

Cultural Appropriation for Improved Knowledge Acquisition in Medical Education [Letter]

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Dear editor

We thank the authors Ahmed et al for their insightful exploration into the impact of cultural variables on human behaviour. Their astute assessment of the potential efficacy of cultural appropriation in enriching medical knowledge acquisition and fostering transformative shifts in attitudes toward healthcare was enlightening. As students enthusiastic about medical education, we wish to offer our perspective.

It is noteworthy that the authors have assembled participants possessing attributes conducive to the study's objectives,¹ however, there was reliance on recruiting predominantly Middle Eastern individuals with a proclivity towards superstitions from a single Facebook page. This risks selection bias² that compromises the generalisability of the study's findings. The researchers could have diversified their recruitment strategies by employing targeted advertising across various social media platforms, establishing connections with local organisations and religious institutions, and offering incentives to entice participation from individuals who might not otherwise have volunteered.³ Through these diversified approaches, the authors could have attracted a more heterogeneous cohort of respondents representing diverse backgrounds and interests.

The researchers recruited many participants in the study, totalling a sample size of 986, which increased the generalisability of the results.⁴ They used both open and closed-ended questions as well as quantitative and qualitative techniques, providing an excellent basis for exploring the impact of these videos related to forensic medicine. However, the discussion omitted an examination of the validity and reliability of the tools used, and further compounded this oversight by neglecting implementation of randomisation⁵ and control groups, thereby potentially eliciting inherent biases.

Limitations of the study included an appreciation of the biases introduced. There was an acknowledgement and discussion of the practical implications of the findings for medical research and education. The survey comprehensively addressed a spectrum of items pertaining to cultural appropriateness, aligning with the study's objectives. Nonetheless, the exclusive utilisation of the chi-squared statistical test suggests the potential for alternative analyses that could have been employed.

The results of the study were from questionnaires completed by participants immediately after watching the videos, which introduces the possibility of measurement error. Responses may have been affected by social desirability bias or inaccurate recall. As the questionnaire was designed by the authors specifically for this study, the questions may not have been appropriately validated, potentially leading to misunderstanding of the questions and incorrect or inconsistent answers. Using a validated assessment and objective measures of knowledge retention could reduce measurement errors in the future. The study did not use a control group for comparison, nor was prior knowledge of the topic assessed, as acknowledged by the authors, which makes it difficult to judge whether the observed results were solely due to the use of the videos or if other factors were involved.

In conclusion, the study provides valuable insight into the role of cultural appropriation in medical knowledge acquisition. Although the sample size and methods provide a strong foundation for the study, there are concerns regarding selection bias and measurement validity. However, addressing these limitations will enhance future research in this area.

Disclosure

The authors report no conflicts of interest in this communication.

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