

ORIGINAL ARTICLE

Volume 9 Issue 1 2017

DOI: 10.21315/eimj2017.9.1.3

ARTICLE INFO

Submitted: 05-11-2016

Accepted: 26-12-2016

Online: 31-03-2017

Medical Students' Opinions Regarding Possible Influence of Culture and Social Issues on Health Seeking Behaviour

Pathiyil Ravi Shankar¹, Christopher Rose^{2,3}, Albertina Sebastian⁴

¹Department of Medical Education, Xavier University School of Medicine, Aruba

²Department of Behavioral Sciences, Xavier University School of Medicine, Aruba

³Kompass Solutions, Calgary, Alberta, Canada

⁴Medical Student, Xavier University of Medicine, Aruba

To cite this article: Shankar PR, Rose C, Sebastian A. Medical students' opinions regarding possible influence of culture and social issues on health seeking behaviour. *Education in Medicine Journal*. 2017; 9(1):29–41. <https://dx.doi.org/10.21315/eimj2017.9.1.3>

To link to this article: <https://doi.org/10.21315/eimj2017.9.1.3>

ABSTRACT

Introduction: Cultural, social and ethnic issues have a major impact on healthcare and care-seeking behaviour. Xavier University School of Medicine admits students from a diversity of backgrounds. A cultural beliefs project where interested students were invited to present about their 'country of origin' was initiated. Participant perceptions about the project, and information regarding their preparation for the same and their perceptions about migration and cultural diversity was explored using focus group discussions (FGD). **Materials and Methods:** The opinions of interested students regarding possible influence of cultural and social issues on healthcare and healthcare seeking behaviour was studied. Twelve students eventually presented. These students were provided guidance to initiate their project. Participants presented briefly about their country of origin. Following the presentation the students were invited to participate in FGD. The FGDs were held in a neutral venue and were audio-recorded. The recordings were listened to by the authors multiple times and written transcripts created. Statements were grouped together using the various categories mentioned in the FGD guide. **Results:** A total of 11 individuals participated in the FGDs. Among the countries presented were: Hispaniola (Haiti and the Dominican Republic), Sri Lanka, Greece, Nigeria, Ethiopia, China, Venezuela, Iran, Jordan and Lebanon. Detailed information was obtained about the respondent's perception on migrating to the adopted country, about participating in the cultural beliefs project, how they prepared their write-ups and presentations, influence of cultural issues on health and healthcare seeking behaviour. Their perceptions regarding practicing in a multicultural society, preparing for these challenges and whether the western political and cultural system adequately meets the needs of immigrants was also discussed. **Conclusion:** The presentations and interactions which occurred during the cultural beliefs project provided participants and members of the audience with information about the beliefs of the presented cultures with regard to health and healthcare seeking behaviour. A similar project could be considered with other interested students in the institution. A similar project may be useful in other schools with a diverse student population.

Keywords: Caribbean, Culture, Healthcare acceptability, Medical students, Patient acceptance of healthcare

CORRESPONDING AUTHOR

Dr P Ravi Shankar, Xavier University School of Medicine, 23, Santa Helenastraat, Oranjestad, Aruba | Email: ravi.dr.shankar@gmail.com

INTRODUCTION

Cultural, social and ethnic issues have a major influence on health among different populations and can play an important role in determining health seeking behaviour. Various studies have been conducted among migrant populations in developed nations. Many Vietnamese migrants in Australia cited communication difficulties as barriers in accessing health care despite high self-rated English language skills (1). Another study examined the health information seeking behaviour among native Koreans and among Korean Americans (2). The authors concluded that Korean Americans were more likely to trust health information from newspapers and magazines and increasing the availability of health information in Korean language magazines and newspapers could have a positive impact on increasing awareness and promoting screening behaviours (2).

The use of traditional medicines (TM) may also be influenced by cultural beliefs as shown by a number of studies in the literature. A study conducted among Vietnamese immigrants attending a community health centre in the United States (US) showed that most immigrants continued to use traditional Vietnamese medicines (3). In a study conducted in southwestern Uganda among type 2 diabetics, reasons for seeking help from traditional practitioners were symptoms related to diabetes, and failure to respond to western medicines (4). In Ghana, the ‘pull factors’ with regard to TM for example personal health beliefs, desire to take control of one’s health, perceived efficacy, and safety of various modalities of TM were stronger in shaping their use (5). Though many individuals strongly believe that TM are safe and without adverse effects, interactions have been reported between TM and modern allopathic medicines. A population-based study examined interactions between traditional Chinese medicines (TCM) and western medicine in Taiwan (6). The authors concluded that interactions between TCM and western medicines were frequent

and western practitioners changed their prescriptions more frequently in response to medication interaction alerts, compared to TCM practitioners.

Patient’s beliefs about medicines is influenced by a number of factors including cultural beliefs and can influence adherence to treatment. A recently published study examined factors influencing adherence to anti-hypertensive treatment among individuals of African descent living in the Netherlands (7). The authors concluded that patient-related determinants including medication self-efficacy, beliefs about medicines and hypertension, social support and satisfaction with care-influenced adherence. Hence it is important for doctors and medical students to be aware of the influence of cultural beliefs and factors on healthcare seeking behaviour of patients.

A paper published by Bloomer and Al-Mutair in 2013 examined considerations for ensuring culturally sensitive care for Muslim patients in the Australian intensive care unit (ICU) (8). The authors mention that being open and flexible in the way that care is provided, and being respectful of the needs of patients and their families is important. Seven strategies for initiating and sustaining cultural competence at the systemic level were discussed by Delphin-Rittmon et al. (9). Ensuring linguistic competency, developing cultural competence action plans, were among the various strategies mentioned. At the Hospital for Sick Children located in Toronto, Canada, a quality improvement initiative to enhance health equity through cultural competence was undertaken (10). An institutionally meaningful curriculum with the hospital’s values of patient-centered care, patient safety and service excellence was developed and delivered. Use of champions as change agents and role-models for cultural competence were used.

The issue of cultural competence and introducing students to cultural diversity is receiving increasing attention in medical education. At the Perelman School of

Medicine at the University of Pennsylvania, a course titled *Introduction to Medicine and Society* is offered to first year medical students (11). The authors conclude that the course successfully engages students and trains future doctors to critically examine experiences, manage interpersonal dynamics and contextualise patient experiences. At an emerging medical school a multidisciplinary team of librarians, medical school faculty and students explored techniques to promote diversity and address cultural competence (12). Various events were organised to create awareness about health disparities and promote cultural competence.

Xavier University School of Medicine (XUSOM) is an offshore Caribbean medical school located in Aruba, Kingdom of the Netherlands. The school admits students from a variety of backgrounds and countries to the undergraduate medical (MD) program. The school shifted to a fully integrated basic science program with early clinical exposure from January 2014 (13). Cultural competency and cultural diversity are important topics in the curriculum. A medical humanities module utilising small group, active learning strategies is offered to all first semester students (14). Sessions on cultural diversity are also offered during both the basic science and the clinical years. To take advantage of the diversity of the student population in the institution a cultural beliefs project, where interested students were invited to present about their 'home country' was initiated. Participant's perceptions about the project, and information regarding their preparation for the same and their perceptions about migration and cultural diversity was explored using focus group discussions.

METHOD

The opinion of interested basic science medical and premedical students regarding the possible influence of cultural and social issues on healthcare and healthcare seeking behaviour was studied. All students were informed about the study and invited to

participate. Though many student expressed initial interest they later withdrew due to various reasons including the tight academic schedule. A total of 12 students eventually participated. These students were provided guidance and a set of questions to help them initiate their project. Students were to provide a brief description of their country of origin and describe the health system in the country. Information about traditional and home remedies used by the population, communication preferences while interacting with healthcare providers, cultural and religious practices involved during major life events like: birth, death and marriage, perceptions about health, role of the family in taking healthcare decisions, perceptions about gender and disability, and about accessing healthcare in the US and/or Canada after they had migrated to these countries was noted.

These questions were only intended as a guide and respondents/students were provided freedom to address areas and concepts which they felt were important. Students were first asked to submit a write-up to the faculty members involved and after obtaining their inputs to create slides for presentation. The presentations were held on the afternoon of 19 July 2016. Each student was allowed a maximum of 10 minutes for their presentation, though, many were not able to finish within the time limit. Following the presentation, students were invited to participate in a focus group discussion/s (FGD). Written informed consent was obtained from all participants. Respondents were briefly introduced to the aims and objectives of the study and provided with an overview of qualitative research methodology. They were assured about the confidentiality of their responses. The FGDs were held during October 2016. The FGD guide used is shown in the Appendix. The FGDs were held in a 'neutral' venue and were audio recorded. Prior to the start of the FGD each participant was asked to select a number from 1 to 15 and refer to each other during

the FGD using the number only. Each FGD lasted about 70 to 75 minutes.

The recordings were listened to by the authors multiple times and written transcripts created. Statements were grouped together using the various categories mentioned in the FGD guide. The FGDs were conducted by the first author in English. The study was approved by the institutional review board of the institution vide reference number XUSOM/IRB/2016/04 dated 15 July 2016.

RESULTS

A total of 12 individuals participated in the focus group discussions (FGDs). During the FGD the participants briefly introduced themselves and the countries which they had presented using the numbers they randomly selected.

Migration to the US/Canada and Initial Reactions on Migrating

One of the respondents had migrated as a refugee to the US during the late 1970s and her mother's application for refugee status was expedited as she was pregnant with the respondent. The families of most respondents after migrating, had settled in large metropolitan centers. These cities have a diverse population and had members of their native country or region, who did help them feel at home initially. Some of the respondents were born in the US and Canada while others migrated as young children. Others migrated when they were in high school. Respondents did mention that they were discriminated by other students at school for being 'different'. Some of the Canadian respondents and a respondent who had migrated to both the US and Canada mentioned that Canada was a more welcoming place and had more robust programs in place for migrants. The respondents felt more welcome in their adopted country as they assimilated and became more proficient in the native language. Also most of them were willing to

adapt as they were of the opinion that they and their family had migrated to the US/Canada on their own free will. A respondent mentioned how young girls belonging to a particular country are viewed negatively and many have a preconceived notion that they may be migrating to be sex workers. Some respondents of Middle Eastern ancestry mentioned the rise of terrorism and how this has influenced how they are perceived in the US and Canada. With all the negative publicity in the media some members of the public have begun to view young Arab men with suspicion.

A respondent stated:

Yes and no. I grew up in can I say a very white neighborhood. My parents felt you just work hard and work your way up. I think most of the people in my parent's age felt this way. They were young when they got here (US) and then they had me. They were always working and were not even aware that there was a difference or any kind of discrimination. (Participant 4)

Perceptions Regarding Participating in the Cultural Beliefs Project

One of the respondents, who was a mature student with multiple Bachelors and Masters Degrees, felt that she had adopted a slightly different approach towards the project compared to other presenters. As mentioned students were provided with a broad outline about their presentation and they had considerable freedom to interpret these guidelines. Many participants were initially skeptical about the project and their presentation. Many of their concerns were addressed following discussion with the faculty members involved in this project. Many respondents were of the opinion that the project entailed a lot of hard work and through their research and other methods they had much more material than what they finally presented. Some respondents had faced problems while adapting to life in their adopted country and their family members also had problems while

interacting with practitioners of modern medicine. In many Asian societies, the correct order of greeting is very important and the eldest family member is usually addressed first. Failure to not follow this sequence on the part of the physician can result in problems. Some respondents regarded the project as a good opportunity to clear misconceptions about their country of origin and also regarded it as a great initiative to learn about other cultures. Interacting with students from different cultural backgrounds at the institution made some respondents curious to know about other cultures.

A respondent mentioned:

I was actually very curious. Because even though I was born in ... I do not remember the three years which I had lived there. I was not sure about their healthcare system, political system and it was all like stories I had heard from my parents so doing actual solid research was very interesting. (Participant 15)

Preparing the Write Ups and Presentations

Many respondents obtained help from their parents and relatives for preparing for the presentation. Some of the respondents were born in the US/Canada and others had migrated when they were very young so they had little personal experience about their country of origin. Others had migrated after completing some years of schooling in their country of origin and also had visited these countries. Some had relatives in the health sector in their home country and these individuals proved to be valuable sources of information. The parents of some of the respondents were escaping war and/or social upheaval in their home countries and were not willing to talk about these countries. The internet was a commonly used source of information by respondents. The World Health Organization had a number of publications dealing with the health system in different countries which was found to be very useful. One respondent had migrated to Aruba from a neighboring country and

still maintained close links with her home country. Faculty members from certain countries were used by the respondents as sources of information. Movies and TV programs were also used by some respondents to stay in touch with events in and the culture of their home country.

As far as preparing and presenting I mainly spoke to my parents, especially my mom and I learned more cultural and social things from her.. like how the government worked and I talked about her experience coming to the United States. I was the first generation of my family born in the United States I also did my research using resources from the internet and found resources from the WHO very helpful. (Participant 14)

Addressing the Topic of Cultural Beliefs and its Influence on Health during the Basic Science Years

Many respondents were of the view that this issue is not adequately addressed during the basic science years. One respondent mentioned the issue of 'draping' a patient prior to physical examination as an example. Preserving female and even male modesty during the examination process is an important issue in many areas of the world and not properly draping the patient can result in problems in the patient-doctor relationship. Others mentioned that some sessions, and/or courses do partly address some of these issues. Also didactic sessions and early clinical exposure on the island do provide respondents with information about Aruba's health system.

Regarding suggestions to strengthen learning of this topic, respondents suggested utilising the diversity of the student body at the institution. A cultural day and a brief presentation about and celebration of important holidays of different cultural, ethnic and religious groups was mentioned. A respondent mentioned about a video where a doctor demonstrates important technics to deal with different cultures.

This video could be obtained for teaching-learning at the institution. Another respondent suggested sessions where respondents could address important misconceptions about their country of origin.

Influence of Ethnic, Cultural and Other Factors on Healthcare Seeking Behaviour

In many Asian cultures, the elderly depend on younger family members to support them and provide care. In some cultures, individuals adopt a more fatalistic approach and are of the opinion that if you faced major difficulties in accessing care then you were not meant to obtain the same. They may not consider themselves good enough to be eligible for care. Many respondents mentioned that individuals may feel most comfortable with a doctor belonging to the same ethnic/cultural group. There is either none, or less, of a language barrier. Many groups use traditional or home remedies which are influenced by their culture and respondents were of the opinion that a doctor from the same ethnic/cultural group may be more accepting about their use of these remedies. Another area where these beliefs may affect healthcare behaviour that was mentioned was the issue of abortion. Many traditional cultures are against abortion and this is an issue which is not usually discussed in public. In certain countries, abortion clinics have been opened in big cities under pressure from western countries.

A respondent mentioned:

In East Africa it is not mentioned at all. A large percentage of the population is Muslim and it is not a part of the religion to have an abortion so within the community it is not exactly spoken off. We don't talk about it, go to a doctor to discuss it and is completely not spoken about. Of course it is not legal there. (Participant 11)

Suicide is regarded negatively in many cultures and it is believed a person who has

committed suicide does not go to heaven in the afterlife. Another issue with negative connotations is homosexuality. It is still illegal today in many countries around the world. Western governments may be exerting pressure on many countries to have a more favorable attitude toward homosexuality.

Respondents also mentioned many factors as influencing the acceptance of modern healthcare by immigrants. Respondents mentioned geographical differences with regard to the acceptance of immigrants. Immigrants usually felt more welcome in big multicultural cities. In many areas there was a shortage of translators who could interpret during the patient-doctor consultation. Some respondents described the increasing technical sophistication of translator apps and how these could play a more important role in the future.

Challenges as a Future Doctor Practicing in a Multicultural Society

The great diversity of cultures and immigrants was mentioned as a challenge for doctors. Many immigrants settle in large, multicultural cities in the US and Canada and reside within areas dominated by their own communities. This may result in less inclination to learn English and adapt to the culture of their adopted country. Many respondents intended to practice in their home town and among their own communities. Many patients also use traditional remedies which are generally regarded as safe, but these may have significant interactions with modern medicines. Sources and software which provide information about these interactions are becoming increasingly available. Also, in today's globalised world, home and traditional remedies, may spread easily across cultures creating more challenges for the physician. Respondents also mentioned how some female patients may not feel comfortable visiting a male doctor for obstetrical care and gynecological problems. Some religions and cultures regulate contact between the genders, but many mentioned

that for medical consultation and treatment these restrictions may be relaxed. Some respondents were of the opinion that they have not been adequately exposed to other cultures thus affecting their confidence to practice in a multicultural society.

Preparing for These Challenges

Most students mentioned keeping an open mind and respecting other cultures as one of the most important steps to deal with future challenges. The school provides a diverse body of students with interactions, in informal situations, which may provide ample opportunities to learn about other cultures. Keeping a neutral facial expression and learning to adjust to the patient before conducting a medical interview, were also mentioned. Some respondents also mentioned specific languages and cultures about whom they would like to learn more. They mentioned that this may be influenced by their area of practice and the major cultures they interact with.

I think rather than learning about a culture in general, maintaining an open attitude and a neutral expression is important. So when you listen to something your patient tells you and your shock and disapproval shows up in your facial expression then your patients may hesitate to come to you and tell you these things the next time. So just learning to accept whatever your patients tell you and focusing on making them feel comfortable I think is going to be important.
(Participant 11)

Western Political and Cultural System and the Needs of Immigrants

Many respondents mentioned that both the US and Canada are becoming more multicultural. They also mentioned the possibility of migrants competing among themselves for resources. Some family members adopt more westernised names for a variety of reasons. A respondent mentioned the largely unmet need of

cultural competency guides and how medical students could play an important role in their creation. Due to a variety of reasons doctors may not be able to devote adequate time to their patients and this may interfere with obtaining a proper cultural history. Most respondents were of the opinion that Canada offers better health coverage to immigrants. Some mentioned that the cultural diversity in New York City may facilitate health care seeking by immigrants. However, countries are cutting back on funding for health programs which could impact many of these services.

A respondent who had lived in both the US and Canada mentioned:

I had been to both and lived in both the US and Canada. So I saw the difference. And there is a very big difference. Moving to the United States we were left alone, you find out everything on your own. There is not much help from the government that is offered to you. Moving to Canada was a completely different story. It was like having a mother in a country. Canada takes care of you from the moment you arrive. From finding a house, language classes, finding a healthcare provider, schools for your kids. They will help you till you are completely assimilated into the Canadian culture. There are programs for new immigrants like I when I first went there which help you assimilate. (Participant 10)

DISCUSSION

The cultural beliefs project demonstrated that it was possible to use the diversity among basic science medical students in the institution to present information about their countries of origin. Though it was optional for other students to attend the presentation and the numbers who attended were low this was regarded as an active and fun way to learn about the cultural beliefs of different ethnic and cultural groups and

the possible influence of this on healthcare seeking behaviour.

Migrating to Another Country

Many respondents reported negative or unfavourable reactions on migrating to another country and also reported some problems at school for being different. Three stages of adapting to a new country or culture have been described previously. These are: the honeymoon stage, the rejection stage and the adjustment stage (15). As mentioned many of the participants had migrated to the US and/or Canada of their own free will and thus were motivated to adapt to their adopted country and succeed in their new environment.

Sources Consulted during Preparation

Respondents used internet resources and inputs from their parents and relatives to prepare for the project. A study conducted among Canadian medical students had explored their information seeking behaviour (16). Most respondents reported that they had received formal instruction regarding information searches but this did not include non-traditional sources like Google, Wikipedia and social media. Medical students relied more on nontraditional information sources which was also noticed in our medical school during the present study. In a study conducted in India, over 97% of students accessed the internet and many did so using their mobile phones (17). Wikipedia was again a commonly used information source.

Cultural Competence and Cultural Humility

As patient populations all over the world are becoming increasingly diverse, introducing students to various cultures and inculcating cultural competence is becoming increasingly important. Cultural competence may imply healthcare providers learn a quantifiable set of attitudes and

communication skills that enable them to work effectively within the cultural context of the patients they encounter (18). Cultural humility is being aware of how people's cultures can impact their health seeking behaviours and using this awareness to cultivate sensitive approaches to dealing with patients (19). A recent article argues the importance of including social medicine and global health in the pre-clinical curriculum and describes a course which teaches social medicine in a way that integrates global health (20).

Acculturation and Bias toward Certain Groups

Studies from the literature have described a variety of factors as influencing the patient-doctor interaction. Acculturation orientations (AO) has been described based on Berry's acculturation model (21). Four categories were described which were: assimilation, integration, separation and marginalisation. AO could have a significant impact on the relationship between the immigrant patient and doctor (22). A proper understanding about AO can be used to create interventions for both doctors and immigrant patients improving the interaction. Patients' ethnic background could influence patient-doctor interaction and the decision making process. In a study conducted in Australia and Hawaii in the US, subtle biases were detected in the students' way of talking about an indigenous person and about the anticipation of dealing with the patient (23). Another study examined the interactions between black patients and non-black doctors in the US (24). The authors concluded that the physician's affect and engagement were influenced by their implicit and explicit racial bias, but only when they interacted with patients who had complained about previous episodes of discrimination. Patient's affect was only influenced by perceived discrimination.

Factors Influencing the Patient-Doctor Interaction

A study had shown a negative correlation between physicians' perceived cultural competence and the patients' perception of physician competence (25). Patients complied better with doctor's recommendations if they perceived the doctor as culturally competent and ethnicity had a significant influence on patient perceptions' regarding the cultural competence of their physicians and their satisfaction with medical care. Hispanic and African American patients perceived their physician as being significantly less attentive towards them compared to Caucasian patients (26). An article examining culture, language and the patient-doctor relationship mentions that minority patients are more likely to choose minority physicians, and while interacting with these physicians, have lesser problems with language and feel more connected and involved with the decision making process (27). Professional interpreters can bridge the communication barriers experienced by patients who do not speak English.

Attitudes toward Different Issues

Respondents also mentioned conservative attitudes toward abortion and homosexuality. This has been reported in the literature. In Pakistan, respondents were in favor of abortion only in cases where there was a risk of imminent fetal death as a result of congenital anomalies (28). Women had more favourable attitudes toward induced abortion. In Nigeria a large percentage of medical students had a negative attitude toward provision of medical services to men having sex with men (MSM) (29). They were however, less homophobic than their non-medical counterparts. Predictors of homo-negativity was studied in the US and the Netherlands (30). Homo-negativity is more likely to occur in the US than in the Netherlands and was associated with negative attitudes toward immigrants and HIV patients. A study conducted in Brazil

mentions that adherents of the Protestant, Pentecostal and Catholic traditions had the most restrictive views toward homosexuality and same-gender unions while those with no religious commitment and followers of Afro-Brazilian and spiritualist religions had a more favourable attitude (31).

Preparing Students for Practice in Multicultural Settings

Preparing physicians to care for culturally diverse populations has received a lot of attention. The concept of transnational competence (TC) was introduced by Koehn and Swick in 2006 (32). TC education offers a comprehensive set of core skills derived from international relations, cross-cultural psychology, and intercultural communication. Having students prepare a mini-ethnography for each patient, where they not only address issues related to physical and mental health, but also issues related to displacement and adaptation to a novel setting is important. Issues of health policy, social factors, and individual considerations which can reduce suffering and improve health in a globalising world are regarded as important. A study conducted in the US mentions that students perceive that they learn from others who are different ethnically or racially (33). This association may be of particular importance for institutional admission policies that encourage diversity among the student population. This point was repeatedly stressed by different participants in the present study.

Strengthening Learning of Cultural Issues

Respondents made a number of suggestions to strengthen learning about issues of cultural diversity and competence in medical education. Most of this involved leveraging the existing diversity of the student body. In the US, the learning action network (LAN) was designed as a part of the national initiative on gender, culture and leadership in medicine (C-change) (34). In a recent article, the authors discuss the various

lessons learned from C-change. The opinion of native Hawaiian medical students, patients and physicians about a cultural competency curriculum was obtained (35). All groups wanted traditional healing to be included in the training program. Students wanted a variety of teaching-learning methods to be employed and cultural issues to be assessed. They also were of the opinion that faculty members may need cultural competency training. Patients wanted students to learn about the host culture and its values while physicians emphasised personal transformation as an effective tool in teaching about cultural competence.

CONCLUSION

The presentations and interactions which occurred during the cultural beliefs project provided participants and members of the audience with information about the beliefs of the cultures presented with regard to health and healthcare seeking behaviour. The semi-structured interviews and the focus group discussions provided insights into participants' perception regarding the project, preparing their notes and their presentations. Further insights were obtained regarding their perception about migrating to another country, how cultural beliefs can influence health seeking behaviour, concerns of migrants and problems which respondents envisage while practicing in a multicultural society and how they plan to deal with these challenges. Suggestions to further strengthen learning of cultural issues during the basic sciences were also obtained. A similar project could be considered with other interested students in the institution and may be useful in other schools with a diverse student population.

ACKNOWLEDGEMENTS

The authors would like to acknowledge the support of the Dean of Basic Sciences, Dr. Dubey to the module. They would like

to thank Ms. Hilda for logistic support. We thank the students, Mr. Sanad Alghizzawi, Ms. Kahmalia Sada, Ms. Komathini Jothikumar, Mr. Christopher Iordanou, Ms. Adebola Adegbite, Mr. Biruk Gote, Ms. Jennifer Tuong, Ms. Maria Cristofori, Mr. Pouria Mohammadi, Mr. Samir Tohme, Ms. Grace Doan and Ms. Alyzeh Alibhai for participating in the project and the FGDs.

APPENDIX

FGD Guide Cultural Beliefs

1. Briefly introduce yourself and your country of origin/the country you presented.
2. When did you migrate to the US/Canada and what were your reactions on migrating?
3. Do you feel accepted in your adopted country? What are the facilitating and hindering factors?
4. What were your perceptions regarding participating in the cultural beliefs project?
5. How did you prepare your write up and your presentation?
6. Do you feel this topic is adequately addressed during the basic science years?
7. What are your suggestions for improvement?
8. According to you how does ethnic, cultural, social beliefs influence care seeking behaviour?
9. Does this influence acceptance of modern healthcare and healthcare practitioners by migrants? How does it influence, if yes?
10. What challenges do you foresee as a doctor practicing in a multicultural society?
11. How do you plan to prepare for these challenges?

12. Do you think the western political and medical system adequately address concerns and apprehensions of immigrants? Provide examples and reasons.
13. Any other topic.

REFERENCES

1. Maneze D, DiGiacomo M, Salamonson Y, Descallar J, Davidson PM. Facilitators and barriers to health-seeking behaviours among Filipino migrants: inductive analysis to inform health promotion. *Biomed Res Int.* 2015;2015:506269. <https://doi.org/10.1155/2015/506269>
2. Oh KM, Zhou QP, Kreps G, Kim W. The influences of immigration on health information seeking behaviors among Korean Americans and Native Koreans. *Health Educ Behav.* 2014;41:173–85. <https://doi.org/10.1177/1090198113496789>
3. Nguyen LT, Kaptchuk TJ, Davis RB, Nguyen G, Pham V, Tringale SM, Loh YL, Gardiner P. The use of traditional Vietnamese medicine among Vietnamese immigrants attending an urban community health center in the United States. *J Altern Complement Med.* 2016;22:145–53. <https://doi.org/10.1089/acm.2014.0209>
4. Atwine F, Hultsjö S, Albin B, Hjelm K. Health-care seeking behaviour and the use of traditional medicine among persons with type 2 diabetes in south-western Uganda: a study of focus group interviews. *Pan Afr Med J.* 2015;20:76. <https://doi.org/10.11604/pamj.2015.20.76.5497>
5. Gyasi RM, Asante F, Yeboah JY, Abass K, Mensah CM, Siaw LP. Pulled in or pushed out? Understanding the complexities of motivation for alternative therapies use in Ghana. *Int J Qual Stud Health Well-being.* 2016;11:29667. <https://doi.org/10.3402/qhw.v11.29667>
6. Chen KC, Lu R, Iqbal U, Hsu KC, Chen BL, Nguyen PA, Yang HC, Huang CW, Li YC, Jian WS, Tsai SH. Interactions between traditional Chinese medicine and western drugs in Taiwan: a population-based study. *Comput Methods Programs Bio Med.* 2015;122:462–70. <https://doi.org/10.1016/j.cmpb.2015.09.006>
7. Meinema JG, van Dijk N, Beune EJ, Jaarsma DA, van Weert HC, Haafkens JA. Determinants of adherence to treatment in hypertensive patients of African descent and the role of culturally appropriate education. *PLoS One.* 2015;10:e0133560. <https://doi.org/10.1371/journal.pone.0133560>
8. Bloomer MJ, Al-Mutair A. Ensuring cultural sensitivity for Muslim patients in the Australian ICU: considerations for care. *Aust Crit Care.* 2013;26:193–6. <https://doi.org/10.1016/j.aucc.2013.04.003>
9. Delphin-Rittmon ME, Andres-Hyman R, Flanagan EH, Davidson L. Seven essential strategies for promoting and sustaining systemic cultural competence. *Psychiatr Q.* 2013;84:53–64. <https://doi.org/10.1007/s11126-012-9226-2>
10. Karmali K, Grobovsky L, Levy J, Keatings M. Enhancing cultural competence for improved access to quality care. *Healthc Q.* 2011;14(Spec No. 3):52–7. <https://doi.org/10.12927/hcq.2011.22578>
11. Dao DK, Goss AL, Hoekzema AS, Kelly LA, Logan AA, Mehta SD, Sandesara UN, Munyikwa MR, DeLisser HM. Integrating theory, content, and method to foster critical consciousness in medical students: a comprehensive model for cultural competence training. *Acad Med.* 2016. (Epub ahead of print) <https://doi.org/10.1097/ACM.0000000000001390>

12. Swanberg SM, Abuelroos D, Dabaja E, Jurva S, Martin K, McCarron J, Reed-Hendon C, Yeow RY, Harriott MM. Partnership for diversity: a multidisciplinary approach to nurturing cultural competence at an emerging medical school. *Med Ref Serv Q.* 2015;34:451–60. <https://doi.org/10.1080/02763869.2015.1082379>
13. Shankar PR, Balasubramanian R, Dwivedi NR, Nuguri V. Student feedback about the integrated curriculum in a Caribbean medical school. *J Educ Eval Health Prof.* 2014;11:23. <https://doi.org/10.3352/jeehp.2014.11.23>
14. Shankar PR, Rose C, Toor A. Student feedback about the medical humanities module in a Caribbean medical school. *Edu Med J.* 2016;8:41–53. <https://doi.org/10.5959/eimj.v8i1.411>
15. Anonymous. Adapting to a new culture. [Accessed Oct 24 2016]. Available from: <http://internship2industry.eu/tools/Adaptingtoanewculture.pdf>
16. O'Carroll AM, Westby EP, Dooley J, Gordon KE. Information-seeking behaviors of medical students: a cross-sectional web-based survey. *JMIR Med Educ.* 2015;1:e4.
17. Venkatesh S, Chandrasekaran V, Dhandapani G, Palanisamy S, Sadagopan S. A survey on internet usage and online learning behaviour among medical undergraduates. *Postgrad Med J.* 2016. <https://doi.org/10.1136/postgradmedj-2016-134164>
18. Reitmanova S, Gustafson DL. “They can’t understand it”: maternity health and care needs of immigrant Muslim women in St. John’s, Newfoundland. *Matern Child Health J.* 2008;12:101–11. <https://doi.org/10.1007/s10995-007-0213-4>
19. Miller S. Cultural humility is the first step to becoming global care providers. *J Obst Gynecol Neonatal Nurs.* 2009;38:92–3. <https://doi.org/10.1111/j.1552-6909.2008.00311.x>
20. Kasper J, Greene JA, Farmer PE, Jones DS. All health is global health, all medicine is social medicine: integrating the social sciences into the preclinical curriculum. *Acad Med.* 2016;91:628–32. <https://doi.org/10.1097/ACM.0000000000001054>
21. Berry JW. Immigration, acculturation, and adaptation. *Applied Psychol.* 1997;46:10. <https://doi.org/10.1111/j.1464-0597.1997.tb01087.x>
22. Whittal A, Lippke S. Investigating patients with an immigration background in Canada: relationships between individual immigrant attitudes, the doctor-patient relationship, and health outcomes. *BMC Public Health.* 2016;16:23. <https://doi.org/10.1186/s12889-016-2695-8>
23. Ewen SC, Barrett J, Paul D, Askew D, Webb G, Wilkin A. When a patient's ethnicity is declared, medical students' decision-making processes are affected. *Intern Med J.* 2015;45:805–12. <https://doi.org/10.1111/imj.12800>
24. Hagiwara N, Dovidio JF, Eggly S, Penner LA. The effects of racial attitudes on affect and engagement in racially discordant medical interactions between non-Black physicians and Black patients. *Group Process Intergroup Relat.* 2016;19:509–27. <https://doi.org/10.1177/1368430216641306>
25. Ohana S, Mash R. Physician and patient perceptions of cultural competency and medical compliance. *Health Educ Res.* 2015;30:923–34. <https://doi.org/10.1093/her/cyv060>

26. Basáñez T, Blanco L, Collazo JL, Berger DE, Crano WD. Ethnic groups' perception of physicians' attentiveness: implications for health and obesity. *Psychol Health Med.* 2013;18:37–46. <https://doi.org/10.1080/13548506.2012.672750>
27. Ferguson WJ, Candib LM. Culture, language, and the doctor-patient relationship. *Fam Med.* 2002;34:353–61.
28. Arif MO, Fatmi Z, Pardeep B, Ali T, Iqbal H, Bangash HK, Pervaiz R, Altaf H, Baba JA. Attitudes and perceptions about prenatal diagnosis and induced abortion among adults of Pakistani population. *Prenat Diagn.* 2008;28:1149–55. <https://doi.org/10.1002/pd.2144>
29. Sekoni AO, Jolly K, Gale NK, Ifaniyi OA, Somefun EO, Agaba EI, Fakayode VA. Provision of healthcare services to men who have sex with men in Nigeria: students' attitudes following the passage of the same-sex marriage prohibition law. *LGBT Health.* 2016;3:300–7. <https://doi.org/10.1089/lgbt.2015.0061>
30. Haney JL. Predictors of homo-negativity in the United States and the Netherlands using the fifth wave of the world values survey. *J Homosex.* 2016;63:1355–77. <https://doi.org/10.1080/00918369.2016.1157997>
31. Ogland CP, Verona AP. Religion and the rainbow struggle: does religion factor into attitudes toward homosexuality and same-sex civil unions in Brazil? *J Homosex.* 2014;61:1334–49. <https://doi.org/10.1080/00918369.2014.926767>
32. Koehn PH, Swick HM. Medical education for a changing world: moving beyond cultural competence into transnational competence. *Acad Med.* 2006;81:548–56. <https://doi.org/10.1097/01.ACM.0000225217.15207.d4>
33. Morrison E, Grbic D. Dimensions of diversity and perception of having learned from individuals from different backgrounds: the particular importance of racial diversity. *Acad Med.* 2015;90:937–45. <https://doi.org/10.1097/ACM.0000000000000675>
34. Krupat E, Pololi L, Schnell ER, Kern DE. Changing the culture of academic medicine: the C-change learning action network and its impact at participating medical schools. *Acad Med.* 2013;88:1252–8. <https://doi.org/10.1097/ACM.0b013e31829e84e0>
35. Kamaka ML. Designing a cultural competency curriculum: asking the stakeholders. *Hawaii Med J.* 2010;69(6 Suppl. 3):31–4.