Chapter 9
Using the Intercultural Development Inventory (IDI) With First-Year, Pre-Med Students:
Impacting the Human Side of Healthcare

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ABSTRACT

Medical education emphasizes cross-cultural training programs to meet the needs of diverse patients and understand social determinants of health as root causes leading to healthcare disparities. The question remains about how to best accomplish this in the curriculum. Students in pursuit of medical education need intercultural training early to examine implicit biases, treat the patient not just the disease, and become patient advocates before they practice. This chapter addresses critical issues related to the human side of healthcare. The Intercultural Development Inventory® (IDI®) and accompanying reflection prompts were administered to 40 pre-med students. Findings revealed students overestimated their intercultural understanding and 97.5% had monocultural mindsets. Six themes demonstrated how the IDI® can be used to develop critically reflective future healthcare providers: Reframing Reactions, Lack of Exposure to Other Cultures, Lack of Cultural Self-Awareness, Bi-cultural Identity and Fitting In, Healthcare Connections, and Diversity and University Opportunities.

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INTRODUCTION AND BACKGROUND

More than 40% of the United States population will be comprised of minorities by 2030; and 20% of the United States population does not currently speak English at home (Price, 2019). Literature in medical education has emphasized the need for cross-cultural training programs to meet the needs of increasingly diverse patient populations (Jernigan, Hearod, Tran, Norris, & Buchwald, 2016). Additionally, training programs that focus on health equity have been recommended to understand social determinants of health as root causes of structurally embedded healthcare disparities (Tervalon & Murray-Garcia, 1998). Social determinants of health are defined as the "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Office of Disease Prevention and Health Promotion, 2019). Studies show that 80% of healthcare outcomes involve the influences of social determinants (Heath, 2019). Relatedly, patients often report that these determinants aren't acknowledged, leading them to feel a lack of respect from healthcare providers. Yet the question remains about how to best address these problems. Social determinants of health and health equity are essential topics in the medical school curriculum so students can develop the necessary competencies to reduce health disparities. The long-standing argument is that the science-heavy curriculum is too full to incorporate this material. Wear, Zarconi, Aultman, Chyatte, and Kumagai (2017) purport that the existing medical education curriculum actually inadequately addresses healthcare disparities. Furthermore, she maintains that a "silent curriculum" exists in which individual bias is invisible--and individual bias can affect health outcomes. Attending one-off trainings or including a lecture into coursework will not effectively address this problem (Mgbako, 2019). Intercultural understanding is also not simply acquired with experience as many assume.

The extant medical education literature does not adequately address these topics with pre-med undergraduate students (Lin et al., 2013). This chapter seeks to address that gap as a critical issue related to the human side of healthcare. The authors introduce the use of the Intercultural Development Inventory®, commonly referred to as the IDI®, as an innovative training tool for developing intercultural competence. Findings of this study demonstrate merit for using the IDI® in medical education training programs to increase student's cultural self-understanding, identifying blind spots and implicit biases, and shifting student's mindsets to become more empathetic to cultural differences in others. Empirical evidence has demonstrated that "what happens to students prior to entering medical school affects their performance during medical school and beyond" (Lin et al., 2013). The addition of the IDI ® to curriculums is only one component to a more complete system of medical education; yet when done in the early years of pre-medical education, it can offer students an opportunity to reflect and then develop their cultural readiness before entering medical school. Waiting until students in pursuit of medical education have achieved their goal of becoming a practicing physician is too late. The curriculum must evolve to address the diversity that exists in 21st century healthcare.

Medicine is constantly changing and the 21st century physician will be different than that of the past. When the MCAT underwent its' 5th revision in 2015 to focus on psychological, social and behavioral foundations of behavior, it became clear that addressing the human side of healthcare is a priority. "If members of the professional school admissions committee truly desire humanists, the hard numbers [GPA and test scores] can be but one aspect of the selection process" (Solomon, 2016, p. 17). Becoming the best, most compassionate, and respectful doctor is more than the Flexner report's prescription for rote science memorization (Morris, 2016). The wide acceptance of holistic admissions policies has been one way that medical education has changed to create more diverse environments. "In fields such as health-

care, diversity literally saves lives. Prior research has shown that diversity ensures better access to care, improves the quality of care, and strengthens trust between patients and providers" (Ono, 2016, para 5).

Still, transformation of medical education involves more than changing a test or admission processes. "As more and more campuses incorporate diversity training programs into their undergraduate curriculum, the IDI® is one of the most valid and reliable instruments currently available to the education community to assess the efficacy of such programs" (Wabash College, 2019).

Medical educators should invite lasting change with students by pushing them out of their comfort zones early (Barnes & Souza, 2019). Students pursuing healthcare careers need training to listen to cultural differences while understanding our common humanity, particularly in today's polarized political climate where a lack of civil discourse has been heavily documented. One study documented that patients have approximately 11 seconds to explain the reasons for their visit before they are interrupted by their doctors (Singh Ospina, et al., 2019). Culturally responsive patient care requires active listening. Pre-med students are capable of developing these professional skillsets as early as their freshman year. "This empathy can be learned, and the structure of medical training programs should include more strategies to traverse these differences" (Mgbako, 2019).

Due to the increased emphasis on the human side of healthcare in medical education, more practicing physicians are speaking up and sharing personal reflections about the importance of building trust with patients and connecting across cultural differences. Critical reflection is defined by first identifying gaps in one's knowledge and then seeking ways to close this gap (Ash & Clayton, 2009). Doctors are leading the way by calling into question their own privileges, implicit bias, and behavior. For example, Cohan (2019) writes,

If I truly want to be part of the solution, I need to explore those parts of me that are most unwholesome, embarrassing, unflattering, and generally not discussed in the context of one's career. My goal is to dismantle the insidious thoughts that reinforce a hierarchy based on race, education, and other markers of privilege that separate me from others. These thoughts, fed by implicit bias, are more common than I find easy to admit. Although I know not to believe everything I think, I also know that thoughts guide attention, and attention guides actions. Until I bring to light and hold myself accountable for my own racist tendencies, I am contributing to racism in health care (p. 806).

Medical education training programs that prioritize critical reflection must be created. If physicians know themselves well, they can practice better self-care, in turn affecting the disturbing trend of physician burnout (Ariely & Lanier, 2015). The practice of critical reflection for healthcare providers may even make them more resilient (West et al., 2014). In short, critical reflection is a necessary part of cultivating tough-to-teach 21st century skills like cross-cultural communication that are highly valued in healthcare providers.

The renowned patient advocate and global health expert, Dr. Paul Farmer argued, ''Medical education does not exist to provide students with a way of making a living, but to ensure the health of the community. Physicians are the natural attorneys of the poor, and the social problems should largely be solved by them'' (as cited in Verghese, 2003, para. 6). Given this, it is the authors contention that students in pursuit of medical education should have formal training in intercultural preparation as early as possible. This way they can take the first steps towards examining their implicit biases and prepare to treat the patient and not just the disease. Hopefully this leads to becoming advocates for under-served patient populations (Levinsohn et al., 2017). The concept of implicit bias has gained recent attention

in medical education (IHI Multimedia Team, 2017). Implicit bias is something everyone experiences and should therefore be addressed as a concept to be explored in without guilt and with responsibility in mind (Sukhera & Watling, 2018). Additionally, the concept of medical professionalism has evolved to include conduct that protects "patient welfare, patient autonomy, and social justice" (DeAngelis, 2015). With medical education paying increased attention to impacts on the human side of healthcare, the art and science of medicine must come together early. Students can then recognize the importance of being both a scientist *and* a humanist. Seeing patients as fully human requires listening, empathy, critical reflection, and perspective-taking across cultural differences. In summary, this topic is important because increasingly diverse patient populations require that physicians have an understanding of social determinants of health, implicit bias, health disparities and equity, and intercultural understanding to build trust and mutual respect. For physicians to lead in a culturally diverse and globally interconnected world, they need to commit to a lifelong process of critical reflection on the human side of healthcare; and that should begin as early as possible in their medical educational training.

POTENTIAL SOLUTION: IMPLEMENTING CROSS-CULTURAL ASSESSMENTS

Implementation of a cross-cultural assessment tool during the medical education journey can help establish a baseline for developmental growth and be an effective way to promote critical reflection related to diverse patient care. Yet many training programs omit these tools, even though employers consistently state they need employees with excellent soft skills like the ability to adapt, communicate, collaborate, and problem-solve across differences. In fact, intercultural awareness is ranked as #4 in the top 10 work skills needed for the future (Institute for the Future, 2011). However, most people do not receive any formal training or education to become interculturally effective. These skills are now more essential than soft (Blumenstyk, 2019). Students must obtain them during their undergraduate education to sustain the pipeline into medical school and then succeed in the workplace afterwards. With medical schools placing a growing emphasis on soft skills, some form of baseline assessment is necessary.

Cross-cultural assessments typically measure cultural competence. Cultural competence is defined as "having the knowledge, understanding, and skills about a diverse cultural group that allows the health care provider to provide acceptable cultural care" (Giger et al., 2007, p. 100). There are numerous cross-cultural assessments, including but not limited to, Cultural Intelligence (CQ), Inclusive Behaviors Inventory (IBI), Harvard's Implicit Association Test (IAT), and the Intercultural Development Inventory® (IDI®). Situational judgment tests, like the Computer-Based Assessment for Sampling Personal Characteristics (CASPer®), are also used in some medical school admissions and assess soft skills related to cultural understanding such as communication, empathy, equity, and ethics. This being said, the American Council of Education's working group on intercultural learning was charged with researching 20 assessment instruments and concluded that the IDI® was 1 of only 2 assessments that met their standards (Intercultural Development Inventory®, 2019). Moreover, The Society for Education, Training, and Research found that the IDI® was the most widely used assessment tool by professionals in the intercultural field (IDI®, 2019). According to the IDI®'s website, there are over 60 IDI®-related published articles and 80 PhD dissertations completed using the tool.

For the purposes of this research study, authors used the term "cultural humility" with student participants rather than cultural competence because the word "competence" conveys there is an end point. However, actively engaging with cross-cultural learning is a lifelong process of reflection and self-

critique that requires humility (Tervalon & Murray-Garcia, 1998)). Cultural humility involves critically reflecting on our limitations as an opportunity to develop rather than trying to become fully competent or an expert in someone else's culture. This critique of cultural competence led to the discovery of the term, "intercultural competence." Bhawuk & Bruslin (1992) said, "To be effective in another culture, people must be interested in other cultures, be sensitive enough to notice cultural differences, and then be willing to modify their behavior" (p. 416). Intercultural competence is defined as appropriate shifting of one's mindset and behavior based on successful navigation and bridging of commonalities and differences to incorporate multiple perspectives into one's worldview. It relates to one's "capacity to generate perceptions and adapt behavior to cultural context" (IDI®, 2019). While the word competence is used, the emphasis is developmental in nature and places onus on the person for intentional growth. The IDI® measures intercultural competence and can help medical educators gain a better understanding of how to achieve diversity and inclusion goals. Corporations, non-profit, organizations, governmental organizations, primary/secondary schools, and colleges and universities use the IDI®. By examining intercultural competency from a developmental perspective, training can be targeted better based on where the individual or group is developmentally situated towards a deeper understanding of cultural differences.

UTILIZING THE IDI® AS A CROSS-CULTURAL ASSESSMENT TOOL

The IDI® is an online psychometric assessment that can be completed in 20 minutes. To be clear, the IDI® is not a personality test or opinion survey. It is a scientific test that calculates developmental mindsets, not typological traits or skills. It costs $12 each for the student version of the assessment. The IDI® centers understanding "culture" as the starting point for all intercultural efforts. Therefore, respondents are asked to think about which culture groups they feel they belong to first. The assessment asks respondents to think of a culture with which you have had personal, direct experience that has shaped how you experience the world. The IDI® includes 50 statements that track rigid to complex thinking patterns about cultural difference and are scored on a five-point Likert agreement scale. After the 50 statements, the IDI® also includes four open-ended contexting questions that allow respondents to describe their intercultural experiences:

Contexting question 1: What is your experience across cultures?
Contexting question 2: What is most challenging for you in working with people from other cultures?
Contexting question 3: What are key goals, responsibilities or tasks you and/or your team have, if any, in which cultural differences need to be successfully navigated?
Contexting question 4: Please give examples of situations you were personally involved with or observed where cultural differences needed to be addressed within your organization, and: • The situation ended negatively—that is, was not successfully resolved. • The situation ended positively—that is, was successfully resolved.

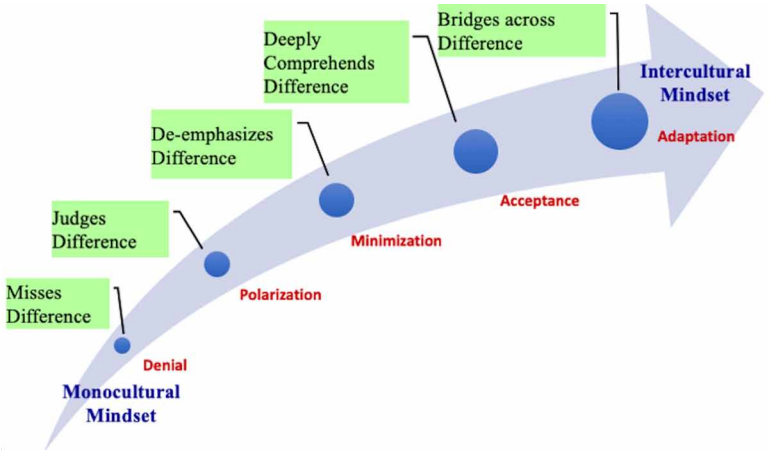
The IDI® must be purchased and administered by a Qualified Administrator (QA). Qualified Administrators also have the ability to add up to six unique multiple-choice questions. One can become a QA by undertaking the Qualifying Seminar which requires taking the IDI® assessment, participating in a debrief, and completing other training materials including authorizing a licensing agreement to use

the tool ethically and appropriately. Upon completion of the assessment, a customized, graphic IDI® profile report and an actionable intercultural development plan (IDP) with suggestions for growth are generated by the QA and distributed by email to the respondents. The QA also provides feedback in an individual or group debrief session. An IDI® profile report may not be distributed without feedback. The IDI® profile is confidential unless the respondent shares it.

The IDI® statements are categorized into different constructs that are organized into 1 of 5 orientation scales on the Intercultural Development Continuum (IDC): 1) Denial, 2) Polarization, 3) Minimization, 4) Acceptance, and 5) Adaptation. These orientations explain how individuals and groups make meaning of and behave in their interaction with cultural differences. Orientations move from monocultural/ethnocentric to intercultural/ethno-relative. Monocultural mindsets are characterized by making sense of cultural differences/commonalities based on one's own cultural values/practices. Intercultural mindsets are characterized by making sense of differences/commonalities based on one's own and others culture values and practices. Individual profile results communicate the perceived orientation (PO) where they place themselves and the developmental orientation (DO) where the IDI® actually placed them on the IDC, in order to determine a meaningful difference. The key factor is that people engage difference from their developmental orientation (DO). The IDP gives participants a chance to clarify intercultural goals that are important and leads to positive action plans. Figure 1 illustrates the IDC, provides a brief explanation of each orientation, and distinguishes between monocultural mindsets at the bottom and intercultural mindsets at the top.

Denial is characterized by two parts: disinterest and avoidance. Those in Denial have limited experience with other cultural groups and tend to ignore or avoid cultural difference. Often, they use stereotypes about the cultural other. The goal for those with a Denial orientation is to recognize observable cultural differences like food or music and also behaviors they have in common with other cultures. The following sample IDI® statement illustrates Denial: "People should avoid individuals from other cultures who behave differently." The next IDI® orientation is Polarization. Those placed in Polarization judge differences as "us vs. them." Polarization can be experienced in two ways: Defense and Reversal. Polarization Defense occurs when individuals view their culture as superior and cultural difference as threatening to their own way. Someone in Polarization may agree with the following sample IDI® statement: "Our culture's

Figure 1. Intercultural Development Continuum



way of life should be a model for the rest of the world." Polarization Reversal is when an individual is overly critical of their own culture and uncritical towards other cultures. This sample IDI® statement, "People from our culture are less tolerant compared to people from other cultures" represents Polarization Reversal. A goal for people in Polarization is to encourage recognition of when they may not fully understand difference and may be overemphasizing it. Minimization is the most common orientation and focuses on cultural similarities and universal values while masking differences. This is a transitional orientation and can take on different meaning depending on one's positioning as part of a dominant or non-dominant group. Dominant groups can hyper-focus on similarities, while non-dominant groups may minimize difference to blend in as a survival strategy. Overall, those in Minimization "go along to get along." A participant in Minimization is likely to agree with the following sample IDI® statement: "Our common humanity deserves more attention than cultural difference." The goal for people in Minimization is to facilitate a deeper cultural self-understanding along with trying to draw out and identify differences.

Acceptance is the first orientation with an intercultural mindset, meaning the cultural values of others are taken into consideration along with their own. Those in Acceptance see commonality amongst cultures and appreciate cultural differences. Difference feels understood, but not fully engaged. They see other's perspective as valid but may still lack the ability to appropriately adapt to cultural difference. Here is a sample IDI® statement that reflects Acceptance: "I evaluate situations in my own culture based on my experiences and knowledge of other cultures." Adaptation is the final intercultural orientation on the IDC. Those in Adaptation value and fully engage cultural diversity while utilizing strategies to adapt their perspectives and behaviors in a culturally appropriate way. This is a sample IDI® statement representing Adaptation: "When I come in contact with people from a different culture, I find I change my behavior to adapt to theirs." In summary, Denial, Polarization, and Minimization orientations are monocultural mindsets. Acceptance and Adaptation orientations are as intercultural mindsets.

In addition to the assignment of orientations, the IDI® calculates a Cultural Disengagement score between 1.0-5.0. Cultural Engagement measures a person's sense of disconnection from their primary cultural group. Those who fall below a 4.0 are classified as unresolved, while participants with scores of 4.0 or higher are classified as resolved. Cultural Disengagement is not part of the IDC. An IDI® sample statement that gauges a participant's Cultural Disengagement is: "I do not identify with any culture, but with what I have inside." In May 2019, the IDI® is making changes and Cultural Disengagement will no longer be included so that the debrief can focus on their developmental orientation. In summary, implementing a cross-cultural assessment tool like the IDI© during the medical education journey is recommended as a first step to address the lack of training and intentional opportunities to critically reflect on diverse patient care. The results of this study demonstrate it is an effective way to bring about desired change.

FINDINGS FROM THE USING INTERCULTRAL DEVELOPMENT INVENTORY IDI®

The primary author of this chapter is a QA and administered the IDI® with 40 first-year, Medical Science majors who identify as pre-med at a large, public, urban research university. All students were enrolled in an Exploring Health Professions course as a required part of their major. The goal was to help them explore how they adapt across cultural differences as future healthcare providers. All research activities were approved by the university's Institutional Review Board. Thirty-nine students signed consent forms

to participate. The population was high achieving as measured by admissions criteria to their major including minimum ACT score of 29/SAT score of 1360 and high school GPA of 3.5 or above. They were mindful that there might be a desire to achieve the top point of the IDC continuum. The process was confidential. Participants were not expected to share their results with one another. Ninety-seven percent of participants were ages 18-21. United States was the primary country of citizenship for 92% of participants. 10% of participants had lived in another country for 1-2 years.

After taking the assessment, students received their IDI® results and Individual Development Plan (IDP) by email. They were asked to complete a reflection assignment to 1) consider what their results mean 2) share insights about their goals and challenges, and 3) list 3 intercultural goals they would like to accomplish next. The reflections were made anonymous and used as data. The last step in the research design was to provide a group debrief which is mandated by the IDI®. The group debrief took place in the classroom where group's perceived and developmental orientation, cultural engagement, and contexting question results were presented. Students were encouraged to discuss their thoughts and feelings about the results and what they plan on doing in response. Using the IDI® provided a shared language.

Figure 2 displays the student's perceived orientations. Figure 3 presents their developmental (actual) orientations. The orientation gap between their perceived and developmental orientation is indicated on a scale of 55-145 in Figure 4. A gap of 7 points on the scale is significant.

These results showed significant overestimation of their developmental orientation and that 97.5% of students have a monocultural mindset. This means they have a less complex perception and experience of cultural difference. Overpredicting one's mindset is common because people generally think of themselves as accepting of others. They equate being exposed to differences as being interculturally competent, especially if they have life experience, have traveled, or moved a lot. Participant 34 illustrated this assumption: "*My family did take frequent vacations, visiting places like Canada, Mexico, France, Germany, Czech Republic etc. I considered myself cultured after being exposed to so many.*"

This is why it is important to highlight the IDI® as a developmental tool from the beginning. It is also critical to emphasize the curiosity and humility required in this process upfront. Because the IDI® placed the majority (59.5%) of students in Minimization, the class debrief was helpful in processing that in the United States, many people are raised to believe that "*everyone is equal regardless of race, color, creed, or sexual orientation"* (Participant 29). This can lead to an overemphasis on searching for

Figure 2. IDI® group results: perceived orientation

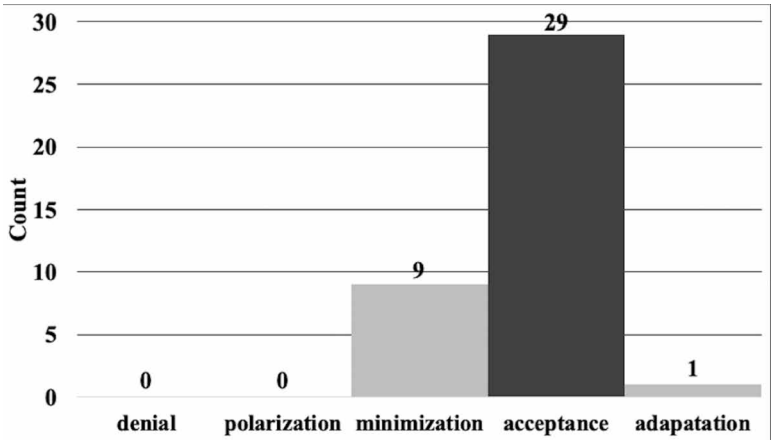
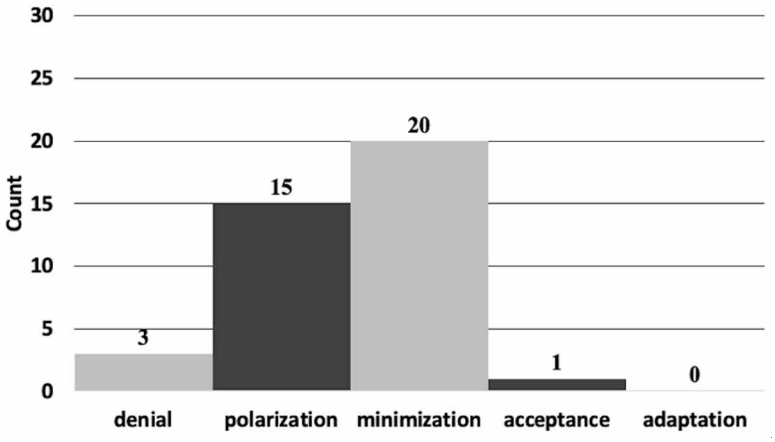


Figure 3. IDI® group results: developmental orientation



commonalities and downplaying differences. Participant 8 shared a thoughtful reflection on Minimization when stating, *"I still believe the common unity all people share through humanity is important, but I now understand that the recognition of the diversity and differences among cultural values are just as vital, if not more."* Participants need to have time and space to process to critically reflect after they have taken the assessment.

The Cultural Disengagement group score result was 3.76 of 5.0, indicating some lack of connection with a primary cultural community. The pie chart in Figure 5 represents the percentage of individual students who are resolved (no sense of disconnection) and unresolved (sense of disconnection).

Participant 8's cultural engagement score was 3.2 of 4.0 and wasn't surprised. This student stated, "*I've never truly felt a part of any one culture. This lack of belonging is a contributing factor to why I cast cultural distinctions aside at times*."

The QA added 3 additional questions regarding influences on intercultural development, why intercultural awareness is important to their future healthcare career, and whether they think they had a monocultural or intercultural mindset coming into college. The bar chart in Figure 6 shows 50% percent of students said intercultural awareness is important to their future healthcare career because it will allow them to achieve the best health outcomes for patients, indicating that students see the clear connection to their future healthcare careers. The bar chart in Figure 7 shows education was found to have the most significant influence on shaping their intercultural development, with family not far behind. Knowing the influence education has on intercultural growth is important because integration of the IDI® into curriculum could add impact.

Figure 4. Group orientation gap. adapted from group profile ©1998-2019, IDI®, LLC.

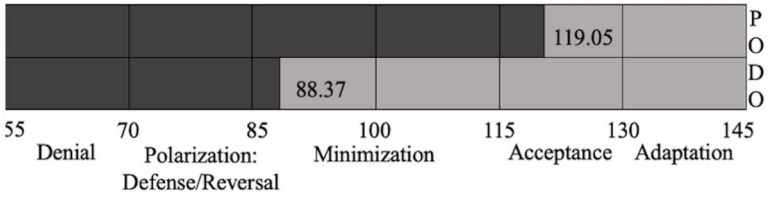
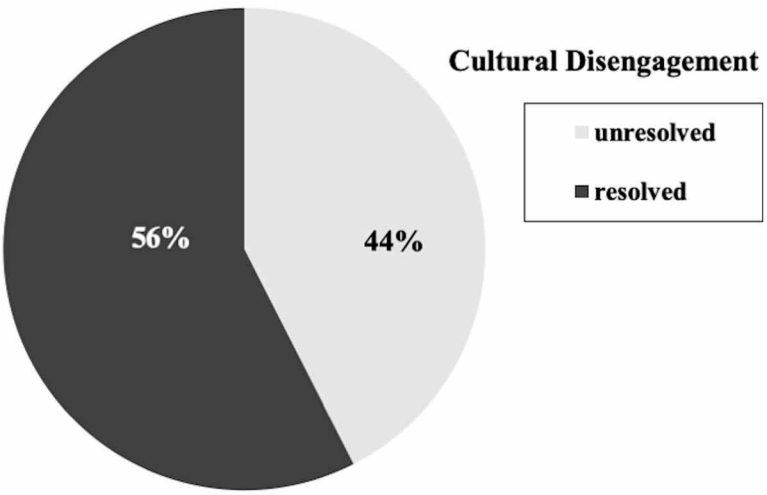


Figure 5. Cultural disengagement results



In the final stage of data analysis, authors reviewed reflection responses regarding the student's IDI® results. The three reflection prompts were: 1) consider what your results mean 2) share insights about your goals and challenges, and 3) list three intercultural goals you would like to accomplish next. The responses were analyzed for repetition of key words to identify similarities across experience. Codes were denoted in the transcripts to determine context and as a way to generate themes. Six themes were identified as salient in demonstrating how the IDI® can be used to develop critically reflective future healthcare providers: *Re-framing Reactions, Lack of Exposure to Other Cultures, Lack of Cultural Self-Awareness, Bi-cultural Identity and Fitting In, Healthcare Connections, and Diversity and University Opportunities.*

Figure 6. Reasons to value intercultural development. Adapted from the group profile provided by ©1998-2019, IDI®, LLC

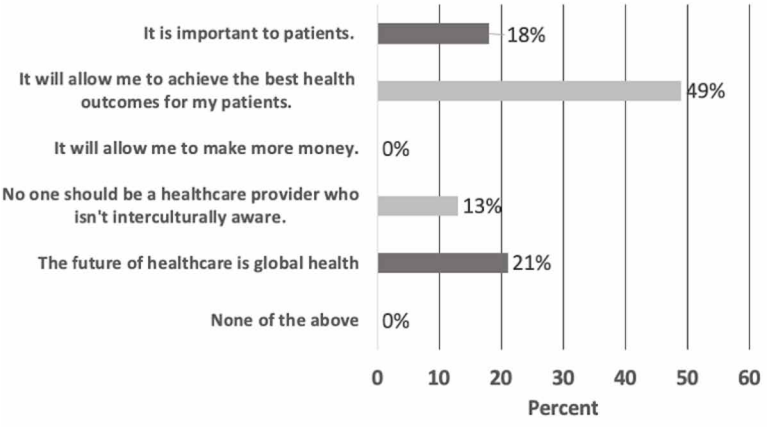
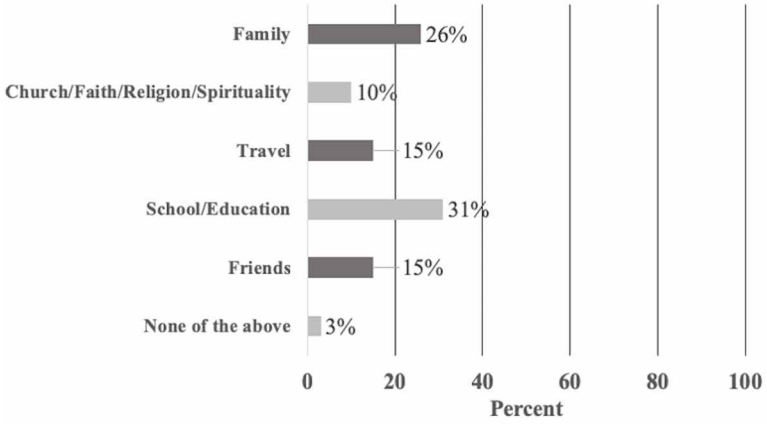


Figure 7. Influences on intercultural development. Adapted from the group profile provided by ©1998-2019, IDI®, LLC



Reframing Reactions

Students experienced an initial uncomfortable reaction to their IDI® results because it was not what they expected. In fact, 28% of students used the word "*surprised*" as their specific reaction. Other reactions included response words like, "s*hock, stunned, concerned, upset, appalling, embarrassed, discouraged, confused, insecure, and defensive*." Participant 12 did not agree with the results. Other students called it "*a wakeup call,*" "*eye opener,*" and "*metaphorical smack in the face*" (Participants 8, 15, 29). For instance, participant 27 said, "*Before this, I believed as long as you acknowledge cultural difference, it was okay to ignore it. I need to learn how to adapt to other people's expectations."* With the opportunity to reflect, students were able to re-frame the results in a more open-minded way and showed flexibility when changing how they viewed their results. Some even began to agree with their results. For instance, many students conveyed surprise because they thought they were "*a very open person when it came to culture*" or because they "*try to be an inclusive and accepting person*" (Participants 20, 16). Overall, the range of emotions involved some skepticism and nervousness before they took the IDI®, but moved towards a deep interest in the opportunity to grow interculturally. This reframing example is from Participant 7 in Polarization:

When initially reading my IDI® report, I denied the fact that my cultural competence could fall in such an exclusive mindset—one that critically evaluates my own culture or another culture. I do not actively discriminate or regularly compare my own culture and self to the cultures and beings of people around me (especially to people unlike me), but I realized I may subconsciously engage in such prejudices. Trying to find and explanation for this, I considered my upbringing; for my entire youth, I lived in suburbs with people just like me. My neighbors went to the same school as I did, spoke the same language as I did, and had similar backgrounds (in terms of family and experiences) as I did. With an unvaried environment, I understand how I could have slipped in a mindset that polarizes my cultural competence.

A second reframing example from Participant 17 in Minimization represents the common assumption that intercultural awareness just happens without intention:

I felt that I would be higher because I have lived abroad for two years in Turkey, and I have also taken 5 years of Spanish. However, I was only 8 when I lived in Turkey, and most of my life was spent on an Air Force Base surrounded mostly by other Americans. Overall, while I was upset when I originally read the report, I find myself excited for the future, as it means I am not starting off in a bad place, and I can only improve myself from here.

Overall, the fact that first-year pre-medical students were able to reframe their reactions to results as a learning opportunity to grow rather than resisting and shutting down was one of the most significant and promising outcomes of the study. Evidently, they may be a desirable population to work with on this topic because of their strong motivation to achieve as illustrated by Participant 21's reflection: "*I am going to try to hold on to my indignation from when I first got my results and strive to improve myself instead of remaining stagnant*." Intercultural growth includes personal discomfort and medical educators must ask their students to rise to the occasion.

Lack of Exposure to Other Cultures

Many students cited an absence of surprise at their results due to lack of exposure to cultural difference prior to coming to college. *For instance, Participant 30* "*grew up in a homogenous region*" and Participant 13 *shared, "because I grew up in a predominantly White, Christian atmosphere without much exposure to other cultures, I can partially understand these results."* Participant 16 even cited the media: "*I am not surprised by my results. I recognize I have a level of cultural ignorance due to where I lived, how I was raised, and ideas imprinted on me by the media growing up*." Again though, students were able to reframe their results as a learning and growth experience.

This quote exemplifies how Participant 14 took accountability for the results despite a lack of exposure to cultural differences:

My first reaction was to make excuses for myself. I come from a small town, where everyone is primarily White, straight, middle-class, and Republican. I tried to tell myself that I haven't been exposed to cultures to possess an intercultural mindset. But then I realized I can't make excuses because there are all kinds of cultures out there. Men and women deal with situations differently. There are mannerisms that older people care about more than younger generations that I have witnessed in my part-time high school job. Just because where I grew up isn't considered racially diverse doesn't mean I have any reason not to develop an intercultural mindset.

Some students indicated they need additional support on how to navigate communicating across difference. For example, Participant 5 stated, "*A lot of the time a conversation with someone of a different culture is difficult because I don't know the right questions to ask or I don't want to offend the person.*" Still others realized culture is more than surface-level objective artifacts when saying, "*I want to learn more about other cultures on a deeper level than just how they eat and dress*" (Participant 14). Many students cited their lack of exposure to racial diversity in particular and named being from predominately White backgrounds. In the end, cultural "other" awareness was recognized as important and the desire to see new perspectives showed the development of empathy.

Lack of Cultural Self-Awareness

"*Before now I never really thought about my own culture*" (Participant 5). "*I never previously thought about what my culture was and how it affected me*" (Participant 26). "*I don't really know what my own culture is*" (Participant 28). Different than the lack of exposure to other cultures, these quotes were indicative of another salient theme, lack of cultural self-awareness. Students who fell into this category realized they "*need to be aware of what is important to me and how my culture has influenced my worldviews before I can begin to understand other cultures*" (Participant 17). Participant 18 wanted "*to look further into how my culture treats other cultures*" and provided examples of joining cultural affinity groups on campus like the Muslim Student Association. Participant 15 expressed a desire to "*travel around Ireland to truly understand where my family comes from, and how growing up Irish Catholic has affected me into the present day."* Participant 25 explored more dimensions of cultural self-awareness when stating,

The most important thing I need to do is feel connected to a culture before I can fully comprehend other cultures. Therefore, to connect to a culture I need to look deeper than my ethnicity. Currently one of the most significant aspects is my sexual orientation. Being bisexual I feel most connected to the LGBT community. Throughout my time at the university, I want to get more involved in this community, so I can have a group of people like me. Once I have a group that I relate to, I will be able to better comprehend other culture.

Participant 12 mentioned, *"College is the first time I have actually formed relationships with people of other cultures, because where I'm from, there aren't other cultures."* The premise of the IDI® is every individual has a culture(s). These reflection prompts are part of the debrief process and provide an opportunity to discuss how students define their own culture. It might also be an opportunity to discuss how students might conflate culture with race or ethnicity. According to American Association of Medical Colleges [AAMC] (2018), about half (49.6%) of United States medical school matriculants self-identify as White. It would be interesting to determine if they also self-identify with White culture or acknowledge the homogeneity of their experiences as many have done in this study.

Without taking the IDI®, students would not have been faced with having to ask themselves these tough questions about their own culture. Participant 25 shared, "*Taking the IDI® caused me to truly think about how I view other cultures and how I even look at my own culture."*

Bi-cultural Identity and Fitting In

23% of participants identified as having a bi-cultural identity. In some cases, having a bi-cultural identity led participants to overpredict their intercultural awareness. For example, Participant 20 stated, "*I am influenced by Indian and American cultures heavily, making it seem as if I would have a much higher developmental orientation score."* Participant 22 shared, "*Growing up in a household that grappled with balancing both Pakistani and American culture, I learned to be accepting of others as I understood the struggle of formulating an identity from two contrasting cultures."* Having a bi-cultural identity also played a role in processing why students may view one culture as superior over another. Participant 21 explains how bi-cultural identity can feel contradicting and makes sense of the Polarization mindset:

I am now more aware that I see my Korean culture and American culture separately which probably is where the us versus them judgment came from. I was immersed in the Korean culture at home and at church while I was immersed in the American culture at school. I spend almost every summer in Korea and have a chance to really feel the culture in its origin. The experiences were really separate from each other and did not mix really well. The fact that my experiences with each culture were completely separate probably contributed to my developmental orientation. I need to challenge myself to bridge the differences in between them.

Participant's ownership of this identity helped process the results, particularly how the Minimization mindset overemphasizes similarities and downplayed differences. For instance, several students cited the interplay of national identities as Americans and ethnic backgrounds as Indian or Pakistani as leading them to constantly adapt to "fit in." Participant 1 shared,

These results reflect my own complicated history with integrating the different American culture that I grew up with everywhere and the Indian culture that followed me home whenever I visited India. Minimization occurs as a way to navigate different values and practices created by the dominant culture and this is why I struggled when I was younger. I would accept certain beliefs or ideas in school to 'get along' while trying to connect them to what I was told at home and because of that I masked the unique qualities teach culture has.

Participant 2 said,

Being that I was born into a Muslim household, the expectations for me differed between home, school, and friends—and I was many different people being pulled along. Because I was always surrounded by differences, I tried to find similarities between the people in my life to feel like there wasn't such a gap between what was expected of me and who I was depending on where I was.

Minimization is the most common orientation and is meant to be a transitional developmental stage. This approach of minimizing differences to blend in can be a survival strategy.

Healthcare Connections

Several students made the explicit connection between healthcare and intercultural awareness in their reflections. They addressed intercultural awareness as "*vital for providing quality healthcare"* (Participant 16). For example, Participant 7 opened the reflection by stating,

The concept of cultural competence in a medical setting proves itself a fundamental foundation for providing and encouraging proper patient care. One's religion, skin tone, accent, culture, orientation, and identification should never affect the distribution of individualized, reliable, and effective healthcare. As a future medical professional, I aim to increase my cultural competence so that I may perform my duties with utmost inclusiveness and the least biases.

Participant 10 stated, "*The ability to give the same care despite cultural, social, age or gender differences seems to me to belong in the category of medical professionalism.*" This focus on uniform and

equal treatment of patients indicates further conversation about health equity, but still showed progress in their thinking. Participant 10 made the connection between intercultural awareness and building trust with future patients:

My goal as a healthcare professional is to provide care to all individuals in a way that they are comfortable and don't have to worry about trusting me. I want my patients' only concern to be about improving their health. I don't want them to have to worry about any sort of disparity concerning their health on account of any cultural, social, gender age, difference. As a doctor, I will be seeing many different people from different cultures. My number one goal is to make sure every patient is comfortable and well taken care of. Having an intercultural mindset will be imperative in this goal.

This type of mature concern as a freshman points to the promise the IDI® has for developing future healthcare providers who identify as patient advocates. It is also worth noting that a few students made healthcare connections to global health. For example, Participant 8 stated, "*The future of health is global health. Mastering a global health mindset is incredibly important to being a health professional in this day and age."*

Diversity and University Opportunities

Students in this study were enrolled in a large, public urban, research university. Therefore, many of them discussed exposure to the university's *diversity as an opportunity to help them grow in their intercultural awareness. For example, students commented that the university "*is the perfect backdrop because of how ethnically diverse it is*" (Participant 1). Participant 29 stated, "*It wasn't until I arrived here at the university that I began to experience what diversity truly meant.*" The word "diversity" is denoted with an asterisk above because of the difference between the perception versus reality of diversity. In terms of race and ethnicity, the demographic data indicates the composition of Associate's and Baccalaureate degree-seeking students was 75% White; while 19.5% of faculty were considered minorities (University of Cincinnati's Office of Equity and Inclusion, 2018). Another student declared that "there are so many international students." The University of Cincinnati's Office of Institutional Research (2018) cites 7.7% of students are international students. Often dominant group cultures perceive that a large amount of diversity exists, but those in a minority culture do not experience the same perception. Sometimes perception can be the reality though. Therefore, what matters for the goal of this study is that the students thought that being at a university would allow them to take action on their intercultural growth. For instance, Participant 25 compared a lack of past exposure to difference to current opportunities:

I went to a predominantly White high school which caused me to experience practically no cultural diversity. Due to this, I was never able to fully develop intercultural competence while in high school. I can look back on this now and see what was wrong with that, but at the time I thought it was normal to go to school with people that are all the same. Now being at a university with significant amount of diversity, I will be able to improve my intercultural competence.

Overall, the size of campus is an advantage for allowing exposure to other cultures and as Participant 14 noted, "*Hopefully, attending a large school will give me many opportunities to meet many people*

from different cultures." In addition, opportunities to study abroad may be enhanced as a result of being at a large, public, research university as well.

Finally, students were asked what they would do next to grow in their intercultural awareness and to set 3 actionable goals to increase accountability. This aligned with the goals of the IDP which helps the participant understand that it's not only about what orientation the IDI® placed them in, but what they are committed to doing to develop their intercultural growth. Thus, the agency is on them. The IDP furthers the reflective process and specifies that 30-50 hours of concentrated effort can move people forward into a new orientation. Since many of the students made reference to a lack of exposure to other cultures and the IDI® placed the majority of them in Minimization, it made sense that most students' intercultural goal was to "*get out of their comfort zone*" and intentionally gain more interaction and engagement with cultures different than their own in a respectful way (Participant 20). Students wanted to attend programs and events and named LGBTQ, Hispanic, African American, and Indian cultural communities specifically, along with socioeconomically different youth. Traveling or study abroad ranked second highest with students noting place like Columbia, Africa, and Northern Asia as potential destinations. Participant 29 showed a depth of critical reflection related to this goal when saying,

I plan to research where I am travelling before stepping on the soil. My greatest fear is that I will be viewed as the stereotypical American tourist: someone who expects everyone to speak English, expects a McDonalds on every corner, and who views other cultures as taboo. I am going to do everything in my power to go in with an open mind and heart to every country.

Next many students wanted to deepen their own cultural self-awareness" (Participant 28). Some also cited reading more books, paying more attention to international news, or exploring arts, film, and music to understand cultural differences. Finally, a few students mentioned work on not making assumptions or using stereotypes. The goal setting reflection paired with the IDP supports the initiation of intercultural development efforts and is an important part of the assessment process.

FUTURE RESEARCH DIRECTIONS, LIMITATIONS AND RECOMMENDATIONS

There are limitations in this study. If the IDI® was administered to pre-med students at another type of university or from a population not considered 'high-achieving', their reflection on opportunities for intercultural growth might be different. While the participation rate was very high, another limitation is the small number of participants. As a mixed method study, the intent of this study was not to generalize findings from this pre-med sample, but rather to use this sample to describe how gaps in undergraduate and graduate medical school curriculums can be addressed using the IDI®. These results provide foundational knowledge from which further research can be developed. Finally, the IDI® must be ordered and administered by a QA. Institutions need to be willing to spend funding to hire a QA or to send a person to training. While this study explored use of the IDI®, it is only one example of the benefits of using a cross-cultural assessment tool to expand curricula. Other tools may be used as well.

Overall, participants were glad they took the assessment. They said things like:

- *I view my results as a baseline from which I can grow in my future career as well as in my life in general. I am excited to take my newfound awareness and implement my intercultural goals into my life* (Participant 8)
- *I am glad I got this information at this point in my education and in my life, so that by the time I get to the healthcare field, I can find myself being more aware and considerate of others from various backgrounds, as well as using my relative privilege to become an advocate for those in need of care* (Participant 30).

Therefore, it is recommended that future research studies like this be replicated, and a pre-and-post test of the IDI® be conducted so intercultural growth could measure progress over time. For example, it could be administered during undergrad, medical school, into residency, and even practice.

CONCLUSION

Below are key take-aways from this chapter:

1. The capacity for critical reflection is important in medical education. The results of this study reveal that students can develop this skill as early as their freshman year. They are capable of analyzing and re-framing their reaction in accordance with developmental feedback about their intercultural growth. This demonstrates flexibility and resilience. They also see the direct connection between intercultural understanding and their future healthcare careers treating a diverse patient population.
2. Practicing humility is a necessary part of intercultural development and growth. The results of this study signify that students can also exhibit this skill early. The philosophy behind the IDI® tool aligns with prioritizing humility because most respondents overestimate their intercultural developmental (actual) orientation. The concept of humility can be viewed as counter cultural in medical education because of the emphasis on training to become fully competent medical experts who shy away from acknowledging mistakes or failure.
3. The majority of students in this study overestimated their intercultural awareness, but also used it as an opportunity for growth. Most students were in Minimization and mentioned coming from homogenous backgrounds. Students in pursuit of medical education need early exposure to cultural diversity because the results of this study indicate many have been raised with a focus on treating people equally, which can lead to over-focusing on similarities. Exposure to perspective-taking of the cultural other can increase empathy and support future patient advocacy. These findings reinforce the importance of the holistic admissions process to increase diverse environments in medical education. Prior to coming to college, education was found to be the most significant influence shaping intercultural development. This carries forward as the university has been identified as an opportune place to intentionally take accountability for exposure to cultural difference.
4. Students with a bi-cultural identity may experience a struggle and overemphasize similarities as a way to fit in with the dominant culture.
5. Students in pursuit of medical education need time and space to develop their own cultural self-understanding. How can they achieve a deeper understanding of other cultures if they feel confused about which culture(s) they belong to?

6. The incorporation of an assessment tool in intercultural understanding is needed in medical education curriculums to determine baselines and benchmarking of growth over time. Because 31% of students remarked that education shaped their intercultural development before college, using the curriculum to continue that type of development makes sense. This study has shown that high-achieving students are motivated to intentionally develop their intercultural proficiency because of their drive for self-improvement.

All of these points relate to changes needed in medical education training programs and systems and impact the human side of healthcare. If medical education aims to improve the quality of diverse patient care and outcomes through creating self-aware physician leaders able to work across difference in today's polarized climate, it needs to evolve. What better time to explore these issues with students than as early as possible in their medical education journey? The expectation for future physicians can be set forward from the onset of the college experience. Conducting a cross-cultural assessment, like the IDI®, with students in pursuit of medical education can be a first step. This study has shown the efficacy of using the IDI® to provide an opportunity to pre-med students for critical reflection of their own intercultural experiences. This finding elucidates the influence the IDI® can have on the personal and professional development of future physicians. This significantly impacts their learning about human side of healthcare.

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KEY TERMS AND DEFINITIONS

Cultural Competence: Having knowledge, understanding, and skills to work effectively with diverse cultural groups.

Diversity: The presence of difference or representation in an organization.

Empathy: Connecting with a feeling inside of yourself to feel with other people.

Health Disparities: Preventable differences in health across many dimensions including race, age, gender, sexual orientation, class etc.

Implicit Bias: Unconscious prejudice and stereotyping of people.

Inclusion: Making sure diverse people count, feel valued and engaged.

Self-reflection: Introspective exploration of thoughts and feelings.

Social Determinants of Health: Conditions where people work, live, play, and pray that affect their health.

Social Justice: Equitable distribution of wealth, opportunities, and privileges.