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UNDERSTANDING THE IMPACT OF MULTICULTURAL EDUCATION USING EXPERIENTIAL LEARNING TECHNIQUES TO FOSTER CULTURAL COMPETENCY OF MEDICAL SCHOOL STUDENTS: A QUALITATIVE CASE STUDY AT A MEDICAL SCHOOL

by

Jonathan Parker Jones

A Dissertation

Submitted in Partial Fulfillment of the

Requirements for the Degree of

Doctor of Education

Major: Higher and Adult Education

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Acknowledgments

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Abstract

Jones, Jonathan Parker. Ed.D. The University of Memphis. December, 2015. Understanding the impact of multicultural education using experiential learning techniques to foster cultural competency of medical school students: A qualitative case study at a medical school. Major Professor: Dr. Jeff Wilson.

Cultural competencies of current medical school students were examined by studying part of the multicultural curriculum at a southeastern United States health science center. This study was a qualitative case study that focused on the impact of a multicultural education training exercise, *BaFa' BaFa,'* on first-year medical students. This exercise took place during orientation of the student's first year. The theoretical framework for this study was part of Kolb's model of experiential learning, specifically the active experimentation aspect. There were two research questions that guided this study: (1) How does *BaFa' BaFa'* impact cultural competency on current medical students at a southeastern health science center? (2) How does the experiential learning aspect of *BaFa' BaFa'* impact current medical students? It was found that there were varying opinions regarding the overall impact of the training, as well as when the training should be administered during medical school, if at all. However, it was also found that the participants experienced an uncomfortable feeling while performing the training, had little time to utilize anything that they might have learned from the training, and that the experiential learning aspect of the training had an impact on their learning. Although the *BaFa' BaFa'* training itself had little impact on the cultural competencies of the medical students studied, the experiential learning aspect of the training had a substantial impact on the students.

Keywords: multicultural education, diversity, cultural simulation training, experiential learning, cultural competency, medical education

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Table of Contents

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Chapter 1

Introduction

For most of my life, I have tended to migrate toward those who were similar to me. I am a white male who enjoys college sports and the outdoors. Even though I attended a public high school in rural Mississippi, I was prone to stay around the same set of friends who, in general, looked like me and who had the same interests. I remember when I got to college, I felt like these same trends continued. Once I established my core group of friends in college, I had a tendency to not try and meet other people. I was not someone who attempted to build relationships with those who had a lot of differences from me. At times, I felt like I was secluding myself from the true diversity that represented most of America, if not the world.

Upon graduating from college, I moved to Jackson, Mississippi and began attending a church that had a multicultural mission. This church was open to diverse people and much of the leadership in the church, including the pastor, was of a different race than me. After visiting the church for several months I decided to become a member and join, thus beginning my interest in multiculturalism. Immediately, I began to see the benefits of being around others who were not like me in terms of upbringing and background. I was blessed with the opportunity to build relationships with others who were of different races and ethnicities, while at the same time becoming embedded in a church that was truly multicultural.

At the same time I was becoming involved in my new church, I began working at a health science center in Student Affairs where my job consisted of working with and interacting with medical students on a daily basis. One of the things I learned by interacting with medical students was their exposure to multicultural education in the

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institution. There were several different types of multicultural education instruction these medical students received. One of these multicultural education instruction tools included a cultural simulation exercise, called *BaFa' BaFa'*. In the *BaFa' BaFa'* exercise, students were asked to engage in role-playing scenarios where they were given certain cultural habits to use. Then, they interacted with other medical students who had other cultural habits different than themselves. This role-play exercise gave them the opportunity to better understand how to interact with those different from themselves.

Since I have been a student in the Higher and Adult Education doctoral program at the University of Memphis, one of the most interesting theories I have learned about is experiential learning. One of the more well-known researchers in experiential learning is David Kolb. Kolb's theory dealt with the different styles of learning and how educators can effectively reach their students (Evans, Forney, Guido, Patton, & Renn, 2010; Kolb, 1984). Kolb's experiential learning model consisted of four modes of learning: concrete experience (CE), reflective observation (RO), abstract conceptualization (AC), and active experimentation (AE) (Evans et al., 2010). Kolb (1984), when discussing learners, stated:

> They must be able to involve themselves fully, openly, and without bias in new experiences (CE). They must be able to reflect on and observe their experiences from many perspectives (RO). They must be able to create concepts that integrate their observations into logically sound theories (AC), and they must be able to use these theories to make decisions and solve problems (AE). (p. 30)

With active experimentation, students can learn by participating. According to Claxton and Murrell (1992), some examples for teachers to utilize active experimentation include

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role-play exercises, group projects, hypothetical situation activities, configuration of action plans, and debates. The *BaFa' BaFa'* cultural simulation exercise that the medical students participated in involved active experimentation, specifically role-play.

As I was going through the process of trying to decide on a research topic for my dissertation, I had several conversations with my major professor. Through these discussions, I came to realize that there was a way I could combine my new found interest in multiculturalism with the way it impacts the medical profession. Using the *BaFa' BaFa'* training exercise previously discussed, I wanted to be able to determine the effect multiculturalism has on current medical school students who experienced this training exercise within their medical school curriculum. Furthermore, I wanted to determine if the experiential learning aspect of the training impacted the students. Through this study, data could be gathered that would help educators understand how multicultural education that was taught using experiential learning techniques affected the cultural competency of current medical students.

Background of the Study

The practice of teaching medical students has been around for hundreds of years. The Medical College of Philadelphia was established in 1765 and was the first of its kind in the United States (Smith & Shaker, 2003). According to Smith and Shaker (2003), the number of medical schools began to rise in quantity during the 1800s. However, due to the number of deaths caused by disease in the Civil War, the lack of quality instruction, as well as the lack of medical advancements became obvious during this time. Due to the efforts of Abraham Flexner, the quality of medical education began to improve. Flexner composed what is known as the Flexner Report in the early 1900s, which indicated the

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lack of poor instruction in several medical schools (Gardner, 1960; Smith & Shaker, 2003). Flexner's report made an impact in the way medical schools teach its students. Today, medical schools are held to certain standards. According to the Liaison Committee on Medical Education (LCME) (2012), every medical school in the United States and Canada has an accreditation process to which they must adhere to.

The quality of education is not the only change that has taken place in medical schools over the years. Another change in medical education has been the increase in student diversity. According to the U.S. Department of Health & Human Services (1990), when looking at first through fourth-year enrollment in medical schools, minority students increased more than 18% from 1968 to 1988. By 1987-1988, women comprised 32.8% of the medical school graduates (U.S. Department of Health and Human Services, 1990). However, when looking at more recent data, it is even more obvious the change in demographics. According to the Association of American Medical Colleges (AAMC) (2012), figures published in 2011 showed minorities accounted for 40% of the enrollment in American medical schools. Due to these statistics, medical schools must consider ways to incorporate multicultural education amongst their students.

Medical schools can seek ways to implement multicultural education due to how it could affect the healthcare system (Dogra, Reitmanova, & Carter-Pokras, 2009a; Lakhan, 2003). Dogra et al. (2009a) gave several reasons why medical schools have begun to monitor diversity, including "enhancing cross-cultural patient-doctor encounters" (para. 1). According to Lakhan (2003), "The need for diversification in medicine is fundamental to the health of the U.S. medical system" (para. 3). As the patient

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population becomes more diverse in the United States, current medical students should be well trained to properly treat all people they come in contact with.

Multicultural education, once a foreign concept in medical schools, is now required by the Liaison Committee on Medical Education (LCME). The LCME is the accrediting body for medical schools in the United States and Canada (LCME, 2013a, para. 1). According to the LCME Standards for Accreditation of Medical Education Programs (2015), "The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process" (p. 11). Cross (1988) stated, "cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional and enable that system, agency, or professional to work effectively in cross-cultural situations" (para. 1). Some of the methods that can be utilized to teach multicultural topics include language training, cultural sensitivity training, and training that deals with different minorities (Daugherty, Goodman, Mattis-Peterson, Nora, & Stevenson, 1994).

For the purposes of this study, one example of a multicultural education exercise was researched to help understand its effect on cultural competency. This area is a cultural simulation exercise, called *BaFa' BaFa'*. *BaFa' BaFa'* was originally developed by Dr. Garry Shirts to help military members of the United States when they visited other countries (Dunn, Meine, & Dunn, 2011). *BaFa' BaFa'* can reveal information regarding the following: stereotyping, misperceptions, and open-mindedness (Dunn et al., 2011). The area being researched in this study is taught using experiential learning techniques. Experiential learning is more of a hands-on approach and is a way to experience learning

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instead of simply hearing it in a classroom (Mullins-Nelson, 2008). Evans et al. (2010) stated:

> The most direct application of Kolb's theory may be in the use of the information on learning styles as an empathy and design tool for responding to the increasing diversity represented among the student population as educators seek to provide both challenge and support in learning experiences in the classroom and beyond and in the modes used to deliver services to students. (p. 145)

With this quote in mind, this study looked to better understand how multicultural education, that uses experiential learning techniques, affects cultural competency of current medical school students.

Statement of the Problem

As America becomes more diverse, the needs for advancements in multicultural education become even more important. With the increase in minority enrollment (Ukpokodu, 2010), higher education institutions must consider multicultural education as a part of their curriculum. One study that has found positive effects on college students when they have been exposed to multicultural education is from Bowman (2010), who found that when students take more than one diversity course, they "have greater well-being, are more comfortable with differences, have a greater appreciation of others' similarities and differences, and are more likely to interact and intend to interact with diverse others" (pp. 557-558).

Multicultural education is also important for medical students because they must be able to interact with a diverse population. Doctors treat a diverse patient population that consists of a variety of ethnicities and socioeconomic statuses. Therefore, it is important for future doctors to understand multicultural issues. Medical schools are also

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required by the Liaison Committee on Medical Education (LCME) to offer some type of training that seeks to address cultural competence. Dogra et al. (2009a) believed it is vital for medical students to have an understanding of the biases that are within them and also said that it was important for students to realize the amount of openness they have toward those who might be different from themselves. There have also been studies that discussed the subject of when to teach multicultural education in medical school (Dogra et al., 2009a; Shapiro, Lie, Gutierrez, & Zhuang, 2006). Dolhun, Munoz, and Grumbach (2003) discussed how medical schools practiced their cross-cultural curriculum. For example, they found that 32% of the medical schools in their study offered courses that contained some type of cultural competence material.

There seems to be few studies that seek to understand how a multicultural education curriculum experience impacts cultural competency on current medical school students. Moreover, there is little, if any research on whether experiential learning techniques, which are used to teach multicultural education, impact current medical school students. A study that seeks to determine the effect of multicultural education taught with an experiential learning technique on current medical school students' cultural competencies could help medical schools have a better understanding of the activities and content it should offer in its curriculum. A study such as this could help medical schools understand what should be taught within the multicultural education curriculum, as well as how it should be taught to the medical students.

Purpose Statement and Research Questions

The purpose of this research was to understand how a multicultural education curriculum experience impacted cultural competency on current medical school students

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at a southeastern health science center. By exploring the experiences of current medical school students in their exposure to *BaFa' BaFa'*, it can help us understand the impact of a curriculum that is focused on multicultural education.

The questions that guided this research were:

1. How does *BaFa' BaFa'* impact cultural competency on current medical students at a southeastern health science center?

2. How does the experiential learning aspect of *BaFa' BaFa'* impact current medical students?

Significance of the Study

The significance of this study is twofold. First, this study could lead to a deeper understanding of Kolb's experiential learning model that could be beneficial for faculty in higher education who might want to use Kolb's model to instruct their own students. Depending on what is found, higher education faculty could decide to use experiential learning methods, such as role-play exercises, to effectively reach their students. Second, this study has the potential to demonstrate ways that multicultural education could be implemented into medical school curriculums. This study provided detailed, personal accounts from current medical school students on the experiences they had within part of their multicultural education curriculum.

Theoretical Framework

The theoretical framework that guided this study was David Kolb's theory of experiential learning. As stated in the background section of this study, Kolb's theory consists of different styles of learning and discusses how educators can effectively reach their students by implementing these styles (Evans et al., 2010). His model consists of

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four modes of learning: concrete experience, reflective observation, abstract conceptualization, and active experimentation. However, I will be focusing on his last learning mode of active experimentation. With active experimentation, individuals learn by participating in the subject being taught. According to Claxton and Murrell (1992), some examples for teachers to utilize active experimentation include role-play exercises, group projects, hypothetical situation activities, configuration of action plans, and debates. In the *BaFa' BaFa'* exercise students are required to participate in role-play situations, which lead them to actively participate in the learning process.

Limitations

One limitation of this study is that I will be unable to control the amount of prior experience the participants have had with multicultural education. Some of the participants could be experts on multicultural education where they have taken several classes on this topic or have life experiences that have provided them educational opportunities. However, other participants might be novices. The amount of prior experiences could impact the results of the study.

Another limitation of this study is the fact that I am only studying one part of Kolb's Experiential Leaning Model. There are four modes of learning within Kolb's model. I am only studying the active experimentation learning mode. Additional information and data might be found if all four learning modes were studied.

A third limitation of this study is that I did not conduct member checks with my participants. Within member checking, the researcher provides a copy of the transcriptions to the participants to allow them to review what they said. This allows the participants to confirm that what was transcribed by the researcher is accurate.

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The final limitation of this study is that I am studying only one multicultural education experience, the BaFa' BaFa' training. I am studying students who had a one-time experience, instead of multiple experiences over time. More data could be gathered by studying more than one multicultural education experience.

Delimitations

This study is delimited to current medical school students who are enrolled at the same health science center. All participants must have experienced the *BaFa' BaFa'* exercise. All participants must sign a consent form and be approved by the researcher. Any student who does not meet these qualifications cannot be included in the study. The study is also delimited to understanding current medical school students' cultural competencies after they experienced a specific multicultural education exercise, which uses experiential learning techniques. Cultural competency will be understood by using a case study design. A focus group interview, a photo recognition interview, and three individual, in-depth interviews was used to gather data.

Definition of Terms

BaFa' BaFa'. *BaFa' BaFa'* is a cultural simulation exercise that addresses cultural topics, such as stereotyping, misperceptions, and open-mindedness (Dunn et al., 2011; Jarrell, Alpers, Brown, & Wotring, 2008).

Kolb's Model of Experiential Learning. "It offers a system of competencies for describing job demands and corresponding educational objectives and emphasizes the critical linkages that can be developed between the classroom and the 'real world' with experiential learning methods" (Kolb, 1984, p. 4).

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Cultural Competency. "Cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional and enable that system, agency, or professional to work effectively in cross-cultural situations" (Cross, 1988, para. 1).

Experiential Learning. This is a type of learning that can be experienced, instead of just hearing it in a classroom (Mullins-Nelson, 2008).

Liaison Committee on Medical Education (LCME). "The LCME is recognized by the U.S. Department of Education as the reliable authority for the accreditation of medical education programs leading to the MD degree." (LCME, 2013b).

Study Overview

This chapter began with an introduction to the study. It was followed by background information, a statement of the problem, a purpose statement, research questions, the significance of the study, the theoretical framework, the assumptions, the limitations, the delimitations, and the definition of terms. Chapter 2 will contain a detailed review of the literature. The topics that will be discussed in chapter two include diversity, multicultural education, medical students, medical education curriculum, *BaFa' BaFa'* training, and experiential learning. Chapter 3 will discuss the methodology, including design and data analysis. Chapter 4 will present the findings of the study. In chapter 5 I will discuss the findings of the study and their relevance to the literature.

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Chapter 2

Review of the Literature

This chapter will provide a comprehensive review of the literature for the proposed study, regarding multicultural education and its impact on medical school students. This literature review contains several topics that are important to understand. These topics include the following: history of medical education, diversity, challenges for medical students, medical education curriculum, cultural competency, multicultural education, *BaFa' BaFa'*, and experiential learning. The goal of this literature review is to provide an in-depth understanding of these topics, as well as provide information from past studies.

History of Medical Education in America

Before discussing the challenges and curriculum of medical school, it is appropriate to begin with its history. It is important to know where and when medical education began, in order to grasp the complete picture of its practice. According to Smith and Shaker (2003), the Pennsylvania Hospital is considered the first hospital in America and received its first patient in 1756. Soon after, the Medical College of Philadelphia was established in 1765 and was the first of its kind in America. In fact, when this college opened, there were only two faculty members. Some of the other early medical schools that were established included Columbia Medical College and Harvard (Smith & Shaker, 2003).

It is often said that positive things can come from bad situations. There are times when certain information would have never been known unless an event occurred that allowed us to realize it. This was the case for medical education due to two historical

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events: The Revolutionary War and the Civil War (Smith & Shaker, 2003). Smith and Shaker (2003) noted, "It was said that the War of the Revolution was 'the making of medicine' in the new country; it brought to the front some of the leading American physicians of the time" (p. 103). Years later, during the 1800's, America began to see an increase in the formation of medical schools. However, they were not considered quality institutions due to not having to obey licensing restrictions. This lack of training became apparent during the Civil War. Smith and Shaker (2003) stated, "It has been estimated that of the 335,000 Union deaths, about two thirds were due to diseases and one third to wounds" (p. 114). This fact showed the lack of medical training, as well as the need for medical advancement in America at the time.

Within medical education, one of the pioneering schools was Johns Hopkins University, which was one of the first schools in the nation to implement tougher restrictions and better instruction (Smith & Shaker, 2003). The curricular methods used at Johns Hopkins spread to other medical schools around the country. According to Smith and Shaker (2003), "It was now shown that a superior medical college could be developed in America" (p. 116). However, one question still remained: how can more medical schools become similar to Johns Hopkins? The person who would help answer this question was Abraham Flexner. According to John W. Gardner, former U.S Secretary of Health, Education, and Welfare, Flexner did not have a background in medicine. Gardner (1960), when describing Flexner, stated "All that he had was a razor-edged mind, fierce integrity, limitless courage, and the capacity to express himself clearly and vividly" (p. 594).

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In 1910, Flexner was asked by the Carnegie Commission to compose a comprehensive study of medical education (Smith & Shaker, 2003). "After a period of careful study and preparation, Flexner visited over 150 medical schools throughout the United States and Canada" (Gardner, 1960, p. 594). The findings of this report, known as the Flexner Report, showed inadequacies in medical education. Smith and Shaker (2003) observed:

> It portrayed the poor quality of institutions, the inadequate preparation of students (even some Harvard students could barely write English), the lack of standards of some schools that were outright "diploma mills," and the obvious rigging of the schools for financial gain by the owners. (p. 120)

Flexner felt that medical schools were producing too many doctors at a lower standard of education. Flexner (2002) also found that medical schools in the early twentieth century advertised falsely, which misled future students. He was able to classify the schools he studied into three categories. These categories dealt with the level of education that each school required for admittance. This ranged from at least two years of college education to, "nothing more than the rudiments or the recollection of a common school education" (p. 598). As a result of this report many medical schools either closed or combined with other institutions (Smith & Shaker, 2003).

Flexner's report has had a lasting impact on medical education. Today, there are over 100 medical schools, all of which go through a rigorous accreditation process and help train thousands of future doctors. Medical schools are constantly looking for ways to improve the education they offer to its students. If it were not for the efforts of Abraham Flexner, the high standard of American medical education would have taken

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much longer to achieve. This is important for this particular study because in today's medical education accreditation process, medical schools must be able to demonstrate their efforts to incorporate cultural competency within their curriculum.

Diversity in Higher Education

Johnson (2011) defined diversity as "seeing the differences, distinctions, and dividing lines of others with a soft gaze but with clear vision" (p. 11). Today, diversity in higher education is much more commonplace than in the past. However, getting to this point has taken much work, patience, and in some cases, legislative action. One organization that has had a dynamic impact on diversity in higher education is the National Association for the Advancement of Colored People (NAACP) (Cohen & Kisker, 2010). According to Cohen and Kisker (2010), the NAACP worked with legislators and filed lawsuits in hopes of enhancing the educational experience for African Americans. Cohen and Kisker (2010) discussed two Supreme Court decisions that took place in 1950 that affected diversity in higher education, ultimately impacting medical education. The first was *Sweatt v. Painter*, which dealt with equality in law schools in the state of Texas. The other decision was *McLaurin v. Oklahoma State Regents for Higher Education*, which required the University of Oklahoma to treat an African American doctoral student equally as compared to other students. However, Cohen and Kisker (2010) stated that:

> The breakthrough challenge to the concept of separate but equal came in *Brown v. Board of Education* in 1954, when the Supreme Court ruled that separating children solely because of their race generates a feeling of inferiority, therefore separate educational facilities are inherently unequal. (pp. 195-196)

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Cohen and Kisker (2010) discussed the importance of the decision of the Civil Rights Act of 1964 and found that the act helped the cause of integration by allowing voter equality. Also, it helped create diversity in universities, especially the southern region of the U.S., because of its effect in blocking politicians' efforts against integration (Geiger, 2011). Cohen and Kisker (2010) talked about how President Lyndon Johnson's Executive Order 11375 was important in the realm of equality in higher education. This executive order enforced equality in the workplace by making employers consider all races when hiring for jobs. This eventually made an impact on college campuses by forcing universities to hire more minorities.

Title IX was an important law that helped improve equality for women. Title IX was passed in 1972 as part of the Education Amendments to the 1964 Civil Rights Act (Stevenson, 2007). As stated by Stevenson (2007), a portion of Title IX says, "No person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving financial assistance" (para. 8). There are many ways Title IX influenced higher education; however, it arguably affected athletics more than any other sector. Ironically, colleges were uncertain at the beginning if athletics would be included in this bill (Anderson, Cheslock, & Ehrenberg, 2006). Today, most all institutions, especially athletic departments, realize the importance of Title IX.

While athletics saw an increase in equality due to Title IX, Cohen and Kisker (2010) stated that college admission numbers also became more equal for males and females. After this law was passed, degrees in law and medicine increased. There were 830 women who graduated in medicine in 1972, while 1,629 women graduated in 1975.

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Also, 1,498 women obtained a law degree in 1972, compared to 4,415 in 1975 (Cohen & Kisker, 2010). This shows that Title IX had multiple positive effects on higher education and continues to shape it today.

There were also several affirmative action cases regarding admission practices. One of the first cases was California v. Bakke. Bakke was denied admission to the University of California Medical School on two different instances (McBride, 2007). According to McBride (2007), "The medical school reserved 16 out of 100 seats in its entering class for minorities, including 'Blacks,' 'Chicanos,' 'Asians,' and 'American Indians'" (para. 1). Bakke, a Caucasian male, took legal action stating that the school had erred in regards to the Fourteenth Amendment's Equal Protection Clause and Title VI of the Civil Rights Act of 1964. The case went to the Supreme Court, who found that while race may be looked at in regards to admissions, it must be held up to other factors. Since the school did not hold up race to other factors within their quota system, the Supreme Court ruled against this part of their admissions practice. However, the Court also ruled that "A school's use of 'affirmative action' to accept more minority applicants was constitutional in some circumstances" (McBride, 2007, para. 1).

Another important court case involving affirmative action within admission practices took place at the University of Michigan. In Grutter v. Bollinger, Grutter, a female Caucasian, was not admitted into the University of Michigan Law School. It was known that the school looked at many factors when deciding who to admit, including race. Grutter took action against the schools admission policy. The Supreme Court ruled in favor of the school, citing that the school looked at many more factors than just race when deciding who to admit (The Oyez Project website, 2011).

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While equality for race and gender was addressed, those with disabilities had to wait several more years before a monumental act was passed in their name. This act, The American with Disabilities Act (ADA), "was passed in July 1990 and became effective on January 26, 1993" (Mazumdar & Geis, 2010, p. 304). Although it was not passed until later in history, it became a driving force behind implementing equality for the disabled. One reason it was passed was because those with disabilities increased their efforts to make known their desire for rights (O'Brien & Ellegood, 2005). According to Mazumdar and Geis (2010), the ADA "prohibits discrimination on the basis of disability in employment, programs, services, and facilities by state and local governments, commercial and public accommodation facilities, and transportation and telecommunications" (p. 304). This affects higher education in that it mandates that certain facilities be built with modifications to help those with disabilities (Mazumdar & Geis, 2010). Most college campuses are now structured so that those who have physical disabilities will be accommodated. Some of the ways universities assist with this is by installing automatic doors, erecting ramps, or constructing more sidewalks. Enrollment for students who have disabilities has gone up (Hamblet, 2009). This trend will likely continue to increase, as institutions become more sensitive to this matter.

Diversity in Medical Education

Diversity has expanded in many professions, and medicine is no different. Diversity allows individuals to build relationships with people different from themselves. Medical schools now enroll a diverse study body. Coombs (1998) noted, "Today's beginning medical student may be a single Latina parent, an African-American liberal arts graduate, a grandmother, a disabled Asian American, a lesbian, or an engineer with

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several years of work experience" (p. 32). Why is it important to discuss diversity within this study? It is important for several reasons. First, the *BaFa' BaFa'* exercise within this study is focused on addressing diversity. As will be discussed later in this paper, at the core of the *BaFa' BaFa'* exercise is a role-play game that forces individuals to be around those who are different from themselves. Second, one of my research questions that I am seeking to answer is how does *BaFa' BaFa'* impact current medical students perceptions about those different from themselves? I plan to ask my participants their perceptions about how the exercise impacted them, specifically what it was like to be around a different group of people. Last, it is important to discuss diversity within this study, because it is vital to understand diversity's history within medical education to help us better understand it in today's medical schools.

Before the beginning of the nineteenth century, it was difficult for minorities and women to become doctors (Lakhan, 2003). Medical schools that accepted minorities and women began in the 1800s. However, due to the findings of Abraham Flexner's report, all of the schools that contained primarily women were closed, and only two of the medical schools for African Americans remained open (Lakhan, 2003). According to the U.S. Department of Health and Human Services (1990), "It is generally agreed that 1968 was the year in which medical schools began a collective effort to recruit and admit minority medical students" (p. 27). The percentage of African American first-year medical students in 1968 was 2.7%, and the majority of these students attended Howard University, located in the nation's capital, and Meharry Medical College in Nashville, both Historically Black Colleges and Universities (HBCU's). According to the U.S.

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Department of Health and Human Services (1990), by 1974, the enrollment of African American first-year students had increased to 7.5% of the total.

There were also increases in medical school enrollment for first-year Hispanic and American Indian students between 1978 and 1988 respectively. However, the minority group that grew the most during this time was Asian Americans. The enrollment percentage for first-year Asian American medical students went from 2.7% to 12.4% of the total first-year population from 1978 to 1988 (U.S. Department of Health & Human Services, 1990). Coombs (1998) added, "Racial and ethnic minority students made up 12.2% of all medical students in 1996 – a record high but still far short of the original goal of 3,000 underrepresented minorities by the turn of the century set by the AAMC" (p. 41).

According to the U.S. Department of Health and Human Services (1990), when looking at first through fourth-year enrollment in medical schools, minority students increased more than 18% from 1968 to 1988. The number of women enrolled in medical schools began to increase in the 1970s. "Annual female medical school graduates increased from 204 to 700 in the 40-year period from 1929-1930 to 1969-1970" (U.S. Department of Health and Human Services, 1990, p. 105). By 1987-1988, women comprised 32.8% of the medical school graduates (U.S. Department of Health and Human Services, 1990). Dr. Elizabeth Blackwell, who trained at Geneva Medical School, is considered the first woman doctor in America (Coombs, 1998).

Individuals with disabilities who have a desire to practice medicine can be encouraged by the number of doctors who might have similar impairments (Coombs, 1998). Coombs (1998) reported, "It is estimated that more than 1,000 physicians in

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training have physical or learning impairments" (p. 49). This shows that the medical profession is accepting of those with disabilities. While diversity can be improved upon by medical schools, they have made significant strides to ensure that diversity is an important part of their mission. To the interest and advancement of the profession, medical schools will continue to strengthen their diversity mission, which will be beneficial for all involved in the medical community.

However, as the years have passed, there has been more diversity seen in the medical field. According to the AAMC (Association of American Medical Colleges) website (2012), figures published in 2011 showed minorities accounted for 40% of the enrollment in American medical schools. The largest minority group was Asian students at 21.9%. Since the number of minorities will continue to grow, this will also affect healthcare (LaVeist, 2005). LaVeist (2005) stated, "What we now call minority health will become the nation's health" (p. 7). It is estimated by the U.S. Bureau of the Census that by 2050, whites will no longer comprise over 50% of the population (LaVeist, 2005). Due to this trend, medical schools will not only begin enrolling a more diverse student body, but will be forced to teach their students how to interact with different cultures.

Challenges for Medical Students

The path a medical student must take to achieve their dreams of becoming a medical doctor is one that is long and difficult. It begins as an undergraduate where students begin taking pre-medical classes and build their resume through volunteer work and employment. Some of the things that an undergraduate, who is considering medical school, must consider includes selecting an appropriate college major, meeting the requirements necessary for entrance into medical school, holding jobs during breaks, and

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engaging in other social/community activities (Ablow, 1987). Then, preparation begins for the Medical College Admission Test (MCAT), which most medical schools use as part of their student selection process. If students have a high enough grade point average and MCAT score, they are granted an interview. The interview can help decide whether a student receives an acceptance letter. As Ablow (1987) stated, "In every case, the interview has the potential of significantly influencing the committee's final decision, and no one should take it lightly" (p. 87).

Once a student is accepted into medical school, they begin what is often described as one of the toughest four-year academic periods of their lives. Most schools require their students to take basic science classes the first two years, followed by clinical rotations the last two years. Some of the classes medical students take their first two years include Biochemistry, Gross Anatomy, Histology, Physiology, as well as many more. Some classes are more difficult than others, yet all require discipline in order to do well. Once students enter their third year, they begin to have more patient interaction. They rotate through the different aspects of the medical field. Some of the rotations they experience include surgery, medicine, obstetrics/gynecology, pediatrics, and psychiatry. Clinical rotations help students decide what field they want to practice when they finish medical school. Clinical rotations also help students decide if they want to do primary care, such as family medicine or if they want to specialize in a field, such as dermatology. Once medical school is complete, most students attend a residency program that can last anywhere from three to seven years, depending on what field is chosen.

During the four-year medical school process, challenges are not uncommon and can affect even the most prepared medical students. One aspect that must be understood

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is that each entering medical student excelled in college. If they did not excel as an undergraduate, they would not have made it into medical school. A common challenge first year medical students have is learning that the grades they obtained in college are harder to maintain (Coombs, 1998). Students who are used to performing well in undergraduate work can quickly find themselves failing tests in medical school (Coombs, 1998). This is a difficult concept to handle for some medical students. When students have excelled their entire academic career, and then begin to make lower grades, it can add stress.

Another challenge for medical students is that most of them will have to dissect a real human body (Coombs, 1998). In high school or college, students are accustomed to dissecting animals, such as frogs. However, in medical school, dissecting becomes much more personal. Coombs (1998) quoted a medical student by stating, "It didn't really bother me at all until we got up to the face, and then it struck me for the second time that this is a human being I'm working on" (p. 24). It must be a unique experience for anyone to have to stand over a dead human body and carefully dissect it. However, this is one of the more important classes in medical school, because it introduces the students to the human body.

Each year of medical school brings about different challenges. One of the factors that make the second year difficult is the thought of having to take the USLME STEP 1 test at the end of that year (Coombs, 1998). The STEP 1 test is given to all second-year students that assesses their knowledge of the first two years of medical school. Also, most residency programs use these scores to help determine who they select into their programs. This can cause a great amount of stress on students toward the end of the

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second year. Not only do they have to finish out their coursework, but they have to begin preparations for STEP 1 as well. This forces them to decide how much time they want to commit to their coursework.

As with any profession, there exists an urge for individuals to not be humiliated by their bosses or colleagues. It is no different in medical school. A challenge that arises for students after their second year is something known as, "pimping" (Coombs, 1998). This involves an attending doctor asking a question to a medical student in front of their peers to see if they know certain information. While not knowing the answer can be discouraging, it can become even worse when one of their peers steps in and gets the correct answer. Coombs (1998) stated, "Although the alleged purpose of pimping is to test knowledge or teach, it often illuminates the third-year student's lowly status and shaky confidence" (p. 108). The third and fourth-year students also begin to interact with patients on a daily basis. Once students begin interacting with patients, the threat of getting sick themselves increases (Coombs, 1998).

Medical students receive some of the most in-depth training in the educational realm. However, this training does not come without a cost. Medical school tuition and fees are expensive, which causes many students to have to take out federal loans in order to attend school. Although most medical students will one day be paid a high salary, they still must be careful with the amount of money they borrow. According to the Association of American Medical Colleges (AAMC) website (n.d.), tuition and fees for public institutions for in-state residents can range from around $12,000 a year to over $40,000 a year. Students could end up borrowing over $150,000 in tuition and fees alone, not counting living expenses.

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How much do these challenges truly affect medical students? One study by Dyrbye et al. (2006) helped answer this question. This study researched medical students at three medical schools in Minnesota: the Mayo Clinic and the two campuses of the University of Minnesota. There was an electronic questionnaire sent to 1,087 medical students and 545 completed it. Some of the questions that were asked focused on topics such as depression, alcohol consumption, and burnout. This study found that 333 students (30.6%) were either feeling moderate or high emotional exhaustion. Also, it was found that 164 students (15.1%) felt low personal accomplishment. Over 56% of the students measured positive for depression and 14.7% were found to binge drink, which was defined as, "more than five drinks on one occasion within the last year" (Dyrbye et al., 2006, p. 377). This research displayed the amount of stress that can be evident in medical students. Medical schools, especially the Student Affairs Office, must be aware of these issues with their students. Dyrbye (2006) stated, "Programs need to educate students about the variety of personal and professional stressors experienced during training and inform them how to access available resources" (p. 380).

It is debatable whether medical school students experience more challenges than the average higher education student. However, what is not debatable is the difficulty of medical school. Whether it is dissecting a human body or getting "pimped," medical school students have plenty of challenges that await them. Yet, students are not by themselves. One of the positives about medical school is students are able to go through this rigorous process with a group of classmates (Coombs, 1998). Being able to experience these challenges with a large group of classmates can make the process more

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tolerable, as well as help build relationships. This support can help make medical school easier, regardless of the challenges standing in the way.

Why is it important to understand and discuss these challenges regarding medical students within this study? When I interview my participants, it might not be uncommon for them to mention some of these challenges. Also, these challenges could possibly distract my participants from fully concentrating on my questions. Lastly, due to the busy schedule of my participants, it could cause them to not answer my questions as fully as hoped.

Medical Education Curriculum

Appropriate curriculum in higher education is vital for the success of students and the reputation of institutions. Deciding how and what to teach students can be challenging for any medical school. Each program desires for its students to consume knowledge and become successful doctors in the future. Medical schools can be somewhat creative in their teaching methods, as long as they continue to be approved by their respected accreditation bodies. While there are many curriculum methods used by medical schools, I have chosen to concentrate on three of them. These include the hidden curriculum, the problem-based learning curriculum (PBL), and the community-oriented curriculum.

The first type of curriculum is referred to as the hidden curriculum. This curriculum is based on what is learned outside of the classroom (Hafferty, 1998). Hafferty (1998) defined the hidden curriculum as "a set of influences that function at the level of organizational structure and culture" (p. 404). Hafferty (1998) believed that the majority of concepts learned by medical students come from the hidden curriculum, as

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opposed to the classroom. After students are forced to attend class for an extended period, they could begin to feel that going to class is a mundane activity. The hidden curriculum could make learning medicine even more exciting.

According to Hafferty (1998), there are challenges that can come from researching and implementing a hidden curriculum. Because the hidden curriculum could be unique from traditional curriculum, it is difficult for everyone to agree on policies. Also, schools must be conscious of accreditation organizations and make sure they are in compliance, no matter what decisions are made regarding curriculum.

The hidden curriculum is important to understand for this study, because the *BaFa' BaFa'* exercise, while intentionally incorporated into the curriculum, is somewhat unique compared to traditional classroom teaching. Students are forced to actively engage in the learning by role-playing. This exercise also takes place during orientation of the medical students first year. Because the exercise takes place during orientation, students might not even realize the amount of learning that is taking place since they have yet to sit in on an actual medical school class.

The next curriculum method is the problem-based learning curriculum. Problem-based learning works by dividing students into smaller groups, and then they are given different types of problems from the field of medicine (Gijselaers & Schmidt, 1990). Students work together to solve these issues and learn medical concepts along the way (Gijselaers & Schmidt, 1990). One of the pioneer schools to use problem-based learning was McMaster University (Lipken, 1989). Some of the reasons McMaster used problem-based learning was to motivate their students, to increase analytical skills, and to encourage self-education (Lipken, 1989).

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While problem-based learning has been proven to work well for students, there is another group that must be considered. The faculty, who teach at these medical schools, must be accepting of it. If faculty were not in favor of this type of curriculum, it would be hard for it to succeed. David Thompson studied the opinions of faculty about problem-based learning. Thompson (1990) studied Southern Illinois University at Springfield in 1984. Southern Illinois University began a change in curriculum in 1981, where it went from a more traditional-based curriculum to a problem-based curriculum. It was found that the faculty supported a PBL curriculum. Thompson (1990) stated, "All felt that the PBL was essentially the style of teaching that had been traditionally used in the bedside teaching of clinical students, and was thus largely a restatement of their pre-existing educational views" (p. 169). It was also found that one faculty member seemed to believe that PBL was allowing students to develop critical thinking skills. While there seem to be many positives of a PBL curriculum, Thompson (1990) does mention one negative. This negative is regarding the issue for faculty of how to grade their students. While the grading can be an issue, there seems to be more positives than negatives associated with problem-based learning.

Within the *BaFa' BaFa'* exercise, problem-based learning is utilized. Students are divided into two separate ethnic groups and must work with their respected group to learn to communicate effectively with the other group. While the problem being solved within the *BaFa' BaFa'* exercise is not related to a medical condition, it is related to communicating and respecting a group of people. As future medical doctors, it is important for these medical students to learn to communicate effectively by problem solving with one other.

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The last curriculum method is community-oriented curriculum. Richards, Bannerman, Wunderlich, and Fulop (1990) stated, "Community-oriented education involves teaching students concepts and methods particularly suited to community practice" (p. 248). Community-oriented education can help foster medical students to work in underserved cities (Richards et al., 1990). Also, community-oriented education promotes that doctors interact with the community around them (Lipken, 1989). Community-oriented education can be beneficial for medical schools that are located close to rural areas, where few options for healthcare exist. Lastly, this type of education can influence students to practice primary care (Lipken, 1989). According to Lipken (1989), the University of the Negev in Israel used a community-oriented approach and reported over 70% of their inaugural class chose a field in primary care.

The community-oriented curriculum is important to understand within this study, because as these medical students go on to practice in different communities, it is vital that they understand how to interact with the population in these communities. Because the world is becoming more diverse, almost any community that these future doctors practice medicine in will be represented by several different types of ethnicities. Therefore, learning within the community-oriented curriculum is important. The *BaFa' BaFa'* exercise relates to the community-oriented curriculum by helping its participants understand the importance of interacting with those they are around.

As stated at the beginning of this section, curriculum is crucial to the success of medical schools. It must be placed toward the top of the priority list for administrators. While there are many different methods to choose from, administrators must find the type of curriculum or curriculums, which they feel is best suited for their students.

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Multicultural Education in Colleges and Universities

According to Kumi-Yeboak and James (2011), "Multicultural education is the teaching and learning of the histories and cultures of all students in the teaching-learning process in any educational system" (p. 10). Defining multicultural education can be difficult, because it can mean different things to different schools (Davila & Peterson, 2011). According to Ukpokodu (2010), many universities attempt to foster diversity through festivals, lectures, and training. However, incorporating multicultural education into the curriculum is challenging (Ukpokodu, 2010). Ukpokodu (2010) stated, "The traditional canon for college and university and public school curricula in the United States has historically been deeply entrenched in Eurocentric paradigms that provide narrow views of history and social realities" (p. 27). With the increase in minority enrollment (Ukpokodu, 2010), higher education institutions must consider multicultural education as a part of their curriculum.

Can implementing multicultural education into a curriculum be successful? Ukpokodu (2010) discussed a change that took place at the University of Missouri-Kansas City in the early 2000s. The university, which was populated primarily of Caucasians, made diversity one of its principle goals. Ukpokodu (2010) started a project called the Diversity Curriculum Infusion Program (DCIP), which was a program "where faculty from across campus would learn to develop the knowledge base, skills and dispositions necessary for successfully infusing diversity into courses" (p. 30). In one of the first meetings of the program, the participants were broken into small groups and they were asked to discuss changing the curriculum. Ukpokodu received praise from the administration at the college. There have been 120 people go through this program and

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eighteen departments have been represented. "Overall, most participants noted that, although the process was challenging they had learned from the experience and gained new ideas for improving their courses and found the effort most rewarding and energizing" (Ukpokodu, 2010, p. 33). While the program had success, there were challenges, such as inadequate support and evident resistance.

Hurtado (2007) performed a project where certain students at ten public universities were studied. Several outcomes were assessed, including the effect on students when they were exposed to a curriculum that dealt with diversity. "Specifically, students who enrolled in diversity courses showed higher scores on 19 of 24 outcomes, while those who participated in diversity-related extracurricular programming scored consistently higher on 17 of the 24 educational outcomes in the study" (Hurtado, 2007, p. 192). It was also found that when students took a course that dealt with diversity within their first two years, they were more likely to vote in an election on the state or federal level.

Bowman (2010), using information from the Wabash National Study of Liberal Arts Education, studied students at nineteen colleges. Over 3,000 students were studied by using the Ryff Scales of Psychological Well-Being Questionnaire. Bowman found that when students took more than one diversity course, they indicated an improvement in several different areas. These areas included well-being, comfortableness regarding differences, appreciation of others' similarities and differences, and interaction with diverse others (Bowman, 2010, pp. 557-558). Bowman (2010) stated, "These findings provide strong support for institutions' adopting a diversity requirement that includes multiple courses" (p. 562).

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Pascarella, Salisbury, Martin, and Blaich (2012) studied the relationship between diversity experiences and orientations toward social/political activism. There were 2,974 total freshmen from nineteen different colleges included in the study. It was found that there was a positive relationship between these two factors. Pascarella et al. stated "…that both interactional and classroom diversity experiences during the first year of college function to accentuate student precollege advantages on both orientation toward social/political activism and liberal political views" (p. 489).

One college that is intentional with their multicultural education mission is Hampshire College in Massachusetts. According to the Hampshire College website (2013), they have a requirement for their students where they have to finish what is called the multiple cultural perspectives. Students are able to pick one of three topics to study: nonwestern perspectives, race in the United States, or knowledge and power. Students must present their findings and tell how their findings affect them.

Multicultural Education in Medical Schools

One sector of higher education that must not be forgotten in regards to multicultural education is medical schools. The Liaison Committee on Medical Education (LCME) is the accrediting body for medical schools in the United States and Canada (LCME, 2013a, para. 1). The LCME has written a policy in regards to what they expect their schools to adhere to when it comes to multicultural education. The LCME (2015) website states:

> 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

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> 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. (para. 2)

Therefore, it is vital for medical schools to develop programs that address multiculturalism. Each school must decide which methods work best for them. Some of these methods include language training, cultural sensitivity training, and training that deals with different minorities (Daugherty et al., 1994). Kripalani, Bussey-Jones, Katz, and Genao (2006) suggest instruction methods, such as role-play and journals, support from faculty, and placing an importance on diversity.

Another reason it is important for medical schools to implement multicultural education is due to the effect it could have on the healthcare system (Dogra et al., 2009a; Lakhan, 2003). Dogra et al. (2009a) listed three reasons why medical schools have begun to pay close attention to diversity. These reasons include "enhancing cross-cultural patient-doctor encounters, eliminating health inequities, and improving health outcomes of the marginalized and underserved" (Dogra et al., 2009a, para. 1). According to Lakhan (2003), "The need for diversification in medicine is fundamental to the health of the U.S. medical system" (para. 3). Due to the rising number of minorities, the future landscape of patient care will look much different than it does today. Therefore, implementing multicultural education in medical schools is vital for the future of the healthcare industry.

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However, one challenge of implementing multicultural education in medical schools is a shortage of clarity of what diversity means (Dogra, Reitmanova, & Carter-Pokras, 2009b). Dogra et al. (2009b) looked at multicultural education within medical schools in the United States, United Kingdom, and Canada. They found that one challenge for all three countries is figuring out the meaning of diversity. They discussed the fact that it is positive for licensing organizations to stress the importance of diversity. However, the communication from these organizations can be vague on how to deal with this topic (Dogra et al., 2009b). Dogra, Giordano, and France (2007) found that defining "cultural diversity" can be comprehensive. Some might see it as related to ethnicity, while others feel ethnicity and cultural diversity are unique on their own.

One of the most pertinent questions facing medical schools is how to implement multicultural education. Where should institutions begin? Should students be trained on this topic during all four years? What type of programs should be implemented? When it comes to starting multicultural education, Ukpokodu (2010) stressed the importance of seeing viewpoints of others. Dogra et al. (2009a) provided recommendations for installing diversity education in a medical curriculum. They believe it is vital for students to have an understanding of the biases that are within them. They also feel it is important for students to realize the amount of openness they have toward those who might be different from themselves.

Another question in regards to multicultural education in medical schools is whether students should be trained in it all four years of their medical education. As mentioned earlier, medical students typically experience basic science classes their first two years, followed by clinical duties their last two years. Dogra et al. (2009a) stated that

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multicultural education should be installed throughout the students' four years, including the clinical rotations. Shapiro et al. (2006) studied third year medical students and how they felt about their cultural competence curriculum (CCC). They found a "strong preference expressed across all three groups for the majority of the CCC to be integrated into the informal curriculum, especially during the third year of training, when students start their clinical rotations" (para. 29).

Dolhun et al. (2003) studied nineteen medical schools in the United States and looked at how each school implemented their cross-cultural curriculum. It was found that 32% of the medical schools in the study offered courses that contained some type of cultural competence material. Eighty-four percent of the medical schools indicated that their students had to complete some type of cultural-competence training. Twenty-one percent of the medical schools incorporated cross-cultural instruction in every year of medical school. It was found that language issues were only implemented by a few of the schools. Dolhun et al. stated, "In preparing medical students for careers in an ever-changing United States, the challenge for each school will be to balance local realities—demographics, resources, expertise, and traditions—with the broader, and often disparate, needs of the nation" (p. 619).

One organization that is striving to implement multicultural education into medical schools is the National Consortium for Multicultural Education for Health Professionals (National Consortium for Multicultural Education for Health Professionals website, 2009). The Consortium's website (2009) stated the following:

> The main goal of this initiative is to increase the overall knowledge and skills of medical students, house staff, and other professionals, including practicing

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> physicians on the ethnic, cultural, religious, socioeconomic, linguistic and other factors that contribute to health disparities, and on culturally competent approaches to mitigating these disparities. (para. 1)

Some of the medical schools that are affiliated with this consortium include the University of Alabama-Birmingham, Morehouse, Baylor, and Wake Forest. These such organizations can be influential in the development of multicultural education within the medical curriculum.

There are numerous multicultural education programs for educators to choose from to offer to their students. Ukpokodu (2010) stated, "It is common to see and experience diversity activities on various campuses – cultural festivals, multicultural celebrations, minority scholars in residence, ethnic cuisines in campus cafeterias, diversity sensitivity training, and lecture series that bring to campus prominent scholars" (p. 27). While there are many different programs to choose from, the important factor is that administrators at medical schools are striving to implement programs for the betterment of their students, who will one day be doctors in various communities.

Foreign Language Training in the Health Field

As the United States becomes more diverse, it is vital that American higher education institutions implement programs to better equip its students to work with a variety of cultures. This is even more pertinent in health science programs, where future medical workers need to learn how to treat patients who come from different backgrounds and who speak different languages. Maben and Dobbie (2005) spent several months reviewing information from web sites and databases regarding Spanish instruction at medical schools. Their search indicated, "Fewer than half of US medical

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schools appear to offer medical Spanish experiences" (Maben & Dobbie, 2005, p. 614). While this research was published in 2005, it does help reveal the inadequacies of Spanish training in health science programs, especially medical schools. One reason that Spanish is being taught is because the most populated minority population in the United States are Hispanics (Bloom, Timmerman, & Sands, 2006).

Nursing students are one sector of the health population that are beginning to see more Spanish training. The University of Texas at Austin offers a class to undergraduate nursing students called, Spanish for Health Care Professionals (Bloom et al., 2006). This is a three-hour class that is mandatory for students to take. It was the first nursing school of its kind in the U.S. to implement a mandatory class in Spanish. The students who took this class had varying levels of prior Spanish training. One of the primary goals with this class was "…to be able to communicate with native speakers in health care settings" (Bloom et al., 2006, p. 272). Bloom et al. (2006) stated "By the end of the semester, students used more communication strategies in Spanish, such as asking clarification questions, using repetition as clarification, and using body language" (p. 273).

The School of Nursing at the University of California, San Francisco, offers their master student's an elective, entitled Communicating with the Latino Patient (de Pheils & Saul, 2009). This course started in 2003. While teaching the language is important, the students are also introduced to cultural issues as well. Surveys were used to gauge success. de Pheils and Saul (2009) found that "for 57% of the graduating students, this course *significantly* or *moderately* affected either their decision or their ability to work with Spanish-speaking patients" (p. 517). Also, it was found that many students possessed a longing to have more resources for their Spanish training. de Pheils and Saul

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recommended keeping class sizes small when teaching Spanish. It was found that 99% of those who responded to the surveys said that the classes should not be over 12 people.

Nursing educators are not alone in providing their students Spanish training. Medical school educators understand its importance as well. One medical school that incorporated language skills was Rush Medical College (Daugherty et al., 1994). Rush Medical College worked with two different organizations "to develop a Spanish Language and Hispanic Cultural Competence Project to improve the medical Spanish language skills and enhance Hispanic cultural awareness of undergraduate medical students" (para. 3). There were several reasons why this program chose Spanish. These reasons included the growth of the Hispanic population, the difficulties Hispanics might experience in their effort to receive adequate medical care, and the shortage of Hispanics working in health care. The program contained three parts, which included training in language, training in culture, and time spent in a Hispanic country. The results were positive. Scores rose by an average of 15% in language skills, and the students increased their understanding of the culture by 18%. Lastly, the part of the program where the students went on a trip to another country received positive feedback (Daugherty et al., 1994).

Reuland, Frasier, Slatt, and Aleman (2008) conducted another study at the University of North Carolina. They found that medical students, who had prior training in Spanish, had a desire to keep their training up-to-date in medical school. This program targeted students who already had some type of training in Spanish. Students who were accepted into the 80-hour class completed grammar lessons, role-playing exercises, and cultural discussions. They were also able to attend culture seminars and worked at least

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twenty hours at health events where Latino representation was high. Research was gathered by speaking with focus groups of different students. "Nearly all believed the program helped them to maintain or improve their Spanish speaking and listening skills and to acquire medically relevant vocabulary" (Reuland et al., 2008, p. 1035).

When I talk with my participants regarding their experience with the *BaFa' BaFa'* exercise, I anticipate that they will discuss prior experiences with multicultural education. Some of my participants might have experienced multicultural education opportunities, such as language training. They could potentially use these past experiences to answer the questions that I ask. Therefore, it is important to understand many different aspects of multicultural education, including foreign language training.

Cultural Simulation Exercises

Simulation exercises are one method of teaching students how to be competent about other cultures. One popular simulation exercise is a program called *BaFa' BaFa'*. This program was originally developed by Dr. Garry Shirts to help military members of the United States when they visited other countries (Dunn et al., 2011). According to Jarrell et al. (2008), "BaFa' BaFa' is a culture simulation game that invites participants to examine their feelings about culture and investigate issues surrounding cultural diversity" (p. 141). *BaFa' BaFa'* can reveal information regarding the following: stereotyping, misperceptions, and open-mindedness (Dunn et al., 2011). According to the Simulation Training Systems (2015) website, "It may be used to help participants prepare for living and working in another culture or learning how to work with people from other departments, disciplines, genders, races, and ages." (para. 2).

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The *BaFa' BaFa'* experiment consists of two fictional cultures: the Alpha culture and Beta culture (Simulation Training Systems, 2015). According to the Simulation Training Systems (2015) website:

> The Alpha culture is a relationship oriented, high context, strong in-group out-group culture. The Beta culture is a highly competitive trading culture. After the participants learn the rules of their culture and begin living it, observers and visitors are exchanged. The resulting stereotyping, misperception and misunderstanding becomes the grist for the debriefing. (para. 9)

BaFa' BaFa' has been used in many different settings over the years. As mentioned earlier, the military was the first sector to utilize it. Dunn et al. (2011) studied its impact in public administration. Sullivan and Duplaga (1997) studied *BaFa' BaFa'* at several different higher education institutions and one corporation. Jarrell et al. (2008) looked at its impact in the medical field by studying nursing students' response to the program. *BaFa' BaFa'* can be used in any setting that seeks to aid "the sub-cultural differences that can seriously impede productive, interpersonal interaction" (p. 224). For the purpose of this study, I will look at its impact on recent medical school graduates from a health science center in the southeastern United States.

How successful is *BaFa' BaFa'* in helping individuals overcome culture challenges? Sullivan and Duplaga (1997) administered surveys to seven different individuals who used *BaFa' BaFa'* in their organizations. These organizations consisted of six higher education institutions and one private corporation. These institutions included Bowling Green State University, Helsinki School of Economics, James Madison University, San Diego State University, University of Virginia, West Texas A&M

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University and Dow Corning Corporation. After gathering data, it was determined that all seven had "positive experiences" with *BaFa' BaFa'* (Sullivan & Duplaga, 1997, p. 266). Sullivan and Duplaga (1997) quoted Mary Teagarden, one of the individuals who responded to the survey, as saying, "many [students] identify it as one of the biggest 'ah ha's' of their education – including executives" (p. 271). Jarrell et al. (2008) stated, "Students consistently report that they enjoy the experience and are able to recognize how easy it is to misinterpret behavior and develop stereotypes" (p. 141).

However, as with many educational programs, *BaFa' BaFa'* has been found to have challenges. Sullivan and Duplaga (1997) offered several challenges of the *BaFa' BaFa'* experience. These included the opportunity for students to not comply with all the rules, the students' shyness or unwillingness to take part in the exercise, and the time commitment it requires to make proper preparations for the exercise. Jarrell et al. (2008) found that students responded in three main ways. These ways included aggressiveness, assertiveness, and intimidation. However, the research indicates that if organizations are willing to tolerate the challenges that can occur with *BaFa' BaFa'*, then their overall experience can produce effective changes in the lives of their students and employees. Sullivan and Duplaga (1997) stated, "Instructors who employ the BBS (BaFa' BaFa' Simulation) typically say that it is one of the most powerful teaching tools they have used" (p. 266).

Cultural Competency

One of the primary purposes of this study is to understand how the *BaFa' BaFa'* exercise impacts the cultural competency of current medical students. Before discussing cultural competency, I believe it is important to discuss two other terms: culture and

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multiculturalism. The reason I believe it is important to understand these terms is because they can easily be confused with one another. While the terms culture, multiculturalism, and cultural competency are related, there are distinct differences among them that make them unique. The first term I would like to discuss is culture, as it is the broadest of the three. Banks and Banks (2001) defined culture as "the ideations, symbols, behaviors, values, and beliefs that are shared by a human group" (p. 428). According to Banks (2001), an important aspect of culture is the way individuals depict, practice, and discern "tangible cultural elements" (p. 8).

It is important to understand the term culture, because it can directly impact multicultural education for students. Banks and Banks (2001) stated, "A challenge that multicultural education faces is how to help students from diverse groups mediate between their home and community cultures and the school culture" (p. 7). The participants in this study will come from different backgrounds where the information they learned in their home and community will vary from each another. The BaFa' BaFa' exercise is attempting to introduce the students to certain aspects of multicultural education, such as biases and stereotypes that might be present. The amount of learning and application from each of my participants might vary depending on their home and community cultures. Therefore, it is important to understand that the results of this study could be directly impacted by the different cultures of my participants. This is why it is important to understand the concept of "culture" within this study.

The next term I would like to discuss is multiculturalism. Banks and Banks (2001) defined multiculturalism as:

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> A philosophical position and movement that assumes that the gender, ethnic, racial, and cultural diversity of a pluralistic society should be reflected in all of the institutionalized structures of educational institutions, including the staff, the norms and values, the curriculum, and the student body. (p. 430)

The primary difference between culture and multiculturalism is that culture relates to practices that a group has in common, whereas multiculturalism relates to bringing different cultures together into one entity. Banks (1986), describing someone in the stage of multiculturalism and reflective nationalism, stated that "the individual has reflective ethnic and national identifications and the skills, attitudes, and commitment needed to function within a range of ethnic and cultural groups within his or her nation" (p. 14).

Why is it important to understand the term "multiculturalism" within this study? It is important to understand it, because the BaFa' BaFa' exercise seeks to utilize multiculturalism by bringing together individuals from many different cultures to enhance learning. Within this study, the medical school class that participates in the BaFa' BaFa' exercise is ethnically and economically diverse. The students come from all types of backgrounds and have different personalities. Within the exercise, these students are asked to portray a culture that is foreign to them, making the exercise even more diverse. However, a goal of the exercise is to help individuals appreciate the differences that exist within each other. Because multiculturalism is being practiced within BaFa' BaFa', understanding its meaning is vital and must be understood, especially as I seek to decipher the results.

How does culture and multiculturalism differ from cultural competency? Before discussing this, it is important to understand what cultural competency is. Merriam-

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Webster, Inc. (2013a) defined culture as "the customary beliefs, social forms, and material traits of a racial, religious, or social group." Furthermore, Merriam-Webster, Inc. (2013b) defined competent as "having requisite or adequate ability or qualities." Cross (1988) stated that "cultural competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or professional and enable that system, agency, or professional to work effectively in cross-cultural situations" (para. 1). When it comes to cultural competence in a health setting, Betancourt, Green, Carrillo, and Ananeh-Firempong (2003) provided a solid definition. Betancourt et al. (2003) stated:

> "Cultural competence" in health care entails: understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural process of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. (p. 297)

Cross, Bazron, Dennis, and Isaacs (1989) proposed a model dealing with cultural differences. This model contained different levels of responses from individuals. These levels of responses included the following: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competence, cultural competence, and cultural proficiency.

Galanti (2008) provided three steps, which are important in obtaining cultural competence. These steps included the following:

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1. Understanding your own culture and biases, becoming sensitive to the cultures of others, and appreciating the differences.
2. Acquiring knowledge and understanding of other cultures, especially their values and beliefs.
3. Apply that knowledge. (p. 2).

Galanti also stated that the effects of cultural competence could be happier patients, better results within clinics, and monetary productivity.

The term cultural competency differs from the term culture and multiculturalism in that cultural competency is more specific. In regards to cultural competency, it is not just relating to the practices that a group has in common, nor is it only relating to how individuals understand that differences exist. It focuses on how individuals apply what they know about those differences. I hope to better understand how current medical students apply what they have learned through the BaFa' BaFa' exercise. This is why I have chosen to specifically study cultural competency. However, I believe that by having a deeper understanding of culture and multiculturalism, it will help me better understand the impact of cultural competency on my participants.

Experiential Learning

Experiential learning is a way to experience learning instead of simply hearing it in a classroom (Mullins-Nelson, 2008). According to Kolb, Boyatzis, and Mainemelis (1999), "The theory is called 'Experiential Learning' to emphasize the central role that experience plays in the learning process, an emphasis that distinguishes ELT from other learning theories" (p. 2). One of the leading pioneers in experiential learning was John Dewey (Kolb, 1984). Kolb (1984) stated, "Yet it is the work of Dewey, without doubt

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the most influential educational theorist of the twentieth century, that best articulates the guiding principles for programs of experiential learning in higher education" (p. 5).

According to Smith, Knapp, Seaman, and Pace (2011), there were three programs that were founded in the 1970's which had an impact on the development of experiential learning. These programs included the Outward Bound schools, Project Adventure, and the National Outdoor Leadership Schools. All of these programs sought to develop a different method of education that focused on direct experience. Smith et al. stated, "These educators believed that students would learn certain concepts, skills, and values better if they occasionally moved away from their desks and books and were provided more opportunities for challenging small group experiences outside the classroom" (p. 1). According to Smith et al., outdoor activities were used for experiential learning, such as rock climbing, spelunking, and community service. Those who worked in the corporate sphere began using experiential learning due to hearing about these outdoor activities. As the 21st century began, experiential learning was continuing to grow more and more.

One of the more well-known researchers in experiential learning is David Kolb. Kolb created a model of experiential learning. Kolb's model deals with the different styles of learning and how educators can effectively reach their students (Evans et al., 2010). When discussing his model, Kolb (1984) stated, "It offers a system of competencies for describing job demands and corresponding educational objectives and emphasizes the critical linkages that can be developed between the classroom and the 'real world' with experiential learning methods" (p. 4). His model consists of four modes of learning: concrete experience, reflective observation, abstract conceptualization, and active experimentation. However, his last learning mode of active experimentation aligns

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closely with the educational opportunities that my participants will experience. With active experimentation, the learners learn by participating. "Kolb suggests that learners engage in active experimentation, during which phase they introduce innovations that have been informed by the learning that preceded them in the three earlier phases" (Bess & Dee, 2012, pp. 678-679). According to Claxton and Murrell (1992), some examples that teachers may use to implement active experimentation include role-play exercises, group projects, hypothetical situation activities, configuration of action plans, and debates. Evans et al. (2010) stated:

> The most direct application of Kolb's theory may be in the use of the information on learning styles as an empathy and design tool for responding to the increasing diversity represented among the student population as educators seek to provide both challenge and support in learning experiences in the classroom and beyond and in the modes used to deliver services to students. (p. 145)

The National Society for Experiential Education (2012) lists Eight Principles of Good Practice for Experiential Learning. These principles include intention, preparedness and planning, authenticity, reflection, orientation and training, monitoring and continuous improvement, assessment and evaluation, and acknowledgment. According to The National Society for Experiential Education (2012), the third principle of authenticity is where "the experience must have a real world context and/or be useful and meaningful in reference to an applied setting or situation" (para. 4). Within this study, what these current medical school students will experience has "a real world context" of learning how to interact with those different from themselves.

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Experiential Learning in Multicultural Education

I would now like to discuss experiential learning as it relates to multicultural education, specifically Kolb's learning mode of active experimentation within *BaFa' BaFa'*. Bennett (1995) stated, "An experiential approach is especially effective with culturally diverse groups of students because (with the important exception of language) there are no specific knowledge, attitude, or skill prerequisites for the initial involvement" (p. 245). The *BaFa' BaFa'* exercise at this medical school is experienced by the entire medical school class, which is made up of individuals from different backgrounds and ethnicities. Therefore, it can be argued that this exercise should be taught using experiential learning. Bennett also stated that "students can participate in the introductory activity regardless of their achievement levels or cultural orientation" (p. 245). Within the *BaFa' BaFa'* exercise I am studying, it allows all the medical students in the class to participate and does not require previous experience with multicultural education. This is important, as it means no student has to miss the exercise based on prior experience.

How can using experiential learning techniques help teach multicultural education? Rainey and Kolb (1995) discussed experiential learning theory (ELT) and how it might help combat the difficulties of teaching diversity education. These ways included the following:

1. ELT is an inclusive paradigm that allows for a range of responses to the learning requirements of diversity education.

2. ELT in the concept of learning style offers a perspective for addressing the dilemma between equality in education and individualized learning.

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3. ELT proposes that the foundation of learning resides not in schools, books, or even teachers; rather, it rests in the experience of the learner. (Rainey & Kolb, 1995, p. 130).

Within the *BaFa' BaFa'* exercise I am studying, students are provided the freedom to have many different responses through role-playing and answering questions in the debriefing session. Also, within the *BaFa' BaFa'* exercise, students are able to learn without the use of books or professors, but primarily through their experience of role-playing with one another.

One important aspect of *BaFa' BaFa'* consists of student role-play exercises. One group of students is asked to act as if they are from a certain culture, while the other group of students acts as if they are from a different culture. As discussed previously, Claxton and Murrell (1992) listed role-play exercises as an example of active experimentation, one of Kolb's modes of learning. While multicultural education may be taught in many different ways, I hope to learn how effective the learning mode of active experimentation is when it is used to teach current medical students about diversity issues. Little, if any, research exists on the effect of Kolb's specific learning mode of active experimentation on multicultural education. I anticipate that this study will make a contribution to this area of research.

Summary

This chapter discussed several different topics. These topics included the following: history of medical education, diversity, challenges for medical students, medical education curriculum, cultural competency, multicultural education, *BaFa' BaFa'*, and experiential learning. There have been numerous studies and documents

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composed about each topic. This chapter is a conglomeration of some of these studies and documents, which allows us to better understand the topic of this study, which is multicultural education in a medical school setting.

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Chapter 3

Methodology

As mentioned in chapter 1, the purpose of this research was to understand how a multicultural education exercise impacted cultural competency on current medical school students at a southeastern health science center. There were two research questions that guided this study:

1. How does BaFa' BaFa' impact cultural competency on current medical students at a southeastern health science center?
2. How does the experiential learning aspect of BaFa' BaFa' impact current medical school students at a southeastern health science center?

This chapter will discuss the methodology for this study and will include the rationale for using a qualitative approach, including discussion regarding the epistemology, theoretical framework, methodology, participant selection, study context/setting, data collection, and data analysis of the study. This chapter will also discuss the trustworthiness of the study, and include my subjectivity statement.

Rationale for Qualitative Research Design

Glesne (2011) defined qualitative research as "a type of research that focuses on qualities such as words or observations that are difficult to quantify and that lend themselves to interpretation or deconstruction" (p. 283). Merriam (2002) stated, "The key to understanding qualitative research lies with the idea that meaning is socially constructed by individuals in interaction with their world" (p. 3). The participants in this study were current medical students of a medical school in the southeastern part of the United States. For these students, a portion of their medical school education was

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directed toward multicultural education. I believe that meaning (Merriam, 2002) can be found through studying current medical school students' experiences with multicultural education.

Epistemology

For this study, constructivism was used to guide this study. Crotty (1998) stated, "In the constructionist view, as the word suggests, meaning is not discovered but constructed" (p. 42). Creswell (2009) lists four primary elements of constructivism: "understanding, multiple participant meanings, social and historical construction, and theory generation" (p. 6). Within this study, I sought to understand the effect of multicultural education on medical students and using multiple participants' viewpoints to help with this understanding.

When discussing the social constructivist worldview, Creswell (2009) stated, "The goal of the research is to rely as much as possible on the participants' views of the situation being studied" (p. 8). All of the data gathered in this study will come directly from interviewing participants of the *BaFa' BaFa'* exercise. The participants' words will help construct meaning behind the effect of multicultural education on medical students. The methodology for this study is a case study, which is discussed later in the chapter.

Theoretical Framework

An interpretivist theoretical framework was used for this study. Glesne (2011), when discussing the interpretivist paradigm stated that "what is of importance to know, then, is how people interpret and make meaning of some object, event, action, perception, etc." (p. 8). Glesne went on to state "Thus, accessing the perspectives of several members of the same social group about some phenomena can begin to say something

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about cultural patterns of thought and action for that group" (p. 8). I wanted to understand how current medical students "make meaning" of an event, in this case the BaFa' BaFa' exercise. Furthermore, I had hoped to understand the perspectives of multiple medical students as it relates to their cultural competency.

Methodology

This study employed a case study design. Glesne (2011) defined a case study as "an intensive study of an individual, institution, organization, or some bounded group, place, or process over time" (p. 279). The individuals and bounded group in this case are current medical school students. The institution is a health science center, with the organization being the School of Medicine. The place of this study is the southeastern United States. The process is part of the multicultural curriculum at the health science center.

Merriam (2002) stated that "qualitative case studies share with other forms of qualitative research the search for meaning and understanding, the researcher as the primary instrument of data collection and analysis, an inductive investigative strategy, and the end product being richly descriptive" (pp. 178-179). The goal of my research design was to implement each of these characteristics of a qualitative case study. As Merriam stated, I hoped to find meaning from my participants as it relates to a multicultural education experience. Also, I served as the person who was gathering all data and analyzing it. Lastly, I used an inductive investigative strategy and planned for my findings to contain much description within them. Yin (2014) defined a case study as "a study that investigates a contemporary phenomenon in depth and in its real-world context" (p. 237). I believe that the phenomenon of multicultural education, especially

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within a medical school setting, is contemporary and should be studied in-depth (Yin, 2014).

The combination of the individual, organization, and place (Glesne, 2011) makes this case study very specific. Also, since there are many other medical schools in the country that implement multicultural education, this study could be used as one case of many. Merriam and Simpson (2000) defined a case study as "an intensive description and analysis of a particular social unit that seeks to uncover the interplay of significant factors that is characteristic of that unit" (p. 225). The unit under study will be the participants' experiences with the BaFa' BaFa' exercise. One aspect of the BaFa' BaFa' exercise, which uses an active experimentation learning technique, will be studied to better understand the impact it has on the cultural competency of current medical students. To my knowledge, there has not been a similar study completed with all of these factors present.

For the purposes of this study, I relied heavily on Creswell's definition of a case study. Creswell (1998) defined a case study as "an exploration of a 'bounded system' or a case (or multiple cases) over time through detailed, in-depth data collection involving multiple sources of information rich in context" (p. 61). For this study, the "bounded system" Creswell mentioned is the *BaFa' BaFa'* exercise and its impact on current medical school students. As will be discussed in the data collection section, I am using three types of methods to gather data to help the study be "information rich."

Participant Selection

There were three, first-year medical students studied. A criterion and snowball sampling procedure were used to identify and select participants. "In criterion sampling,

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participants are selected who meet some important predetermined criterion" (Polkinghorne, 2005, p. 141). The following criteria was used:

- Must be over the age of 21
- Must be first-year medical students, currently attending the medical school discussed in this study
- Must have participated in the *BaFa' BaFa'* exercise
- Must be willing to discuss their thoughts and opinions about this exercise, as well as topics such as stereotypes and biases

These criteria were listed on a flier (see appendix F) that was distributed to various areas of the campus where students congregate, such as the student union and classrooms. The flier was distributed after obtaining permission from the university. The flier stated what the purpose of the research was and why it was important. The flier also stated what was expected from each participant. My email address and phone number was on the flier so that interested students could contact me to ask questions or volunteer to participate.

In addition to criterion sampling, snowball sampling was used. When discussing snowball sampling, Marshall (1996) stated "subjects may be able to recommend useful potential candidates for study" (p. 523). Within this study, once the first student agreed to be a participant, I asked him for recommendations for other potential participants. Since he was a part of the medical school class, I assumed that he would know other students who might be willing to participate. If the student knew someone else who might be interested in becoming a participant, I asked the student if he would be willing to mention the study to other classmates. Once three participants agreed to participate in

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the study, I began collecting data from each student. By using criterion and snowball sampling, I was able to ensure that the participants all met the minimum requirements to participate, as well as helped me secure participants for the study.

Once three students agreed to be participants, I asked that each student sign a consent form (see Appendix G) that was approved by the University of Memphis Institutional Review Board (see Appendix H). The consent form contained my contact information, as well as the Institutional Review Board's contact information. It also addressed any questions that I felt my participants might have about being a part of the study. One important aspect of the consent form was addressing privacy for my participants. The consent form stated that pseudonyms were used in the study to protect the privacy of each participant. Each participant was given a pseudonym and was referred to this name throughout the study.

Study Context and Setting

The setting of this research was a medical school in the southeastern United States. This institution has three primary missions: education, health care, and research. It has six separate schools including the School of Health Related Professions, the School of Pharmacy, the School of Dentistry, the School of Nursing, the School of Graduate Studies, and the School of Medicine. This university is the only health science center in its respected state. The School of Medicine was the first school established within this institution.

Students who are enrolled within the School of Medicine have all excelled in their higher education career. All students within the School of Medicine have a bachelor's degree in a respected field, while some have a master's degree. In addition, all of the

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students completed an entrance exam, as well as an interview process. The training exercise in this study took place on campus, during orientation of the participants' first-year of medical school. *BaFa' BaFa'* was one of several sessions that the students experienced during Orientation.

Due to the size of each medical school class, the participants are usually put into multiple groups during the *BaFa' BaFa'* training session. There are multiple training sessions of *BaFa' BaFa'*, one for each group. As discussed in chapter 1 and 2, the Liaison Committee on Medical Education (LCME) requires that medical schools display an effort to incorporate cultural competence. Therefore, this medical school strives to do this by incorporating various multicultural education teaching methods. One of these methods includes the *BaFa' BaFa'* exercise. However, the school has also used language training, as well as mentoring.

Data Collection

For this study, three types of data collection methods were used that included a focus group interview with all three participants, one in-depth, semi-structured interview with each participant, and three content analyses with each participant. Two of the content analyses were an email between myself and each participant asking additional questions about the training. The other content analysis was a photo reflection, where I asked the participants to reflect back on pictures that they saw during the training. The interviews took place about seven months after the participants had experienced the *BaFa' BaFa'* training. Interviewing enables the researcher to not only better understand what the participants are saying, but it also allows the researcher to hear their tone and see their facial expressions. Glesne (2011) talked about how interviewing can be looked

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at "as the process of getting words to fly" (p. 102). In qualitative research, researchers attempt to get their participants to express their thoughts as much as possible (Glesne, 2011).

After arranging a date and time that worked best for my participants, I went to the campus to conduct the individual interview with each participant. After conducting the individual interview with each participant, I then conducted the focus group interview with all three participants in the same conference room. Once the focus group interview was completed, I left campus and began the process of transcribing the participant's interviews. After I finished transcribing the interviews, I then read through the participant's comments. Having read through their comments, I conducted my first content analysis be emailing the participants follow-up questions. Once I received the responses from the participants from the first content analysis, I read through the participants comments. I conducted my second content analysis by emailing the participants three different pictures that they saw while performing the BaFa' BaFa' training. I asked the participants several questions regarding these pictures. I then conducted my final content analysis by emailing the participants other follow-up questions. After the participants emailed me their responses from these questions, I read through them and thus completed the data collection portion.

Individual interview. The first type of data collection method was a one-on-one, in-depth, semi-structured interview with each participant. The first interview took place face to face. I coordinated with one of the participants a date and time that worked well for all three. This participant knew the other two participants. I interviewed each participant on the same day and within the same conference room on campus. These

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interviews were my first face to face interactions with each participant. The interview was semi-structured, using an interview guide (Appendix A). While I had an interview guide with a list of questions I planned to ask, I also asked a few questions that were not planned, based on the responses of my participants.

When it comes to interviewing, Glesne (2011) defined *semi-structured* as having "specified questions you know you want to ask" (p. 134). Merriam (2002) stated that with a semi-structured interview, "the largest part…is guided by a list of questions or issues to be explored, and neither the exact wording nor the order of the questions is determined ahead of time" (p. 13). Within the first individual interview, I had questions written out that I asked; however, I was also willing to ask additional questions, based on the responses from my participants. I used several voice recording devices to ensure all data were collected and recorded. One of these devices was an electronic voice recording instrument. The other device was a cellular phone, which contained a voice-recording option within it.

Focus group interview. The second type of data collection method was a focus group interview. According to Yin (2014), "The focus group procedure calls for you to recruit and convene a small group of persons" (p. 112). I wanted to conduct a focus group interview so that all three participants could dialogue back and forth regarding the questions I asked. I wanted to see how the participants discussed their answers with one another. I coordinated with one of the participants for a date and time to interview the group. This one participant coordinated with the other two participants to ensure the date and time worked for their schedule. I had one focus group interview within this study.

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The focus group interview took place on the campus of the university where the participants were enrolled. The focus group interview took place at a convenient location for the group, which was a conference room on campus. I used an interview guide (see Appendix B) for the focus group interview. Voice-recording devices were used to gather the statements from the focus group. One of the devices was an electronic voice recorder. The other device was a cellular phone, which had a voice-recording option within it. I asked the focus group questions regarding their experience with the *BaFa' BaFa'* training, specifically how it impacted their perceptions about those different from themselves.

Content analysis. The third data collection method used was three separate content analyses with each participant. According to Krippendorff (1989), "Formally, content analysis is a research technique for making replicable and valid inferences from data to their context" (p. 403). Krippendorff also stated, "The most obvious sources of data appropriate for content analysis are texts to which meanings are conventionally attributed: verbal discourse, written documents, and visual representations" (p. 404). The first content analysis was follow-up questions (see Appendix C) with each participant that allowed me to ask questions based on the responses from the interviews. Upon completion of the first interview, I transcribed and analyzed the words of my participants (this process will be discussed in the Data Analysis section below). Once I transcribed and analyzed the first interview, I looked for themes and patterns within my participants' words, which allowed me to create questions for the first content analysis. This content analysis was conducted via email. I emailed my questions to each participant and asked

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that they respond. Once I received the responses, I once again analyzed the participants' words.

The second content analysis was a photo recognition exercise (see Appendix D) with each participant. Gotschi, Delve, and Freyer (2009) stated, "Images such as photographs have been used in various ways in research (e.g., for illustration, documentation, or as research tools [methodology])" (p. 291). I felt that it was important to use photo reflection as an alternate content analysis. Dempsey and Tucker (1991) stated that "informants tend to examine images and react to cues present in those images more carefully than would have been expected using written or spoken cues alone" (p. 3). I wanted to give my participants the opportunity to respond to a visual image, as opposed to just a question that I asked as a researcher.

After the completion of the *BaFa' BaFa'* exercise at this institution, the participants were asked to respond to nine different pictures by stating whether the pictures made them feel comfortable or uncomfortable. For the purposes of this study, I picked three of these pictures and placed them together on one page. I chose three pictures, because my goal was to show the participants only a sample of what they actually saw within the training. I was curious to see what they remembered about this portion of the training after only seeing this sample. I emailed this page to my participants. Within the email, I asked each participant several questions based on this page (see Appendix E).

One reason I wanted my participants to email their responses was because I wanted them to have adequate time to reflect upon the pictures. I did not want my participants to say the first thing that came to mind, which often takes place in a face-to-

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face interview. I wanted them to carefully consider their words. Furthermore, McCoyd and Kerson (2006) found that utilizing email as an interviewing method can be beneficial.

Through this type of content analysis, I hoped to better understand what my participants remembered about this portion of the exercise. I also hope it allowed my participants to talk more about any potential biases or stereotypes they might have. I believe that having a photo reflection as a content analysis provided a better understanding of the effect of this multicultural education exercise on medical students.

The third content analysis was additional follow-up questions (see Appendix E) with each participant. The third content analysis was conducted via email. It was structured similarly to the first content analysis. I emailed my questions to each participant and asked that they respond.

Data Analysis

Throughout the data gathering process, I was analyzing the words of my participants by reading their statements. According to Merriam and Simpson (2000), "If research is carefully planned and conducted, an analysis of data will produce descriptions and inferences about the phenomenon being studied" (p. 11). When discussing data analysis, Creswell (2009) stated, "Some qualitative researchers like to think of this as peeling back the layers of an onion" (p. 183). For the purposes of this study, I used a process borrowed from Creswell (2009) to analyze my data. The reason I chose this process is because it outlined seven steps that I thought would be useful for this study. This process includes the following steps.

1. **Gathering raw data (transcripts, etc.).** Within this study, my raw data was gathered through five separate interviews with my participants. These five

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interviews included a focus group interview, a photo interview, and three individual interviews. Upon completion of the interviews, I had five separate transcriptions as my raw data.

2. **Organizing and preparing data for analysis.** The transcriptions were printed out and organized. For the focus group interview, I put the transcriptions on a document, underneath each question that I asked. For the first individual interview, I also took the transcriptions from each participant and placed them underneath each question asked on a separate document. This helped me to read the question asked, then read the responses from my participants.
3. **Reading through all data.** After transcribing the individual and focus group interviews, as well as receiving the content analyses from my participants through email, I read through the data to look for words and ideas that were mentioned multiple times. By finding words and ideas that were stated on multiple occasions, it helped me determine the themes from this study.
4. **Coding the data (hand or computer).** Glesne (2011) stated that coding "is a progressive process of sorting and defining and defining and sorting those scraps of collected data…that are applicable to your research purpose" (p. 194). Glesne (2011) also stated that "with data coded, you read through all the pieces of data coded in the same way and first try to figure out what is at the core of that code" (p. 187). As I read through the transcriptions, I coded my data by hand, primarily looking for key words and phrases that linked to each other and furthermore, that helped answer my research questions.

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5. **Looking for themes and/or descriptions.** Once I coded my data by finding key words and phrases, I looked for themes from my interviews by using thematic analysis (Glesne, 2011). "In thematic analysis, the research focuses analytical techniques on searching through the data for themes and patterns" (Glesne, 2011, p. 187).
6. **Interrelating themes/description (e.g., case study).** As themes were found, I began to connect them with one another.
7. **Interpreting the meaning of themes/descriptions (Creswell, 2009, p. 185).** Once all interviews were reviewed and the data had been analyzed, I presented my findings. I used a more traditional representation model to present my findings, as opposed to creative analytic practice (CAP). The primary reason I used a traditional model to present my findings was that I felt more comfortable structuring my findings using such a model. I divided chapter four into themes, which were based on the comments from my participants.

Triangulation

According to Roberts (2010), "Validity is the degree to which your instrument truly measures what it purports to measure" (p. 151). After conducting a focus group interview, one individual interview and three content analyses, I believe I garnered a better understanding of the effect of multicultural education on current medical school students' cultural competencies. By using these three data collection methods, I achieved triangulation, which mad this study more valid. According to Roberts, "Reliability is the degree to which your instrument consistently measures something from one time to

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another" (p. 151). By conducting a focus group interview, one individual interview, and three content analyses, it allowed me to gather a plethora amount of information.

Pilot Study

As a part of my Policy-Oriented Research class, I performed a small research project specifically on the *BaFa' BaFa'* training at the same education institution. I interviewed three, fourth-year medical students about their experiences with the *BaFa' BaFa'* training. A face-to-face, structured interview was used to gather the data. Once the data was gathered, it was analyzed. The data revealed that the *BaFa' BaFa'* training had some impact on the participant's views of multiculturalism. The recommendations from this study included the following: consider incorporating the *BaFa' BaFa'* training into the medical school curriculum, incorporate more training exercises, similar to *BaFa' BaFa,'* into the medical school curriculum, and attempt to incorporate active experimentation (part of Kolb's theory of experiential learning) into more didactic sessions in the medical school curriculum.

Subjectivity Statement

As discussed in the introduction of chapter 1, I have recently become interested in multiculturalism. It fascinates me that there are so many different types of people in the world. There are many different languages, cultures, and traditions represented within humanity. What is interesting to me is that while everyone is different in their own way, we can still work together to accomplish many things. We all have different talents and backgrounds that can be used as pieces to a larger puzzle. Personally, I am glad that these differences exist. I think the world is much more exciting because of the unique characteristics that are rampant around the globe. My hope is that others see the

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importance of multiculturalism as well. I would like everyone to see the benefits that multiculturalism can bring. In my opinion, one of the main benefits of multiculturalism is the possibility to learn more. I believe that we can learn more by being around different types of people, as opposed to always being around those who have the same interests and ideas as ourselves. With this particular study, I hoped to find that medical school students value multiculturalism as well. I also hoped to find that when medical school students were exposed to multicultural education they were able to respect their fellow classmates even more. Because of these desires, I was careful when interviewing my participants. I did not want my desires to influence the results of the study. I understood that what I found might be different from my desires; such as that current medical school students do not value multiculturalism as I do. Within my findings, I did my best to present the themes objectively and without bias. I wanted to present the data as it was and not as what I wanted it to be.

I worked at the institution I am studying from July, 2008 to May, 2013. During this time, I developed many relationships with faculty, staff, and students. I developed a deep affinity for this institution, as it helped me develop as a young professional. Due to my affinity for this institution, I have a desire for it to do well in many ways. By conducting this research study, I was aware that I could find negatives within the experiences of my participants. Some of my participants could have negative thoughts or feelings toward this training exercise or toward certain individuals on campus. I was prepared to listen and show respect toward all comments I heard. I assumed that my participants answered all questions honestly, to the best of their ability. I assumed no participant shared fictional information. I did my best to not let my affinity for the

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institution and its training program affect how I displayed the results. My goal with this study was to remain as unbiased as possible.

Chapter Summary

This chapter discussed the methodology with this study. This chapter began by reiterating the purpose of the study, as well as the research questions. I then discussed the rationale for qualitative research design, including the epistemology, theoretical framework, methodology, participant selection, study context/setting, data collection, data analysis of the study, trustworthiness, and the subjectivity statement. I will now discuss my findings in chapter 4.

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Chapter 4

Findings

This chapter discusses the findings of this study. The findings of this study come directly from the statements of the participants. I will begin the chapter with an introduction of each participant and discuss any prior experience with multicultural training they might have had, as well as their preferred learning style. I will then present themes that were found based on the comments of my participants.

John: The active learner with some prior multicultural education training

John is a first-year medical student who attended college at a public university within the same state as the medical school campus. He was very personable and easy to talk with. He had experienced very little multicultural education prior to medical school. The only multicultural training John had experienced was during orientation for his graduate program, which took place prior to medical school. As John stated, this type of training "was more of like a lecture format." When defining cultural competency, John stated:

> Have a rough understanding I guess, you know, why they do some of the things they do and through understanding that be more accepting of, in a way that doesn't offend anyone or belittle anyone or stop them from having an opportunity.

When asked before experiencing the *BaFa' BaFa'* training, how much did he consider multicultural issues, such as diversity, stereotypes, and biases, John stated that within his degree program prior to medical school, there were other ethnicities

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represented and that he "thought about them a lot cause I had to interact with them." John went on to state:

> I guess the summer leading up to medical school, I didn't really consider the diversity that my class would have. But the reason for it, was that I know they only accept people from [a certain state]. And, so, I figured the majority would be either like Caucasian or African American [state the medical school is located in], from roughly the same background. I was pretty much right, accept for, there is obviously probably 30 outliers there.

In terms of his learning style, John prefers active learning. John stated, "I think I definitely learn best through auditory, active learning." He went on to state, "If I have to learn something about Gross Anatomy, I definitely will draw it out and write it out. I take notes when I read, like I have to be doing something that will commit it to long-term memory." When asked his least favorite method of learning, John commented, "Looking at tables and charts and just being like exposed to it." John later stated, "Sitting in a room and having a professor read straight from the powerpoint, looking at the powerpoint, I mean I don't think I have ADHD, but I can't, I mean I have about fifteen minutes and then I'm zoned out."

Anna: The kinesthetic learner with extensive prior multicultural training

Anna is a first year medical student who attended college at a private college within the same state as the medical school campus. Like John, she was very personal and a great communicator. She lived in Wisconsin and New York prior to enrolling in medical school. Anna also experienced a significant amount of multicultural training prior to beginning medical school. Anna lived in Honduras for a year before starting

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medical school. Anna commented, " Prior to doing that [living in Honduras] we did a bunch of diversity training and yeah, it was a really cool experience, so I was really excited when I found out we were doing this…program [*BaFa' BaFa'* training]." Anna defined cultural competency by stating, "I think that has to do with being able to understand and respect, or at least more so respect maybe so than understand another culture that is different from your own." When asked how much she considered multicultural issues prior to the *BaFa' BaFa'* experience, Anna stated, "…now that I spent time in Honduras, I'm very aware of like all the immigration issues, that you know, particularly in the past year that have been all over the news and so I've been following that pretty closely."

In terms of her learning style, Anna said that she is "very much like a kinesthetic learner." She explained by saying, "I like to go and have something to look at and kind of be able to…like a model or something, like that if I'm particularly in Gross Anatomy lab going in and looking at the body was so helpful for me." Anna finished her comments on her preferred learning style by stating, " And so, I think at least for me the best way is a combination of several different things. I don't learn very well just by listening."

Kimberly: The visual learner with no prior multicultural training

Kimberly is a first year medical student who attended a private college in the same state as the medical school campus is located. She was also very personable and wiling to answer any question asked during all the interviews. Kimberly had no experience with multicultural education prior to medical school. She mentioned that the college she attended was not very diverse. When defining cultural competency,

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Kimberly stated, "I would think that, I mean, you're very aware of other cultures, you're not closed minded and very open,…you may not agree with everything in other cultures but you still have an understanding and are acceptable of them." One common word that was used amongst all three participants when defining cultural competency was "understanding." This relates to what Betancourt et al. (2003) stated when defining cultural competence: "Cultural competence" in health care entails: understanding the importance of social and cultural influences on patients' health beliefs and behaviors…" (p. 297).

When asked how much she considered multicultural issues prior to experiencing the *BaFa' BaFa'* training, Kimberly stated the following:

> Rarely, to never maybe. I mean, stereotypes maybe some, because I think in every culture no matter what you always have stereotypes but as far as like multicultural stuff, not really that often. I think even since I've been here though, I mean I've realized there's more cultures than what I thought there would be, you know; different religions, stuff like that, so I mean we have different religions in our class too, so that's been interesting.

When it comes to Kimberly's learning style, she prefers to learn by watching. Kimberly stated the following when asked about her preferred learning style:

> I'm a visual learner to start off with. And by like writing, highlighting, underlining, stuff like that. I mean I sit in class and I listen and pay attention but I don't get as much out of it as if I were to sit there and like actively go over stuff myself. I'll just write stuff like over and over and over again until I learn it.

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Below is a chart that lists each participant, the amount of multicultural education they had experienced prior to the *BaFa' BaFa'* training, and their preferred learning method.

Table 1

Participant Information

Participant	Experience with Multicultural Education	Preferred Learning Method
John	Some training	Active Learner
Anna	Extensive training	Kinesthetic Learner
Kimberly	No training	Visual Learner

As shown in Table 1, all three participants had varied amounts of prior experience with multicultural education. Anna had extensive training by working in another country. John had some training within an orientation session, while Kimberly had no previous training. Also, all three participants had a different preferred learning method. Anna labeled herself as a kinesthetic learner. John enjoyed active learning, while Kimberly preferred learning visually. Because of the different amounts of prior experience with multicultural education, as well as the different learning styles within my participants, it allowed me to have a diverse participant group.

Introduction to Themes

Several themes emerged based on the comments from my participants. Once I conducted the first round of individual interviews and focus group interview, I

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transcribed the words from my participants, looking for themes. As themes were discovered, my second and third individual interview questions were based from the themes that were discovered from my initial interviews. Five themes were found from my participant's interviews. These themes are:

1. Uncomfortable feeling or awkwardness
2. Differing opinions regarding effectiveness
3. Little opportunity to use anything due to schedule
4. Different opinions on timing
5. Role of experiential learning

Theme 1: Uncomfortable Feeling or Awkwardness

The first theme was an uncomfortable feeling or awkwardness while experiencing the *BaFa' BaFa'* training. This theme became very apparent during the first individual interview, as well as the focus group interview. All three of my participants commented on how uncomfortable the training made them feel. I would first like to begin with John's comments regarding this theme in his first individual interview. Below are John's comments regarding his feelings during the training:

> I guess it [the game] made me feel a little bit uneasy going into a room not understanding at all what was going on. And I guess maybe that feeling of uneasiness was supposed to teach us what it would be like coming in as a minority, when the majority of the people are from similar backgrounds, so it was maybe supposed to give us a sense of what someone who had lived in [certain state] two years and just started medical school and like we have a guy that was

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raised in Jordan, few that were raised in Palestine, and so I guess like maybe give an idea of what they could be experiencing.

John further explained this idea in a later question, by stating:

> I just felt really, like dumb, like really silly and out of place, while I was doing the game. But I mean I remember what it was like feeling that and so, I guess maybe that's what some people feel coming into a new, or an area, or a culture that's completely different than what they're raised in. But I don't even think that's probably the feeling they experience. I mean, I don't think they walk around feeling just like completely inadequate and dumb. I think there's like a definite language barrier, they don't understand stuff, but I'm not sure it is an accurate representation of what their probably actually experiencing.

In the first follow-up interview, one question that was asked was what are the positives or negatives of feeling awkward while doing this training? John stated, "A positive impact from the awkwardness is that it makes the game more realistic, since that is likely how people immersed in a different culture feel. A drawback from the awkwardness is that it likely decreases participation." When asked what he thought the main goal of the training was, John said, "I believe the game aims to create an unfamiliar environment for participants, which provides them with a new perspective and a better understanding of what people from different cultures experience. The game was effective in accomplishing this goal."

Anna also had several comments regarding this uncomfortable feeling while experiencing the training. Anna labeled it a "terrifying situation," and she went on to state the following:

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> You know, it's supposed to make you uncomfortable and so you realize that not everywhere is like where you're from. So, yeah, I thought it was a really cool experience and it was interesting too, because it was uncomfortable even for the people in the same you know, Group A versus Group B, like, even before we switched, it was uncomfortable.

Anna followed up on this statement by saying, "But then once you get going, once you understand the customs and everything, it becomes very comforting to have other people who are doing the same thing as you are…"

Anna had several positive comments regarding the uncomfortable feeling of the *BaFa' BaFa'* training. She first talked about the idea of how doing the exercise as a group helped with the awkwardness. She stated, "So, we're in those small groups and we had to go in and talk to people and it was awkward and funny, and so you're just like, 'alright, let's be awkward and funny together. Let's be friends; who are you,' you know." When asked what were the positives or negatives of feeling awkward while doing the training, Anna stated:

> I think it's really important to learn how you handle awkwardness. You will always encounter moments of awkwardness, so it's a good idea to know how to deal with it. By stepping into this scenario that we knew would be a little uncomfortable, we could evaluate how we acted.

Kimberly also shared her thoughts about the positives and negatives of the uncomfortable feeling while experiencing the training. Kimberly said:

> Since during the training most people felt awkward and none of us really knew each other, the awkwardness could help to serve as an icebreaker. However, I do

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> think the awkwardness could lead to decreasing the overall effectiveness of the training because people were so focused on their feelings of awkwardness and not on the intended purpose and overall outcome of the training. I think the training would be much more effective if implemented sometime other than orientation.

There was also a discussion regarding this subject within the focus group interview. In the focus group interview, John stated, "…I didn't know anybody in there, and I just felt so, like, I don't feel awkward a lot and I felt really awkward. I was like 'I feel really silly right now.'" After this statement, Anna stated:

> …Something I found was being in the group where we were all doing the same thing, it was sort of like comfort in numbers and we're all being ridiculous, but in the same way together and it felt more awkward going into the other room.

John followed this statement, by saying, "It did, and I mean that was definitely the point, to see how different cultures would potentially feel being thrown into a situation where they, you know, had not experienced a lot of the things that were going on." Lastly, when the group was asked about their discussions with their fellow classmates following the *BaFa' BaFa'* training, Kimberly stated, "I think we talked about how, kind of, strange and different it was and how awkward we felt."

Theme 2: Differing Opinions Regarding Effectiveness

The second theme was that there were differing opinions regarding the effectiveness of the *BaFa' BaFa'* training. This theme emerged during my first round of individual interviews with each participant. It became evident that two of the participants, John and Kimberly, felt that the training was not as effective. However,

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Anna felt the training was more effective. I would like to begin with John's thoughts regarding the effectiveness of the training.

When asked how the *BaFa' FaFa'* training impacted his cultural competency, John stated, "not much at all, if any," and finished his comments by saying, "I don't really think I got a lot from it." When asked how the training impacted his views about multicultural issues, he stated, "I didn't really have any of my views impacted by the game." John contributed his interactions with his fellow classmates over the course of the year as being more effective than the actual *BaFa' BaFa'* training. When asked about how much more or less he considered multicultural issues after experiencing the training, John said, "I don't think the game made me consider much more, not nearly as much as having to interact with others."

I also asked John whether he has implemented what he learned in the training toward his fellow classmates. John stated the following:

> Not really. Because it seemed that whole game was based on like, language barriers. Because you're going into a room and everyone's doing this thing and speaking words that you have no idea what they mean and that's not at all like what we're really experiencing.

John also said, "I don't know if I've actually implemented anything from the game because it's not really a language barrier."

However, John did comment that the game was not totally ineffective. I asked John what he thought the main goal of the *BaFa' BaFa'* training was, as well as how effective it was at meeting its goal. John stated, "I believe the game aims to create an unfamiliar environment for participants, which provides them with a new perspective and

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a better understanding of what people from different cultures experience. The game was effective in accomplishing this goal."

Kimberly had similar feelings as John, regarding the effectiveness of the *BaFa' BaFa'* training. When asked how the training impacted her cultural competency, Kimberly began by stating, "I would say not, just because I think we had a lot crammed into Orientation in those five days. It's overwhelming. It's your first time. You don't know anybody." Kimberly later stated:

> So, I think that's part of it, you're just kind of exhausted, you're tired, you're trying to learn everything, you're in a new place, new people. I mean, I think it was helpful to somewhat get an understanding of how you should interact and how difficult it can be to interact with people from different cultures and stuff like that, especially if you don't know the language or something like that, because that was part of the game. But overall, I don't think it really changed my view of it too much.

I also asked Kimberly how the training impacted her views about multicultural issues, such as stereotypes, biases, or becoming culturally competent. She said, "I try to be a pretty much open-minded person in general. But, I don't think it really changed too much about stereotypes or anything like that." Kimberly also had similar opinions to John, in that she felt that her interactions with other people have had more of an effect than the training. When asked how much more or less she considers multicultural issues after experiencing the training, Kimberly said:

> I don't think it changed how I think about it. I think just like interacting with other people, kind of makes me think about it more, not necessarily like the

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> training itself made me stop and think about it. But more in day to day as I come across, you know, meeting people and stuff like that.

After this statement, I then asked Kimberly a follow-up question. The question I asked was whether these interactions with other people ever take her back to the training at all? Kimberly stated, "Not really. If I'm being honest, I probably haven't thought about it since." When asked whether she had implemented anything she learned from the training toward her fellow classmates, Kimberly responded, "Not really, I don't think. No."

Kimberly felt that the purpose of the training was to help when being around individuals from cultures different from her own. I asked Kimberly what she thought the main goal of the training was and how effective it was at meeting its goal. Kimberly stated:

> I believe the *BaFa' BaFa'* training's goal was to prepare us for possible situations we could face one day in interacting with people of other cultures. It gave us a chance to see what it is like to be thrown into a completely different culture and for people of another culture to interact within your culture. The training was meant to give us an understanding of how people of different cultures might feel when they speak a different language…and to build empathy and compassion towards those people.

While John and Kimberly had similar opinions of the effectiveness of the *BaFa' BaFa'* training, Anna's opinions were much different. Anna felt like the training did impact her cultural competency. Anna stated:

> …Yeah, I mean…, it kind of puts you in a position of, ok, I'm in this situation where I don't really know what the rules and customs are and I'm like on the

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> verge of insulting everyone around me at all times and so it's a terrifying situation, and I think a lot of people had not been in that situation before.

Anna went on to say that she "thought it was a really cool experience." When asked how her feelings about the training changed after experiencing it compared to when she first heard about it, Anna stated, "I saw that it was diversity training, and I was excited about it. I thought it would be cool." She ended her comments from this question by stating, "And then once I did it, I thought it was really fun, so you know, I would've loved to have, you know, be in a position where I could either do it again or help facilitate it happening for other people. I thought it was great."

I asked Anna if after experiencing the training, how much more or less she considers multicultural issues. Anna responded:

> I think, probably the same. But I think it was a good reminder of having to, you know, being in that situation. I think it's very easy to, you know, to have an uncomfortable experience, then you just forget about it, you know. And so, kind of being put back into that was a really good reminder.

Anna had similar comments when asked how her perceptions about those who are different from herself changed or stayed the same after completing the training. Anna said:

> I think again, maybe more so, just enhanced what my opinions are already were, I suppose. I definitely think it did have an impact, but I don't know that it completely changed my mind about something, you know. I think I went in there already with an idea of what my thoughts were and it was just sort of reaffirming those.

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Anna also felt that she had implemented what she learned in the training toward her fellow classmates. Anna said:

> I think so, you know, there's a huge diversity of you know particularly religion and political basis in our class and so that's been, you know, kind of talking to people about different issues. I'm part of the Students and Physicians for Social Responsibility, and so we deal with a lot of political things, and things can get kind of heated, and so it's kind of a good reminder of like, ok, you need to step back and not try to like tell people that you know their…I don't know where anyone else is coming from, basically. Like, I can never assume what someone else's story is and background is, and so I have to, you know, tread lightly, so as not to, you know, make someone else's point feel invalid.

When I conducted the focus group interview, it was interesting to see the participants discuss the training as a group. Below is an excerpt from the focus group interview. The first question I asked was regarding their initial thoughts after experiencing the *BaFa' BaFa'* training:

> **Kimberly:** It was a waste of time.
>
> **John:** I mean, I still remember how like awkward I felt doing it. I felt very silly right now, but then, cause you know, we had to go look at the pictures to, right, cause it was definitely a lecture component to it. And then, I don't really remember, I guess, that was one of the first times too that like we had all been around each other.
>
> **Kimberly:** So if I would have known everybody.

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John: So I was probably, I'm just thinking about like, ok, like how am I going to apply this, like looking around meeting a lot of people for the first time that were in my class.

Anna: I loved it; I got done with it and was really excited.

The participants then transitioned into discussing another part of the training, which was a video, called a Ted Talk. It was shown after the completion of the experiential learning portion of the training. Below are their comments:

Anna: Then, didn't we go and watch a video right, and I thought the video was so great.

John: The video was great. The video was good. I forgot about the video

Kimberly: Yeah, the video was really good.

Anna: Do you know what the video was? (asking me)

John: I completely forgot about the video.

Anna: It was a Ted Talk about a single story and so it was this woman from Nigeria, I believe, and she was talking about, like how she grew up reading all of these books from the United States and so she sort of in her mind all books were about, like white children who drank ginger beer, and who were British, and she was like, 'I don't even know what ginger beer is, but it was important and that was in the story.' And, you know, and how she had a single story and regards to you know, England, basically. And then when she moved to the United States to go to college, her roommate was shocked that she spoke English and it's, you know, the language of her country, you know, so it just sort of talking about, you know, preconceived notions and things like that. It was a great video.

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John: I forgot, Ted Talks are awesome. I'm a huge fan of those, I forgot.

Anna: So good.

John: That part was really good.

Kimberly: I felt like the video was more beneficial than the actual game. If we had known everybody at that time, it may have been a little more beneficial or not quite as awkward.

As stated in this excerpt, all three participants felt that the video portion of the training was effective.

Another portion of the training that each participant experienced was a photograph session within the presentation. This consisted of several photographs of different people. For example, one of the pictures included a man and woman who were of different ethnicities who appeared to be on a date. Another picture included what appeared to be a family in a home. In this picture, there appeared to be different ethnicities represented. Within the *BaFa' BaFa'* training, the students were polled and asked if each picture made them feel comfortable or uncomfortable. I was interested in finding out how beneficial this part of the training was. Therefore, I conducted a photo recognition interview where I showed all my participants a sample of the pictures they saw during the training. I then asked them questions regarding this part of the training. I found that the opinions were mixed about the impact of this part of the training. Anna and Kimberly felt that this aspect of the training was somewhat beneficial, while John did not think this part of the training was as beneficial. I asked all three participants whether this part of the training was beneficial. Below are their responses:

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John: The Ted Talk following these pictures was the most beneficial part of the training, but I cannot recall what purpose the photos served.

Kimberly: I do think this part of the training was beneficial to gain an understanding of how diverse our medical school class as a whole is. Within the class there are various religions and cultures and therefore it was interesting to see how some of the polls may have been represented different than you may have expected. This helped to demonstrate that not only will we deal with different cultures in the patients we see but also working with our colleagues.

Anna: I think it was, in that it made you try to really understand what was happening in the pictures before making a snap judgment.

I also asked each participant if viewing the photos was more or less beneficial compared to the active learning aspect of the training. John stated, "The active learning was more beneficial, because I remember how taking part in the game made me feel. The photos were presented as passive learning during a time when we were receiving a lot of new information." Kimberly had a different viewpoint. Kimberly stated, "I think this part of the training was more beneficial than the active learning because you were still engaged in the activity but did not have the feeling of awkwardness that came with the active learning game. Anna felt that both aspects worked to complement one another. Anna said:

I think they worked well alongside each other. There's a huge difference in something you observe and something you experience personally. Observation in a way is both easier and harder. It's easier because you can remove yourself from the situation, take time to process it, and then try to make an informed judgment

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about what's going on. On the other hand, when you're not personally involved, it's easier to judge immediately without fully considering all the options, because it doesn't really affect you.

Theme 3: Little Opportunity to Use Anything Due to Schedule

The third theme that emerged from my interviews was that there was little opportunity to use anything the participants might have learned from the *BaFa' BaFa'* training. As discussed in chapter 2, medical students are busy. Their first two years are primarily spent in the classroom, learning basic science information that will serve them well when they begin to treat patients. At some point during the initial individual interview, all three participants mentioned how their busy schedules of being a medical student did not present many opportunities to use anything from the training.

John reflected on his schedule following the training when I asked him how much more or less did he consider multicultural issues after the training. John stated:

> But it is tough to say, because right after the training, we started having class and I was with everyone all of the time. I definitely started to consider it more after being in medical school. They kept us so busy last semester with school…

John later commented, "But, I think everyone recognizes, like we have a lot of fun here and stuff but our job is to learn, to you know, save people. So everyone really focuses on school and that kind of brings everyone together."

In one of my follow up interviews, I sought to find out more information regarding the idea of the busyness of medical students and how that might affect educational opportunities that are not medical related. I asked John what impact his

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schedule had on being able to think about and to apply non-medical subject matter that he has learned. John stated:

> I have found that our schedule only allows for incorporation of non-medical subject matter through interaction with our peers. Personally, I have not reflected on the game since completing orientation and am not sure if I have used the experience to shape any of my interactions with others. This is largely due to having minimal interactions with other as a result of educational responsibilities.

Anna also commented on this subject. When asked in what ways she has used what she learned from the training, Anna said:

> I don't know. I guess not as much. I don't want to say I haven't, because I feel like that's not, I don't know. I've been so wrapped up in my cocoon of medical school, like, you know, all the people I see, all the people I talk to are all doing the same thing as me. So, it hasn't been something that I've necessarily had to use, unfortunately.

I also asked Anna what impact her schedule has on being able to think about and apply non-medical subject matter that she has learned. Anna stated:

> I think what's at the forefront of most medical students' minds is the studying they have to do, are they prepared, what's the schedule for today, etc. That being said, I don't think the information we learn that isn't necessarily medically related goes away. It's there and can be brought up in the right situation. For example, we've had the opportunity to visit a few patients under the guide of internal medicine residents. Every visit I've had, I've been thinking about the medically

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relevant information, but also how to appropriately treat the patient so that they feel comfortable, which I think is a large part of the *BaFa' BaFa'* training.

Kimberly felt like the rigor of medical school was a reason for not being able to use anything she might have learned from the training. Kimberly commented, "I don't really think I've used any of it yet, but we haven't really had the opportunity yet, because we've been more in the classroom." When asked about the impact on a medical student's schedule, Kimberly responded:

> A medical student's schedule is definitely all consuming. We rarely have time to focus on non-school related things, especially during exam times and such. I definitely think our schedule decreases the amount of time we are able to think about non-medical subject matter, but I do not believe it impacts our ability to apply non-medical subject matters. From a first year medical student's perspective though, I do not think the training has been applicable to us thus far.

Theme 4: Different Opinions on Timing

The fourth theme emerged from both the individual interviews and the focus group interview. The fourth theme was that there were different opinions regarding the timing of the training. Two of the participants felt that if the training was going to be used, it would be most beneficial to keep it at the beginning of the first year of medical school. However, one of the participants felt that the training would be more beneficial if moved to the beginning of the third year of medical school. I would first like to begin with excerpts from the focus group interview.

I asked my participants what their thoughts were about the timing of the exercise. Below are their comments:

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Kimberly: I think it could be more beneficial, maybe if you did it before third year when you're actually interacting with more cultures in the hospital and stuff like that.

Anna: I think that's a really good point. I actually agree with that.

John: Definitely not in the middle though of like first year, we have a lot going on.

Anna: It really helped like, for me, in terms of not knowing people it helped me meet people, because like we're all being so awkward…

John: [It] helped us meet each other.

Anna: So in that respect, but I completely agree with you that I think that's something that we need to be reminded of when we start getting into the hospital.

John: Maybe a video and introduction to it, then, like a more active learning I guess third year.

This same topic was discussed in further detail when I asked the group what other ways could training exercises that addressed multicultural issues be implemented into the medical school curriculum. Below is a portion of their comments:

Anna: So, the lecture that I just went to was for Psychiatry and it was on interviewing, like interviewing skills, and I think in kind of that aspect of when you're interacting with, like, not only practicing doing interviews but practicing doing interviews maybe with someone who doesn't speak the same language as you or like trying to figure out how to maneuver cultural barriers and things like that, so a little more hands on, practical approach to talking to people who may have different cultural views.

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Kimberly: I think that would be a good integration like second year, getting ready for the third year.

John: You could almost lump it in with something like Population Health, maybe. But, you could do; we have several like basically online courses that are very short, and I wouldn't mind; I say this now, but like, cause it would be tough to integrate anything else in with as busy as we are. But, you know, maybe like, if you gave someone like a short assignment over one of the breaks or maybe even the summer, like, cause I mean, people have plans but we're not going to be in class…

In one of my follow-up interviews, I asked each participant if they were allowed to pick the timing of when the training took place during medical school, where would they position the training, if they would use the training at all? John stated:

The only time the training would have any impact is before we start our first year. If the game is moved to a later time, everyone has already become too comfortable with each other for an unfamiliar environment to be created. However, another method of training used before we begin our third year would be most beneficial, because it would allow us to immediately employ our training.

However, when it comes to deciding on whether to implement the training or not, John said he would not use it. John commented, "However, the game would not be included, because I do not think it will make an impact in the first two years of school."

Anna felt that the training was best positioned at the beginning of the first year. Anna stated:

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> I actually really liked the training at the beginning. I feel like it helped me drop my guard a bit around my fellow classmates. I also believe it wouldn't be as effective if we all knew each other. I don't think we would have the same experience.

Kimberly not only felt that the training would be more effective at a different time during medical school, but questioned whether the training should be used at all. Kimberly said:

> I would position the training before the start of the third year of medical school. I believe this is an important time to understand and have an appreciation for different cultures and backgrounds. During the first two years of medical school we are in the classroom the majority of the time. However, when we start to see patients third year we need to have a deep understanding of the best way to interact with our patients and probably have forgotten most aspects of the training by this point. I do believe cultural and social acceptance is critical but I do not think the BaFa' BaFa' training is the most effective tool. Therefore, if it were possible I would more than likely eliminate the training from the medical school curriculum.

Theme 5: Role of Experiential Learning

The fifth theme concerns the experiential learning aspect of the *BaFa' BaFa'* training. There was a common theme throughout the interviews that the experiential learning aspect of the training made an impact. As mentioned in chapter 2, the *BaFa' BaFa'* training is centered on an activity where the participants must interact with one another. This part of the training forces them to try and learn by doing, as opposed to just

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watching and listening. It allows the participants to have an active part in the learning process.

I would like to discuss what they said about active learning within the *BaFa' BaFa'* training. When I asked John how he felt that actively participating in the training impacted his learning, John stated, "I think having actually actively done the game makes me remember it. I mean, when I look back on Orientation, I can remember that far better than I can…I don't even know what else we did." John finished his comments by stating, "So definitely, I mean it stands out to me because, I mean, it was something we actually had to actively participate in." While John thought the active learning aspect was important to help remember the training, he questioned whether teaching multicultural education would make a significant impact. John said:

> If you were going to teach it without actually playing the game and doing some active learning, not nearly as many people are going to pay attention, but I'm not sure they're going to be missing that much. Those people aren't going to go in and be, just like, you know, really racist or culturally offensive or something like that. In my class, I mean, that I've experienced, I can't think of anyone that would be dumb enough to do that or be that close-minded…

Anna felt that the active learning aspect helped her to get involved in the training, as well as meet other people. Anna stated:

> …If you're not actively participating, then it's easy to not participate, you know. So, you know, for me personal, like if no one else is going to step up and participate, I will. But, if other people are happy to do it, I'm going to; I'll let them do it, you know. Sometimes I can get into situations where I'm like, alright

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their doing great, I'm going to sit back and watch. I don't necessarily. Even though maybe I'd like to don't get involved, you know, I can rise to the occasion, if necessary. But, I think that active learning, it makes people who maybe ordinarily wouldn't get up and do anything; it makes them do it. And also, like, not even in regards to learning, I met people that day, you know…So, it was even more so than just getting involved; it kind of helped you interact with people.

Anna also thought the active learning aspect of the training was important to learning cultural competency. Anna commented:

…You can talk about being culturally competent or you know, these situations as much as you want, but if you don't actually experience them…it's not going to have the same effect. I don't think, you know. Because everybody can think, oh, you know, and I'm guilty of this myself, like, oh, put in this situation, I would act this way, but probably if you haven't experienced it before, you wouldn't act that way. You know, it's like the, I don't know, I feel like people talk about this a lot with, in terms of World War II. Like, I would have stood up against the internment of the Jews, but would you, would you really, you know. In terms of just going with the flow and I feel like if you don't really have that experience, you wouldn't know how to act, so I think that it's, I mean, I feel like it wouldn't have nearly the same effect without the interactive part.

Kimberly felt that active learning helped her focus better. Kimberly stated:

I think it is more beneficial for you to like be involved in that part of it cause I know it's easy to just zone out when you're sitting there listening to somebody

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talking and you had to be actively engaged in it, so I think it was more beneficial than just sitting there having a lecture on it, for sure.

When asked how the training would be different if it were taught using non-participatory techniques, Kimberly said:

I don't think it would have been as beneficial, cause I think in the setting of Orientation too, when we're learning so much and we've been just sitting and listening to people talk, nobody's really going to pay that much attention.

The topic of active learning and its role in the *BaFa' BaFa'* training was addressed again in the focus group interview. I asked them how they felt when they heard that they were going to have to interact with their classmates during the training. Below is our dialogue:

Kimberly: I thought it was going to be a nice break from just like sitting and listening to people talk all day.

John: I actually liked meeting people…

Anna: It was a little nerve racking, just like, you know, this is kind of the first interaction that we've had with a lot of these people and this is the interaction that we're doing, so.

Question from me: Do you think it would make a difference if you knew each other later on when you know each other; do you think that would make a difference because you are familiar with each other?

John: I think it could go two ways. Either, you know, you could focus more on actually cultural learning instead of, you know, in your mind, like what are all these people going to think of me when I'm, you know, acting this way around

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them and playing this game but then, you know, once you do it with a bunch of your friends, I mean how seriously can you take the game?

Anna: You know… we were in a group of people we didn't really know. Like, we were in a weird cultural experience you know, so I feel like it almost takes away from it, knowing each other. I think it would be a lot of fun, you know, like with everybody that we're friendly with.

I later asked them how did they think that having more multicultural education opportunities in medical school that were taught using participatory teaching techniques, such as role-playing, would impact their medical education. Their dialogue is below:

Kimberly: I think active learning's very beneficial, cause like I said earlier, like you can sit in a lecture and zone out and not really hear anything their saying, but when you're actively involved in it, you're more likely to remember and get stuff out of it.

Anna: I agree with that.

John: It's more similar to what it will be like when we have patients.

Anna: And you can, like imagine all you want you know, and get in there and I'm going to know exactly what to say.

Kimberly: It's much more effective when you have active learning.

I then asked them if they thought the active learning aspect would help prepare them when they interacted with patients, and all three participants agreed that it would.

Conclusions from Themes

I would now like to discuss some conclusions from the themes. Of these five themes, there was agreement from each participant regarding three of the themes. Each

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participant felt that there was an uncomfortable feeling while experiencing the training, that there was little opportunity to use anything they might have learned from the training, and that experiential learning had some impact within the training. By far, the two themes where the participants agreed the most were the uncomfortable feeling experienced during the training, as well as the fact that experiential learning had some impact within the training.

However, within two of the themes, there was an obvious mixture of feelings. There were differing opinions regarding both the overall effectiveness of the *BaFa' BaFa'* training and the timing of the training. Below is a table showing what themes were agreed upon and what themes were not agreed upon.

Table 2

Themes

Participant	Theme 1	Theme 2	Theme 3	Theme 4	Theme 5
John	Yes	No	Yes	Yes	Yes
Anna	Yes	Yes	Yes	Yes	Yes
Kimberly	Yes	No	Yes	No	Yes

As shown in the table above, my participants had similar feelings on three of the five themes. John, Anna, and Kimberly felt that there was an awkward or uncomfortable feeling while experiencing the training, that there has been little opportunity to use anything from the training, and that the role of experience learning was impactful within

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the training. However, it was found that there was disagreement among my participants within two of the themes. There were differing opinions regarding the overall effectiveness of the training. Anna felt that the training was overall effective, while John and Kimberly did not. There was also disagreement regarding the appropriate timing of the training. John and Anna felt that the current timing of the training was appropriate, while Kimberly felt that the time of the training should be moved to the beginning of the third year of medical school.

Answers to Research Questions

There were two research questions that helped guide this study. The two research questions were:

1. How does *BaFa' BaFa'* impact cultural competency on current medical students at a southeastern health science center?

2. How does the experiential learning aspect of *BaFa' BaFa'* impact current medical students?

I would first like to discuss my answer to the first research question. Based on the comments from my participants, the *BaFa' BaFa'* training had little impact on their cultural competency. I believe there was some impact; however, it was not substantial. However, one thing to keep in mind is that these students have not had as many opportunities to use anything they may have learned from the training. The opportunities will increase as they begin interacting with patients in their third year of medical school. If a study were administered with these participants after their third year of medical school, the results may be different. Also, we must keep in mind that this is a small sample of the overall class. Results may vary if a higher percentage of students were

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interviewed. Also, results may vary strictly based on if different participants were interviewed.

Regarding the second research question, the experiential learning aspect of the *BaFa' BaFa'* training had a substantial impact on my participants. One participant mentioned that this aspect of the training helped it become more memorable. Another participant discussed how this aspect helped her stay focused compared to if it were strictly taught with a lecture. Finally, another participant stated that this aspect of the training helped her meet other classmates. Due to these multiple examples, I conclude that the experiential learning aspect of the BaFa' BaFa' training is crucial to its mission of teaching others about diversity. While the curriculum of the training may be adjusted, one thing that must not be removed within the training is the experiential learning aspect.

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Chapter 5

Discussion

In chapter 1, I introduced the study by stating the purpose of the study, as well as research questions. Chapter 2 contained my literature review, discussing topics such as multicultural education, cultural competency, experiential learning, as well as many more. In chapter 3, I discussed the methodology of the study, including my epistemology, theoretical framework, data collection, and data analysis. Chapter 4 included my findings within the study, including the themes that were found from my participant interviews. I would now like to conclude my study with a discussion about the findings. Within this chapter, I am going to discuss how the current literature relates to my findings. I will then discuss implications of my findings for higher education and medical schools, as well as discuss the answers to my two research questions. I will conclude this study with recommendations for future research.

Relationships to Current Literature

I would now like to discuss the relationship between my findings and current literature. Within theme one of my findings, all three participants stated that they had some type of uncomfortable or awkward feeling while experiencing part of the training. I was not surprised to hear all three of my participant's state that they felt this way. The *BaFa' BaFa'* training is supposed to simulate being in an environment that is unique from what we are used to. I would say that the majority of individuals who are introduced to a new culture for the first time (simulated within *BaFa' BaFa'*), experience some type of uncomfortable or awkward feeling.

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Jarrell et al. (2008) researched individuals who participated within the *BaFa' BaFa'* study. Jarrell did not mention an uncomfortable or awkward feeling as one of the three main ways in which students responded. However, their findings do relate to my findings to some extent. Jarrell found that students responded in three main ways, which included aggressiveness, assertiveness, and intimidation. While none of my participants talked in detail about responding in one of these three ways, I believe that intimidation aligns closely with the feeling of uncomfortableness. Typically, when someone feels intimidated, they would say that it is not a comfortable feeling. Also, it is challenging to feel comfortable or confident when initially placed into a totally different culture from what someone is used to.

Sullivan and Duplaga (1997) also offered several challenges of the *BaFa' BaFa'* experience. These included the opportunity for students to not comply with all the rules, the students' shyness or unwillingness to take part in the exercise, and the time commitment it requires to make proper preparations for the exercise. Sullivan and Duplaga's finding that one of the challenges of the *BaFa' BaFa'* training was students' shyness or unwillingness to take part in the exercise relates to my finding of an uncomfortable or awkward feeling. One interesting aspect of this exercise is that participation is difficult to avoid. Students are almost forced to interact with each other due to how the training is designed. This aspect may not only foster shyness or an unwillingness to take part in the exercise, but an uncomfortable or awkward feeling when participating.

Within theme 2, it was found that there were mixed feelings when it came to the overall effectiveness of the training. John and Kimberly felt that the training was not

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overall effective, while Anna felt that the training was more effective. My findings differed from Sullivan and Duplaga (1997), who administered surveys to seven different individuals who used *BaFa' BaFa'* in their organizations. These organizations consisted of six higher education institutions and one private corporation. After gathering data, Sullivan and Duplaga determined that all seven had "positive experiences" with *BaFa' BaFa'* (1997, p. 266). This finding differs from my finding in that while all three of my participants discussed positives of the training, two of my participants, John and Kimberly, were skeptical of the overall effectiveness of the training. Both John and Kimberly stated many negative comments about the training.

Jarrell et al. (2008) stated, "Students consistently report that they enjoy the experience and are able to recognize how easy it is to misinterpret behavior and develop stereotypes" (p. 141). Again, John and Kimberly did not seem to enjoy the training, based on their comments. Anna did seem to enjoy the training and had many more positive comments during the interviews. However, one aspect that must be considered regarding the differences between Anna's thoughts and John and Kimberly's thoughts, is the fact that she had the most exposure to multicultural education prior to medical school. Would John and Kimberly had felt differently about the training if they had experienced more multicultural education prior to medical school? This could be the case; however, I will discuss this in more detail below.

Theme 3 was the fact that there was little opportunity to utilize anything that might have been learned within the *BaFa' BaFa'* training. My participants talked about the large amount of time that is spent focusing on academics within medical school. In chapter 2, I cited several authors who discussed the rigors of medical school, including

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Ablow (1987), Coombs (1998), and Dyrbye et al., (2006). I feel that this is one of the most challenging aspects for medical schools who are trying to implement multicultural education training. Medical students are already required to spend large amounts of time learning the subject matter within their classes and rarely have time to study other topics. I not only witnessed this fact as an employee within Student Affairs at a health science center for five years, but also watched my wife go through the rigors of medical school from start to finish. The authors I cited are correct. Medical students have many challenges. Therefore, medical schools are forced to think about these challenges when they begin to implement multicultural education.

The fourth theme involved the timing of the training. John and Anna felt that if the training was implemented, the timing should stay the same and be performed during orientation of students first year of medical school. However, Kimberly felt that if the training was implemented, it should be moved to the beginning of students third year of medical school. The literature agrees with both options. Dogra et al. (2009a) stated that multicultural education should be installed throughout the students' four years, including the clinical rotations. Shapiro et al. (2006) found that third year medical students recommended that cultural education be input into their education experience, particularly within the third year. Dolhun et al. (2003) studied 19 medical schools and found that 32% of the medical schools in the study offered courses that contained some type of cultural competence material, 84% of the medical schools indicated that their students had to complete some type of cultural-competence training, and 21% of the medical schools incorporated cross-cultural instruction in every year of medical school. I have concluded that there are many different opinions on the subject of proper timing

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with multicultural education at medical schools. While the timing is debatable, there seems to be a stronger agreement within the current literature that implementing some type of multicultural education training at some point during the medical school training process should be done.

Theme 5 dealt with the fact that the experiential learning aspect of the *BaFa' BaFa'* training had an impact. All three participants agreed that the experiential learning aspect was important to this training. As mentioned in chapter four, out of the five themes that were found in this study, there seemed to be more agreement regarding the impact of the experiential learning aspect of the *BaFa' BaFa'* training than any other theme. Bennett (1995) stated, "An experiential approach is especially effective with culturally diverse groups of students because (with the important exception of language) there are no specific knowledge, attitude, or skill prerequisites for the initial involvement" (p. 245). Bennett (1995) went on to state that "students can participate in the introductory activity regardless of their achievement levels or cultural orientation" (p. 245). In this study, one of the participants had no prior experience with multicultural education, while another had very little experience. However, all three participants were able to participate in the training and therefore, had the same opportunities to learn as their classmates who may have had more or less prior experience with multicultural education.

Rainey and Kolb (1995) discussed how experiential learning theory (ELT) might aid in the difficulties of teaching diversity education. One of these ways, according to Rainey and Kolb (1995), was that "ELT proposes that the foundation of learning resides not in schools, books, or even teachers; rather, it rests in the experience of the learner (p.

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130). Within the *BaFa' BaFa'* training, the experience of the learner is crucial to its possible impact. A large part of the learner's experience within the training is their role-play function with other participants. Within this study, it was very evident that this role-play portion of the *BaFa' BaFa'* training had an impact on each participant. While it did not cause each participant to feel comfortable or necessarily enjoy the training, I am firmly convinced that it did help them remember the training, as well as help them understand what the training was trying to teach them.

Implications of the Study

Based on the findings of this study, I believe there are three implications that are important for higher education institutions, including medical schools, to consider. These implications include the following: the *BaFa' BaFa'* training could possibly have mixed reviews from its participants regarding its effectiveness, the logistics will vary for how to implement multicultural education opportunities in higher education, and experiential learning can have an impact when used in multicultural education opportunities. I would now like to discuss each implication.

The first implication for higher education institutions is that the *BaFa' BaFa'* training could possibly have mixed reviews from its participants regarding its effectiveness. Within my study, one of my participants felt that the training was effective, while the other two participants did not think it was effective. I believe this difference in opinion would still be the case if a larger number of students were studied. As with many educational training sessions, some students will learn and enjoy it more than others. When it comes to medical schools, there may be over 100 students in a class. It would be difficult to find any educational training program where 100 students would

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agree that it is effective. Therefore, it is important for higher education institutions, including medical schools, to understand this as they are deciding what multicultural education opportunities to provide to their students.

The second implication regards the logistics of how to implement multicultural education opportunities within higher education. Two primary logistics that higher education leaders must consider are timing and content. Based on the literature, as well as my findings, opinions on these issues vary. When it comes to medical schools, is implementing multicultural education during orientation enough? Should some type of multicultural education training be implemented each year? Would only implementing multicultural education before the third year be the best option? Is *BaFa' BaFa'* the best multicultural training for medical school students, or is there another training exercise that would be more effective? Based on my research, I do not think there is a clear answer to any of these questions. I believe what is more important is the effort that higher education institutions are putting forth to try and implement multicultural education. The logistics of how to implement multicultural education will vary from institution to institution. As more studies are completed regarding the *BaFa' BaFa'* training, as well as studies about other types of multicultural education training exercises, higher education institutions can better determine the logistics they believe fit their institution best.

The third implication is that experiential learning can make an impact when used in multicultural education. As I have already mentioned, all three of the participants in my study agreed that the training would not have been as effective if the experiential learning aspect was removed. The active part of the *BaFa' BaFa'* training forces

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individuals to participate in the learning. They are unable to just watch and listen, which can be the case within a traditional classroom setting. Using experiential learning methods can be especially unique during medical students first two years of medical school. During these two years, medical students are typically attending lectures taught by their professors. Therefore, by using experiential learning within the *BaFa' BaFa'* training, the learning may become more memorable. My participants had not experienced the *BaFa' BaFa'* training for over seven months; however, they were able to recall facts about the training, as well as some of the feelings they had while experiencing the training. This reveals that the training made an impact on each participant, even if it was negative.

Recommendations for Future Research

After completing this study, there are several recommendations that I would suggest for future researchers. These recommendations include gathering data prior to the *BaFa' BaFa'* training, using surveys as well as conducting interviews, and gathering data immediately after the training ends. First, I believe that it would be beneficial for future researchers who are studying the *BaFa' BaFa'* training to gather data prior to the start of the training. I did attempt to gather data from my participants by asking them a question regarding their experiences before they were involved in the training. However, I feel that it would be easier and more productive to be able to gather data prior to any participants experiencing the *BaFa' BaFa'* training. The reason is that once they go through the training, it becomes a vital part of their multicultural education experience. I believe it would be more beneficial to be able to gather data before they have the opportunity to compare any prior experiences to the training. This would allow

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researchers to truly understand their participants' thoughts and perceptions about multicultural education prior to experiencing the training.

Second, I believe that incorporating other research tools besides interviews would be beneficial. In my study, I used several different types of interviews to gather data. I felt that all of these interviews were important and effective; however, I feel that incorporating surveys and adding some statistical data would be beneficial. Because I was gathering data from my participants on five different occasions, I kept the total number of participants to three. However, future researchers could decrease the number of overall interviews and add several surveys. I believe this would make it feasible to help increase the number of participants, which would in turn help researchers understand what a higher percentage of the overall class perceived about the training. Also, by combining quantitative and qualitative data, future researchers could still present their data using their participants' words, but they would be able to combine statistical data to help increase the validity of their findings.

Last, I would recommend that future researchers attempt to gather research as early as possible once the training ends. As mentioned above, my research was conducted around seven months after my participants had experienced the training. I felt that my participants were able to recall many things about the training. However, I also feel that it was somewhat challenging for them to remember everything about the training. One way to avoid this is by gathering data as soon as the training ends. By gathering data early, it will not only help the participants better recall their perceptions of the training, but it will also help researchers have a better understanding of the potential impact the training may have had on the participants.

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Conclusion

Multicultural education is an interesting topic to study. Studying multicultural education fosters discussions about many other topics, such as diversity, stereotypes, biases, and past historical events. There has been much research accomplished regarding multicultural education within higher education institutions. However, my goal with this study was to try and add a unique idea to the study of multicultural education. I wanted to find out the impact of a specific type of multicultural education training on medical students. Going further, I wanted to study the specific aspect of experiential learning within this training and what medical students' perceptions were of this learning style. My hope is that my specific study can help add to the general literature of multicultural education research within higher education.

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References

AAMC. (2012). Table 31. Total enrollment by U.S. medical school and race and ethnicity, 2011. Retrieved from https://www.aamc.org/download/160146/data/table31-enrll-race-sch-2011.pdf

AAMC. (n.d.). Public medical schools – tuition and fees first year medical students 2011-2012. Retrieved from https://services.aamc.org/tsfreports/report.cfm?select_control=PUB&year_of_study=2__012

Ablow, K.R. (1987). Medical School: Getting in, staying in, and staying human. Baltimore, MD: Williams & Wilkins.

Anderson, D.J., Cheslock, J.J., & Ehrenberg, R.G. (2006). Gender equity in intercollegiate athletics: Determinants of Title IX compliance. *The Journal of Higher Education*, *77*(2), 225-250.

Banks, J.A. (1986). *Cultural diversity in western societies: Challenges and opportunities.* Paper presented at the Annual Meeting of the Association for Supervision and Curriculum and Development, San Francisco, CA. Retrieved from http://files.eric.ed.gov/fulltext/ED274577.pdf

Banks, J.A. (2001). Multicultural education: Characteristics and goals. In J.A. Banks & C.A.M. Banks (Eds.), *Multicultural education: Issues & perspectives.* (4th ed., pp. 3-30). New York: John Wiley & Sons.

Banks, J.A., & Banks, C.A.M. (2001). *Multicultural education: Issues and perspectives*. (4th ed.). New York: John Wiley & Sons.

www.manaraa.com

Bennett, C.I. (1995). *Comprehensive multicultural education: Theory and practice* (2nd ed.). Needham Heights, MA: Allyn & Bacon.

Bess, J.L., & Dee, J.R. (2012). *Understanding college and university organization: Theories for effective policy and practice* (Vol. 2). Sterling, VA: Stylus

Betancourt, J.R., Green, A.R., Carrillo, J.E., & Ananeh-Firempong, O. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and healthcare. *Public Health Reports*, *118*, 293-302. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497553/pdf/12815076.pdf

Bloom, M., Timmerman, G.M., & Sands, D. (2006). Developing a course to teach Spanish for health care professionals. *Journal of Nursing Education*, *45*(7), 271-274.

Bowman, N.A. (2010). Disequilibrium and resolution: The nonlinear effects of diversity courses on well-being and orientations toward diversity. *The Review of Higher Education*, *33*(4), 543-568.

Claxton, C.S., & Murrell, P.H. (1992). Education for development: Principles and practices in judicial education. JERITT Monograph 3, Michigan State University, 1-5.

Cohen, A.M., & Kisker, C.B. (2010). *American higher education: Emergence and growth of the contemporary system* (2nd ed.). San Francisco, CA: Jossey-Bass.

Coombs, R.H. (1998). *Surviving Medical School*. Thousand Oaks, CA: SAGE Publications.

www.manaraa.com

Creswell, J.W. (1998). *Qualitative inquiry and research design: Choosing among five traditions (*1st ed.). Thousand Oaks, CA: SAGE Publications.

Creswell, J.W. (2009). *Research design: Qualitative, quantitative, and mixed methods approaches* (3rd ed.). Thousand Oaks, CA: SAGE Publications.

Cross, T.L. (1988). Cultural competence continuum. *Focal Point*, Fall. Bulletin of The Research and Training Center on Family Support and Children's Mental Health, Portland State University.

Cross, T.L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed. CASSP Technical Assistance Center Georgetown University Child Development Center, 3-11.

Crotty, M. (1998). *The foundations of social research: Meaning and perspective in the research process.* Thousand Oaks, CA: SAGE Publication.

Daugherty, S.R., Goodman, L.J., Mattis-Peterson, A., Nora, L.M., & Stevenson, L. (1994). Improving cross-cultural skills of medical students through medical school-community partnerships. *The Western Journal of Medicine*, *161*(2), 144-147.

Davila, E.R., & Peterson, R.R. (2011). Are the walls of injustice tumbling down? *Educational Foundations, 25*(3-4), 37-58.

Dempsey, J.V., & Tucker, S.A. (1991). Using photo-interviewing as tool for research and evaluation. In Proceedings of selected research presentations at the annual convention of the association for educational communications and technology. 1-24.

www.manaraa.com

de Pheils, P.B., & Saul, N.M. (2009). Communicating with Latino patients. *Journal of Nursing Education*, *48*(9), 515-518.

Dogra, N., Giordano, J., & France, N. (2007). Cultural diversity teaching and issues of uncertainty: The findings of a qualitative study. *BMC Medical Education*, *7*(8), doi: 10.1186/1472-6920-7-8.

Dogra, N., Reitmanova, S., & Carter-Pokras, O. (2009a). Twelve tips for teaching diversity and embedding it in the medical curriculum. *Med Teach, 31*(11), 990-993. doi: 10.3109/01421590902960326

Dogra, N., Reitmanova, S., & Carter-Pokras, O.C. (2009b). Teaching cultural diversity: Current status in U.K., U.S., and Canadian medical schools. *Journal of General Internal Medicine*, *25*(2), 164-168. doi: 10.1007/s11606-009-1202-7

Dolhun, E.P., Munoz, C., & Grumbach, K. (2003). Cross-cultural education in U.S. medical schools: Development of an assessment tool. *Academic Medicine*, *78*(6), 615-622.

Dunn, T.P., Meine, M.F., & Dunn, S. (2011). The Bafa' Bafa' simulation revisited: A new way to address diversity issues in public administration initiatives that involve citizen engagement. *The International Journal of Diversity in Organisations, Communities and Nations, 10*(6), 221-230.

Dyrbye, L.N., Thomas, M.R., Huntington, J.L., Lawson, K.L., Novotny, P.J., Sloan, J.A., & Shanafelt, T.D. (2006). Personal life events and medical student burnout: A multicenter study. *Academic Medicine*, *81*(4), 374-384.

www.manaraa.com

Evans, N.J., Forney, D.S., Guido, F.M., Patton, L.D., & Renn, K.A. (2010). *Student development in college: Theory, research, and practice*. San Francisco, CA: Jossey-Bass.

Flexner, A. (2002). Medical education in the United States and Canada: A report to the Carnegie Foundation for the advancement of teaching. *Bulletin of the World Health Organization, 80*(7), 594-602. Extracted from the Carnegie Foundation for the Advancement of Teaching, Bulleting Number Four, 1910.

Galanti, G. (2008). *Caring for patients from different cultures.* (4th ed.). Philadelphia, PA: University of Pennsylvania Press.

Gardner, J.W. (1960). Abraham Flexner, pioneer in educational reform. *Science, New Series, 131*(3400), 594-595.

Geiger, R.L. (2011). The ten generations of American higher education. In P.G. Altbach, P.J. Gumport, & R.O. Berdahl (Eds.), *American higher education in the twenty-first century: Social, political, and economic challenges* (3rd ed., pp. 37-68). Baltimore, MD: The Johns Hopkins University Press.

Gijselaers, W.H., & Schmidt, H.G. (1990). Development and Evaluation of a Causal Model of Problem-Based Learning. In Z.M. Nooman, H.G. Schmidt, & E.S. Ezzat (Eds.), *Innovation in Medical Education: An evaluation of its present status* (pp. 95-113). New York: Springer Publishing Company.

Glesne, C. (2011). *Becoming qualitative researchers: An introduction* (4th ed.). Boston, MA: Pearson.

www.manaraa.com

Gotschi, E., Delve, R., & Freyer, B. (2009). Participatory photography as a qualitative approach to obtain insights into farmer groups. *Field Methods, 21*, 290-308. doi: 10.1177/1525822x08325980.

Hafferty, F.W. (1998). Beyond curriculum reform: Confronting medicine's hidden curriculum. *Academic Medicine*, *73*(4), 403-407.

Hamblet, E.C. (2009). Helping your students with disabilities during their college search. *Journal of College Admission*, *205*, 6-15.

Hampshire College. (2013). Multiple cultural perspectives requirement. Retrieved from http://www.hampshire.edu/offices/2456.htm.

Hurtado, S. (2007). Linking diversity with the educational and civic missions of higher education. *The Review of Higher Education*, *30*(2), 185-196.

Jarrell, K., Alpers, R.R., Brown, G., & Wotring, R. (2008). Using BaFa' BaFa' in evaluating cultural competence of nursing students. *Teaching and Learning in Nursing*, *3*, 141-142.

Johnson, M.T. (2011). *Diversity code: Unlock the secrets to making differences work in the real world.* New York, NY: AMACOM: American Management Association.

Kolb, D.A. (1984). *Experiential learning: Experience as the source of learning and development*. Upper Saddle River, NJ: Prentice Hall

Kolb, D.A., Boyatzis, R.E., & Mainemelis, C. (1999). Experiential learning theory: Previous research and new directions. Department of Organizational Behavior. Weatherhead School of Management. Case Western Reserve University. Cleveland, OH. Retrieved from

www.manaraa.com

http://weatherhead.case.edu/departments/organizational-behavior/workingPapers/WP%2099-9.pdf

Kripalani, S., Bussey-Jones, J., Katz, M.G., & Genao, I. (2006). A prescription for cultural competence in medical education. *Journal of General Internal Medicine*, *21*(10), 1116-1120.

Krippendorff, K. (1989). Content analysis. In E. Barnouw, G. Gerbner, W. Schramm, T.L. Worth, & L. Gross (Eds.), *International encyclopedia of communications* (Vol. 1, pp. 403-407). New York: Oxford University Press

Kumi-Yeboak, A., & James, W.B. (2011). The relevance of multicultural education for adult learners in higher education. *International Forum of Teaching & Studies*, *7*(1), 10-15.

Lakhan, S.E. (2003). Diversification of U.S. medical schools via affirmative action implementation. *BMC Medical Education*, *3*(6). doi: 10.1186/1472-6920-3-6.

LaVeist, T.A. (2005). *Minority populations and health: An introduction to health disparities in the United States.* San Francisco, CA: Jossey-Bass

LCME (2012). Liaison committee on medical education. Retrieved from www.lcme.org/start.htm

LCME (2013a). About the Liaison Committee on Medical Education (LCME). Retrieved from http://www.lcme.org/about.htm

LCME (2013b). Homepage. Retrieved from https://www.lcme.org

LCME (2015). ED-21. Retrieved from https://www.lcme.org/connections/connections_2013-2014/ED-21_2013-2014.htm

www.manaraa.com

LCME (2015). Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the M.D. degree. Retrieved from http://www.lcme.org/publications.htm

Lipken, Jr. M. (1989). Toward the Education of Doctors who Care for the Needs of the People: Innovative approaches in Medical Education. In H.G. Schmidt, M. Lipkin, Jr., M.W. de Vries, & J.M. Greep (Eds.), *New directions for medical education: Problem-based learning and community-oriented medical education* (pp. 3 – 16). New York: Springer-Verlag.

Maben, K., & Dobbie, A. (2005). Current practices in medical Spanish teaching in US medical schools. *Family Medicine*, *37*(9), 613-614.

Marshall, M.N. (1996). Sampling for qualitative research. *Family Practice*, *13*(6), 522-525.

Mazumdar, S., & Geis, G. (2010). Achieving accessibility through the Americans with Disabilities Act: An examination of court decisions. *Journal of Architectural and Planning Research*, *2*(4), 301-324.

McBride, A. (2007). Regents of University of California v. Bakke (1978). PBS website. Retrieved from http://www.pbs.org/wnet/supremecourt/rights/landmark_regents.html

McCoyd, J.L.M., & Kerson, T.S. (2006). Conducting intensive interviews using email: A serendipitous comparative opportunity. *Qualitative Social Work*, *5*(3), 389-406.

Merriam, S.B. (Ed.). (2002). *Qualitative research in practice: Examples for discussion and analysis*. San Francisco, CA: Jossey-Bass.

www.manaraa.com

Merriam, S.B., & Simpson, E.L. (2000). *A guide to research for educators and trainers of adults* (2nd ed.). Malabar, FL: Krieger.

Merriam-Webster, Inc. (2013a). Culture. Retrieved from http://www.merriam-webster.com/dictionary/culture

Merriam-Webster, Inc. (2013b). Competent. Retrieved from http://www.merriam-webster.com/dictionary/competent

Mullins-Nelson, B. (2008). Discovering and appreciating diversity through experiential education. *NSEE Quarterly*, *33*(2). Retrieved from http://www.nsee.org/

National Consortium for Multicultural Education for Health Professionals. (2009). About us. Retrieved from http://culturalmeded.stanford.edu/about/

National Society for Experiential Education. (2012). Eight principles of good practice for all experiential learning activities. Presented at the 1998 Annual Meeting, Norfolk, VA. Retrieved from http://www.nsee.org/standards-and-practice.

O'Brien, G.V., & Ellegood, C. (2005). The Americans with Disabilities Act: A decision tree for social services administrators. *Soc Work, 50*(3), 27-35.

Pascarella, E.T., Salisbury, M.H., Martin, G.L., & Blaich, C. (2012). Some complexities in the effects of diversity experiences on orientation toward social/political activism and political views in the first year of college. *The Journal of Higher Education*, *83*(4), 467-496.

Polkinghorne, D.E. (2005). Language and meaning: Data collection in qualitative research. *Journal of Counseling Psychology*, *52*(2), 137-145.

Rainey, M.A., & Kolb, D.A. (1995). Using experiential learning theory and learning styles in diversity education. In R.R. Sims & S.J. Sims (Eds.), *The importance of*

www.manaraa.com

learning styles: Understanding the implications for learning, course, design, and education (pp. 129-146). Westport, CT: Greenwood Press.

Reuland, D.S., Frasier, P.Y., Slatt, L.M., Aleman, M.A. (2008). A longitudinal medical Spanish program at one US medical school. *Journal of General Internal Medicine*, *23*(7), 1033-1037. doi: 10.1007/s11606-008-0598-9

Richards, R., Bannerman, J., Wunderlich, M., & Fulop, T. (1990). A Study of 10 Innovative Medical Schools: Some methodological issues. In Z.M. Nooman, H.G. Schmidt, & E.S. Ezzat (Eds.), *Innovation in Medical Education: An evaluation of its present status* (pp. 247-264). New York: Springer Publishing Company.

Roberts, C.M. (2010). *The dissertation journey: A practical and comprehensive guide to planning, writing, and defending your dissertation* (2nd ed.). Thousand Oaks, CA: Corwin.

Shapiro, J., Lie, D., Gutierrez, D., & Zhuang, G. (2006). "That never would have occurred to me:" A qualitative study of medical students' views of a cultural competence curriculum. *BMC Medical Education*, *6*(31), 1-7 doi: 10.1186/1472-6920-6-31.

Simulation Training Systems. (2015). BaFa' BaFa'- Cross Culture/Diversity for Business. Retrieved from http://www.simulationtrainingsystems.com/corporate/products/bafa-bafa/

Smith, J.J., & Shaker, L.S. (2003). *Looking back, Looking ahead: A history of American medical education.* Chicago, IL: Adams Press.

Smith, T.E., Knapp, C.E., Seaman, J., & Pace, S. (2011). Experiential education and learning by experience. In C. Knapp & T. Smith (Eds.), *Sourcebook of*

www.manaraa.com

experiential education: Key thinkers and their contributions (pp. 1-12). New York: Routledge.

Stevenson, B. (2007). Title IX and the evolution of high school sports. CESifo Working Paper No. 2159. Retrieved from http://ideas.repec.org/p/ces/ceswps/_2159.html#download

Sullivan, S.E., & Duplaga, E.A. (1997). The Bafa Bafa simulation: Faculty experiences and student reactions. *Journal of Management Education*, *21*(2), 265-272.

The Oyez Project at IIT Chicago-Kent College of Law. (2011). Grutter v. Bollinger. Retrieved from http://www.oyez.org/cases/2000-2009/2002/2002_02_241/#mla

Thompson, D.G. (1990). Reactions to the Introduction of Problem-Based Learning into a Medical School: Faculty and student views. In Z.M. Nooman, H.G. Schmidt, & E.S. Ezzat (Eds.), *Innovation in medical education: An evaluation of its present status* (pp. 165-174). New York: Springer Publishing Company.

Ukpokodu, O.N. (2010). How a sustainable campus-wide diversity curriculum fosters academic success. *Multicultural Education*, *17*(2), 27-36.

U.S. Department of Health & Human Services (1990). Minorities & women in the health fields. Public Health Service. Health Resources and Services Administration

Yin, R.K. (2014). *Case study research: Design and methods*. (5th ed.). Thousand Oaks, CA: SAGE Publications

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APPENDIX A

Individual Interview Guide

(RQ 1) How does BaFa' BaFa' impact cultural competency on current medical students at a southeastern health science center?

1. How would you describe cultural competency?
2. How would you say that the BaFa' BaFa' exercise impacted your cultural competency?
3. How did your feelings about the BaFa' BaFa' training change after you experienced it compared to when you first heard about it?
4. In what ways, if any, have you used what you learned in the BaFa' BaFa' training?
5. Tell me about how the BaFa' BaFa' training impacted your views about multicultural issues (such as stereotypes, biases, or becoming culturally competent)?
6. In what ways have you experienced multicultural education prior to the BaFa' BaFa' training in medical school?
7. Before experiencing the BaFa' BaFa' training, how much did you consider multicultural issues, such as diversity, stereotypes, and biases?
8. After experiencing the BaFa' BaFa' training, how much more or less do you consider multicultural issues?
9. After completing the BaFa' BaFa' training, how have your perceptions about those who are different from yourself changed or stayed the same?

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10. Tell me about whether you have implemented what you learned in the BaFa' BaFa' training toward your fellow classmates since you have graduated medical school?

11. Tell me about whether you have implemented what you learned in the BaFa' BaFa' training toward others since you have graduated medical school?

(RQ 2) How does the active experimentation aspect of BaFa' BaFa' impact current medical students?

1. Talk about how you learn the best? (example: by reading, listening, watching, hands-on)
2. Talk about how you learn the worst?
3. How do you feel that having to actively participate in the BaFa' BaFa' training impacted your learning?
4. How would the BaFa' BaFa' training be different if it were taught using non-participatory techniques, such as lecturing, presentations, videos, etc.?

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APPENDIX B

Focus Group Guide

(RQ 1) How does BaFa' BaFa' impact cultural competency on current medical students at a southeastern health science center?

1. Tell me about your initial thoughts after experiencing the BaFa' BaFa' training?
2. What did you learn through the BaFa' BaFa' training?
3. Talk about your discussions with your fellow classmates after the BaFa' BaFa' training was over?
4. In what other ways could training exercises that addressed multicultural issues be implemented into the medical school curriculum?
5. How did the BaFa' BaFa' exercise help you appreciate differences between yourselves and your classmates?

(RQ 2) How does the active experimentation aspect of BaFa' BaFa' impact current medical students?

1. How did you feel when you heard that you were going to have to interact with your classmates during the BaFa' BaFa' training?
2. How do you think that having more multicultural education opportunities in medical school that were taught using participatory teaching techniques, such as role-playing, would impact your medical education?

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APPENDIX C

Content Analysis I

1. One of the ideas that was mentioned in the first round of interviews was a feeling of awkwardness regarding the BaFa' BaFa' training. What would you say are the positives or negatives of feeling awkward while doing the training?

2. Another idea that was discussed was how busy medical students are with classes, studying, etc. What impact does your schedule of being a medical student have on being able to think about and to apply non-medical subject matter that you have learned, such as possible subject matter through the BaFa' BaFa' training?

3. What do you think the main goal of the BaFa' BaFa' training was? How effective was the training at meeting its goal?

4. If you had to pick one main reason why active learning can be beneficial, what would you say that reason is and why do you feel that way?

5. If you were allowed to pick the timing of when the BaFa' BaFa' training took place during medical school, where would you position the training (if you would do the training at all) and what is your reasoning behind your decision?

6. After experiencing the BaFa' BaFa' training, what would you say is the best reason for individuals who haven't done the training to take part in it (if you think they should take part in it at all)? (i.e. before they go on a trip to another country, before they interact with others who were raised in another culture, before they talked to someone who speaks a different language, etc.)

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APPENDIX D

Content Analysis II

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1. Do you remember viewing or discussing these pictures during the training? If so, what do you remember about this part of the training?
2. Was this part of the training beneficial? Why or why not?
3. Was this part of the training more or less beneficial compared to the active learning aspect of the training? Why?

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APPENDIX E

Content Analysis III

1. Do you feel that the BaFa' BaFa' training can be useful when you begin seeing patients on a regular basis? Why or Why not?

2. If an incoming first-year medical student who was beginning medical school next year at UMMC asked you about the BaFa' BaFa' training, what would you tell them?

3. If you were in charge of planning the Multicultural Affairs session at next year's M1 orientation, would you leave everything the same, change part of it, or change it completely? Why?

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APPENDIX F

Recruitment Flier

University of Memphis

Research Study

University of Memphis,

Higher and Adult Education Student Dissertation

The researcher is attempting to study recent medical students' responses about their experiences they had with the BaFa' BaFa' cultural simulation exercise. Specifically, the researcher is attempting to study what, if any, affect the BaFa' BaFa' cultural simulation exercise had on current medical students.

Who is Eligble?

- Must be over the age of twenty-one
- Must be first-year medical students, currently attending the medical school discussed in this study
- Must have participated in the *BaFa' BaFa'* exercise
- Must be willing to discuss their thoughts and opinions about this exercise, as well as topics such as stereotypes and biases

What will you be asked to do?

Participants will be asked to respond to questions about their experiences with the BaFa' BaFa' exercise and how it has impacted them. Participants will also be asked about their learning styles. Each participant will be interviewed a total of five times, including one focus group interview, one face to face interview, and three email interviews.

Compensation

There will not be any compensation provided to students for your participation in this study.

If you have any questions or are interested in participating, please contact:
Parker Jones at **662-401-3395** or jpjones6@memphis.edu

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APPENDIX G

Consent Form

Consent to Participate in a Research Study

PI Contact Information:
Parker Jones
jpjones6@memphis.edu
662-401-3395

Advisor Contact Information:
Dr. Jeffrey Wilson
Jlwlson4@memphis.edu
901-678-3428

IRB Contact Information:
irb@memphis.edu
901-678-2705

WHY ARE YOU BEING INVITED TO TAKE PART IN THIS RESEARCH?
The researcher is attempting to study recent medical students' responses about their experiences they had with the BaFa' BaFa' cultural simulation exercise. Specifically, the researcher is attempting to study what, if any, affect the BaFa' BaFa' cultural simulation exercise had on current medical students.

WHO IS DOING THE STUDY?
The study is being performed by Parker Jones, as a partial requirement for completing the Doctorate of Education Degree in Higher Education at the University of Memphis.

WHAT IS THE PURPOSE OF THIS STUDY?
The researcher is attempting to study the effect experiential learning techniques within a multicultural education curriculum have on the cultural competencies of current medical students.

ARE THERE REASONS WHY YOU SHOULD NOT TAKE PART IN THIS STUDY?
The only foreseen reasons why you should not take part in this study is if you do not feel comfortable discussing multicultural issues, such as diversity, biases, stereotypes, cultural competency, etc.

WHERE IS THE STUDY GOING TO TAKE PLACE AND HOW LONG WILL IT LAST?
All interviews will take place at a location and at a time that is convenient for you. Each interview is expected to last 30 minutes to 1 hour.

WHAT WILL YOU BE ASKED TO DO?

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Participants will be asked to respond to questions about their experiences with the BaFa' BaFa' exercise and how it has impacted them. Participants will also be asked about their learning styles.

WHAT ARE THE POSSIBLE RISKS AND DISCOMFORTS?
The possible risks and discomforts entail not wanting to discuss personal feelings about multicultural issues.

WILL YOU BENEFIT FROM TAKIN PART IN THIS STUDY?
One benefit could be that each participant could grow in their own understanding of multicultural issues. However, there are no guarantees that there will be any benefits.

DO YOU HAVE TO TAKE PART IN THE STUDY?
No, you do not have to take part in the study. Also, if you choose to take part in the study, you may stop participating at any time.

IF YOU DON'T WANT TO TAKE PART IN THE STUDY, ARE THERE OTHER CHOICES?
There are no other choices at this time.

WHAT WILL IT COST YOU TO PARTICIPATE?
There will be no charge to participate. The only cost will be 1-2 hours of your time.

WILL YOU RECEIVE ANY REWARDS FOR TAKING PART IN THIS STUDY?
No, currently there are no rewards for taking part in this study.

WHO WILL SEE THE INFORMATION THAT YOU GIVE?
This information will be shared with the dissertation committee. Also, this material could be published in a journal. However, all names will be changed to pseudonyms, so as to protect any personal information.

CAN YOUR TAKING PART IN THE STUDY END EARLY?
Yes, participants may remove themselves from the study at any time.

ARE YOU PARTICIPATING OR CAN YOU PARTICIPATE IN ANOTHER RESEARCH STUDY AT THE SAME TIME AS PARTICIPATING IN THIS ONE?
Yes, participants may participate in another study at the same time as this one, if they so choose.

WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS, CONCERNS, OR COMPLAINTS?
Any questions, suggestions, concerns, or complaints can be directed toward the researcher. The researcher will be glad to address any issues that might arise.

WHAT IF NEW INFORMATION IS LEARNED DURING THE STUDY THAT MIGHT AFFECT YOUR DECISION TO PARTICIPATE?

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Participants may remove themselves from the study at any time.

WHAT HAPPENS TO MY PRIVACY IF I AM INTERVIEWED?
Your privacy will be protected at all times. Your real name will not be identified on any published documents and your name will be replaced by a pseudonym (false name) assigned by the participant or the researcher. Also, all transcriptions and data will be kept in a secure location at the researcher's home in a locked drawer.

_____ _____
Signature of person agreeing to take part in the study Date

_____
Printed name of person agreeing to take part in the study

_____ _____
Name of [authorized] person obtaining informed consent Date

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APPENDIX H

IRB Approval

Hello,

The University of Memphis Institutional Review Board, FWA00006815, has reviewed and approved your submission in accordance with all applicable statuses and regulations as well as ethical principles.

PI NAME: Jonathan Jones
CO-PI:
PROJECT TITLE: Understanding the Effectiveness of Multicultural Education Using Experiential Learning Techniques to Foster Cultural Competency of Medical School Students: A Qualitative Case Study at a Medical School
FACULTY ADVISOR NAME (if applicable): Jeffery Wilson
IRB ID: #2609
APPROVAL DATE: 12/5/2014
EXPIRATION DATE: 8/6/2015
LEVEL OF REVIEW: Expedited Modification

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