-based research project where the academic institution and the clinic or health care agency collaborate in designing and implementing a study that examines the use of community members and clinic staff as instructors for physician assistant students that benefit all involved parties.

Recommendations for teaching the provision of culturally appropriate health care. Finally, culturally competent communication means spending time listening to the

patient's concerns and appreciating the patient's frame of reference. Tom went a step further to attribute these skills to helping in the diagnosis of a patient's condition no matter what their background. Learning and practicing culturally competent communications skills must include the physician assistant students' examination of their own beliefs and prejudices in order to be sensitive to the patient's values, beliefs, life ways, practices, and problem-solving strategies (Anderson, Calvillo, & Fongwa, 2007), as well as developing communication strategies that allow the patient and their family to participate in their own health care decisions based on negotiation between two world views—allopathic medicine and the patient's cultural heritage (Leininger, 1993). In short, one communication goal of the physician assistant is to translate the biomedical terminology and allopathic system into something comprehensible within the patient's world view by taking into account the patient's and family's networks and community, and by addressing diversity in all its manifestations including ethnicity, place of residence, immigration status, sexual preference, occupation, religion, and language preference.

I argue that the outcome of cultural competence for the health care provider is what Shaw (2005) described as culturally appropriate care, i.e., care that takes into account the multiple effects of cultural differences in the health care encounter. Proficiency in this arena gives students a way to improve clinical outcomes and reduce health disparities, as well as improve the clinician-patient relationship through developing awareness, knowledge, and skills. This approach to teaching cultural competency includes integration of core competencies into the general PA curriculum, affording cultural competency equal importance to other medical and health care topics.

Reworking the categories of Dogra & Karnik (2003) to conform to existing concepts in medicine, I would label "categorization" as a population-based cultural competence and "sensibility" as a clinically based cultural competence, both of which are important aspects of teaching and learning culturally appropriate care.

The clinically-based cultural competence portion of the curriculum, incorporated in the individual secondary factors of the *Diversity Paradigm*, would cover both the spheres of cultural awareness and skills. This might include an exploration of the student's own background and experiences, as well as his or her prejudices and held stereotypes. In addition, clinically based cultural competence would address the skills of cultural humility (Tervalon & Murray-Garcia, 1998), tolerating ambiguity, appropriate curiosity, and respect (Dogra, Giordano, & France, 2007; Dogra & Karnik, 2003; Shaw, 2005; Taylor, 2003) in the clinical encounter through an experiential pedagogy, e.g., clinical service learning, observed standardized clinical encounters (OSCEs), case studies, and clinician modeling.

In addition, the population-based aspects of cultural competence that are included in the secondary societal factors section of the *Diversity Paradigm* would encompass the spheres of knowledge and skills that might be derived from ethnic studies (Banks, 2001) and ethnography, as well as social and behavioral studies. Furthermore, the examination of historical and current research on disparities in health care, racism, colonialism, immigration, etc. could become a catalyst for critical analysis of the behaviors, beliefs, and values of students, teachers, colleagues, and patients. In addition, population-based cultural competencies could dovetail with the studies of epidemiology and genetics, providing a lens for critical assessment of research in these disciplines. Students could

demonstrate their skills in this area through case-based learning activities that include components that might highlight particular ethnic beliefs and behaviors. In addition, an appropriately scripted OSCE might provide an opportunity for students to practice both clinically and population-based cultural competencies in which the standardized patient (SP) portrays a patient with specific ethnically based health beliefs and behaviors and/or challenging psychological issues along with definitive medical problems

Although physician assistant students and newly certified practitioners might prefer concrete facts about the health care needs, practices and beliefs of specific cultural groups (Dogra, et al., 2007), this is not practical given the great diversity of populations and social groups within the United States. Instead, providing other tools and perspectives to help address the unknown factors that might impact a patient's choices, preferences and outcome might include discussion of cultural humility as a:

> commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves… [A] process that requires humility in how physicians [and physician assistants] bring into check the power imbalances that exist in the dynamics of [clinician]-patient communication by using patient-focused interviewing and care. (Tervalon and Murray-Garcia, 1998, p.118)

Employing this concept of cultural humility allows the physician assistant student and clinician to understand cultural competence as a process that requires life-long learning, an ARC-PA core professional competency ("Accreditation Standards for Physician Assistant Education," 2010), as well as ongoing critical self-reflection. This takes the onus off immediate mastery of all aspects of cultural competence during the PA's formal education, and allows for the integration of cultural factors into the biomedical

curriculum in digestible components that connect the biomedical knowledge to a patient-centered clinical encounter.

Since both the OSCE and CSL afford experiential learning opportunities to improve clinical, cultural and psychosocial (i.e., communication and interpersonal skills) competencies, future research might be directed at comparing these two modalities for their acceptance by physician assistant students, their heuristic efficacy, and cost effectiveness.

Recommendations for before and after PA school. Due to the limited time frame of approximately 24 months for physician assistant education, cultural competence begins before matriculation and must continue after graduation. This study found that pre-matriculation experiences influenced the informants' career choice, specialty choice, and even their understanding of the application of cultural competence in physician assistant medical practice, which indicates the need for a review of admission criteria that might include second language ability, experiences with the medically underserved, and international travel. Although historically physician assistant education has attracted second career students, the emphasis has been on admitting students with adequate patient care experience as opposed to qualities that might pre-dispose candidates to be culturally competent. Whether the latter quality actually results in more culturally competent students and physician assistants is the subject for future study.

Another way to address the acquisition of cultural competence abilities, including psychosocial skills, would be to incorporate cultural competency into post-graduation continuing medical education (CME). This relates directly to one of the physician

assistant professional competencies: lifelong learning (Accreditation Standards for Physician Assistant Education, 2010). A requirement should be developed that a certain number of CME hours per two year cycle would cover clinically applicable cultural and psychosocial knowledge and skills (Brathwaite, 2005). The implementation of such a change in CME requirements would rely on future research demonstrating the impact of cultural competence post-graduate education in order to inform the debate among stakeholders.

Summary. Systematically linking clinical, psychosocial and cultural competence in both the didactic and experiential components of physician assistant education, as well as in continuing medical education courses, requires a reorientation of educational goals to assert parity for all aspects of patient care. Implementation of the recommendations made from this study should be evaluated using existing heuristic methods like the OSCE used throughout the educational process or self-reflection activities following clinical service learning experiences. Just as physician assistant educators encourage students to listen to and learn from their patients, to explore and find out about the community in which they live and work, and to value and continue lifelong learning in order to provide accessible, acceptable, and appropriate medical care to a diverse patient population, I encourage future investigations of cultural competence in both physician assistant curricula and practice to focus on the emic perspective of students, educators, and clinicians.

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APPENDICES

Appendix A

Copy of email sent to the RFUMS PA Department Class of 2010:

Class:

As some of you know, I am working on my doctorate in Educational Leadership and Policy in the School of Education at Marquette University in Milwaukee, WI. My research focuses on the clinical service-learning experience that you, as PA students, underwent at Healthy Families Clinic. I am interested in finding out what you got out of those sessions at Healthy Families Clinic through a series of interviews.

I am asking for volunteers to interview who were able to attend both required sessions at Healthy Families Clinic during your didactic year. I know that some of you were not able to do so due to circumstances beyond your control.

The time commitment for interviews would be a series of 4- 5 interviews. I expect each interview to last about 50 minutes, and will audio record the session. If possible the interviews will take place on the RFUMS campus, but I will try to accommodate the volunteer by meeting at another neutral location, if needed.

Please get back to me within the week, if you are interested in volunteering.

Thanks,

Rea

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Appendix B

Volunteer for Healthy Families Clinic Research

□ I would like to volunteer to be an informant in this study.

Name_____

What ethnic group do you identify with?

Describe any international travel experiences you may have had:

Describe volunteer experiences that you have had before beginning the PA program:

Describe any experiences that you had before beginning the PA program with people that were medically underserved:

Describe any experiences that you had before beginning the PA program with people that were considered to be of low socioeconomic status:

Do you speak (any level of expertise) a language in addition to English?

Appendix C

Observation Report Form: Worksheet and Background Information

Name

Site

Date

Space
Actors
Activities
Objects
Acts
Time Frames
Goal(s) of Activities
Feelings of People involved in Activities
Summary of your reaction/feelings/emotions

Appendix C

Observation Report Form: Worksheet and Background Information (continued)

Observational Report Form (ORF)

Background Information

Observation is a skill that can be learned and honed. Anthropologists use observation to gather data in their attempts to understand and describe human social activities and situations. These observational skills are useful in health care settings, as well, helping to understand your patients and the workings of the medical office, clinic or hospital.

There are nine major dimensions of every social situation that become part of the observational report:

Space: Describe the details of the physical place or space.

Actor: Describe the details of the people involved.

Activity: Describe the details of the related acts people do.

Object: Describe the details of the physical things that are present.

Act: Describe the details of the individual actions that people do.

Time: Describe the details of the sequencing that takes place over time.

Goal: Describe the details of the things that people are trying to accomplish.

Feelings: Describe the emotions felt and expressed by the people.

Your Reactions/Feelings Use this space to make any appropriate personal comments about the experience