Applying Theory to the Design of Cultural Competency Training for Medical Students: A Case Study

Sonia J. Crandall PhD, Geeta George MPH, Gail S Marioni PA, PhD and Steve Davis MA


Abstract
Although literature suggests that providing culturally sensitive care promotes positive health outcomes for patients, undergraduate medical education currently does not provide adequate cultural competency training. At most schools, cultural competency, as a formal, integrated, and longitudinal thread within the overall curriculum, is still in its infancy. In this article, the authors summarize the current practice of cultural competency training within medical education and describe the design, implementation, and evaluation of a theoretically-based, year-long cultural competency training course for second-year students at Wake Forest University School of Medicine. Evaluation of the results indicate that the course was successful in improving knowledge, attitude, and skills related to cultural competence as well as bringing about positive changes in the medical school’s approach to cultural competency training. Also discussed are the implications of the outcomes for the development of culturally competent physicians and how using appropriate theory can help achieve desired outcomes.

Undergraduate medical education does not adequately prepare future physicians to understand how cultural influences a patient’s perception of disease and how perceptions affect treatment and, ultimately, quality of care. Evidence suggests that providing culturally sensitive care promotes positive health outcomes for patients. Although some cross-cultural medical education curricula date back to 1970, requiring cultural competency as a comprehensive curricular thread in undergraduate medical is mostly still in its infancy. However, medical educators and accreditation bodies are increasingly recognizing cultural competency as critical to the professional development of physicians. The Liaison Committee on Medical Education has taken a position in their accreditation standards that “The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students must learn to recognize and appropriately address gender and cultural bias in themselves and others, and in the process of health care delivery. The American Medical Student Association’s Promoting, Reinforcing and Improving Medical Education project (AMSA PRIME) has solicited requests for proposals from schools to pilot a cultural competency curriculum using the association’s established core competencies. The Accreditation Council of Graduate Medical Education and the Council on Graduate Medical Education are increasingly emphasizing the importance of cultural competency and will soon establish guidelines. Guidelines and competencies have already appeared for residency programs. The National Board of Medical Examiners will ultimately focus on cultural competency skill as one requirement for passing licensing exams.
In this article, we summarize the current practice of cultural competency training within medical education and describe the design, implementation and evaluation of a theoretically-based, year-long cultural competency training course for second-year students at Wake Forest University School of Medicine (WFUSM).
Are Residents More Comfortable Than Faculty Members When Addressing Sociocultural Diversity in Medicine?

Tricia S. Tang PhD, Mary Ellen A. Bozynski MD, MS, Joyce M. Mitchell MD, Hilary M. Haftel MD, Sarah A. Vanston and Robert M. Anderson EdD

Abstract

**Purpose:** Sociocultural medicine is a growing curricular area in medical education. Because faculty members and residents will teach these curricula and model these skills in patient care, it is important to assess their attitudes toward diversity. This study examined faculty members’ and residents’ attitudes toward sociocultural issues in medicine.

**Method:** In November 2000, 198 physicians from the Department of Pediatrics at the University of Michigan Medical School completed a questionnaire on demographics and sociocultural attitudes in medicine while they attended a department-wide retreat on cultural competency. A factor analysis of the sociocultural attitudes measure yielded five dimensions accounting for 70% of the variance. These factors included sexual orientation, diversity in professional functions, discussing race/ethnicity in teaching forums, clinical skills, and alternative medicine.

**Results:** Significant differences were found between faculty members and residents for sexual orientation issues ($t = 2.76, p < .01$) and alternative medicine ($t = 2.84, p < .01$), with residents endorsing greater comfort in these areas of patient care. When controlling for demographic/background variables, group differences disappeared. Past exposure to multiculturalism emerged as a significant predictor for both sociocultural attitude dimensions.

**Conclusions:** Findings suggested while residents felt more comfortable than faculty members did with sexual orientation and alternative medicine issues in medicine, attitudes may have been related more to previous diversity education than to seniority of the physician. Integrating diversity education within departments and across the medical education continuum likely benefits all physicians. In the area of sociocultural medicine, both faculty members and residents can offer perspectives valuable to medical students, colleagues, and the larger medical community.

As the US patient population grows increasingly diverse, accreditation committees for both undergraduate and graduate medical education (ie the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education) have recognized cultural diversity training as a necessary skill for delivering effective patient care. In response, medical educators have focused on developing and implementing effective curricula and training models to address the understanding, incorporation, and application of social and cultural factors in health, medicine, and patient care (ie sociocultural medicine).

Goals for most training models are to increase awareness of, sensitivity to, and knowledge about diversity issues in health and health care delivery. Given this
framework, a growing number of medical schools have incorporated curricula that aim to broaden students’ attitudes toward sociocultural aspects in medicine and to introduce how these issues may influence patient-physician communication, health behaviors, and treatment delivery. Although standardized evaluation of these curricula across medical programs is lacking, assessments of existing curricular experiences have reported changes in students’ attitudes and awareness in the positive direction.

While many sociocultural medicine curricula target medical students’ learning, less emphasis has been placed on training residents and faculty members regarding these issues. Clearly, the extent to which faculty members and residents acknowledge, understand, teach, and model social and culturally effective patient care will shape students’ attitudes and behaviors. To ensure an optimal learning environment for medical students, it is important to assess the attitudes of our teachers.

Few studies have examined sociocultural medicine training among medical school faculty members. However, one study conducted by Welch evaluated a three-part workshop series on cultural diversity and cultural competence for the department chairs and course directors of a major academic teaching hospital. Faculty evaluation of the workshop itself was generally positive. Qualitative feedback included holding workshops annually as well as developing department-specific workshops. Absent in the evaluation were baseline and follow-up measures of faculty members’ attitudes toward diversity issues in medicine. Without baseline data, the efficacy of these training programs cannot be accurately demonstrated.

The purpose of our study was to examine attitudes toward sociocultural issues in medicine among a large sample of physicians, to compare sociocultural attitudes between residents and faculty members, and to identify significant predictors of sociocultural attitudes.
Combating Effects of Racism Through a Cultural Immersion Medical Education Program

Peter Crampton PhD, Anthony Dowell FRCGP, Chris Parkin MA, and Caroline Thompson

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Abstract
The purpose of this paper is to provide a perspective from New Zealand on the role of medical education in addressing racism in medicine. There is increasing recognition of racism in health care and its adverse effects on the health status of minority populations in many western countries. New Zealand nursing curricula have introduced the concept of cultural safety as a means of conveying the idea that cultural factors critically influence the relationship between carer and patient. Cultural safety aims to minimize any assault on the patient’s cultural identity. However, despite the work of various researchers and educators, there is little to suggest that undergraduate medical curricula pay much attention yet to the impact of racism on medical education and medical practice. The authors describe a cultural immersion program for third-year medical students in New Zealand and discuss some of the strengths and weaknesses of such an approach. The program is believed to have great potential as a method of consciousness raising among medical students to counter the insidious effects of non-conscious inherited racism. Apart from the educational benefits, the program has fostered a strong working relationship between an indigenous health care organization and the medical school. In general, it is hoped that such programs will help medical educators to engage more actively with the issue of racism and be prepared to experiment with novel approaches to teaching and learning. More specifically, the principles of cultural immersion, informed by the concept of cultural safety, could be adapted to indigenous and minority groups in urban settings to provide medical students with the foundations for a lifelong commitment to practicing medicine in a culturally safe manner.

This paper provides a perspective from New Zealand on the role of medical education in addressing racism in medicine. Coker states ‘Racism and oppression are about the abuse of power that denies people dignity and choice’. Racism may take the form of ideological conviction that certain races are superior to others. However, racism may be more insidious if the abuse of power and the denial of dignity and choice do not flow from ideological conviction, but are mediated non-consciously through inherited mores and institutional structures. The consequences for the oppressed group may be similar regardless of the form of racism, but the attitudes, beliefs, and conscious motivations lying beneath the two forms may differ markedly and in ways that are relevant to medical educational goals and strategies. For example, although it is unlikely that many medical students are ideologically racist, all the same it is probable that their attitudes, beliefs, and prejudices regarding minority groups broadly reflect those of the societies in which they have been raised or are located (inherited mores and institutional structures).
Components of Culture in Health for Medical Students’ Education

Melanie Tervalon MD, MPH

Abstract

Medical educators across the United States are addressing the topics of culture, race, language, behavior, and social status through the development of cross-cultural coursework. Dramatic demographic changes and nationwide attention to eliminating racial and ethnic health disparities make educating medical students about the importance of the effects of culture on health a 21st-century imperative. Despite the urgent need for including this topic material, few medical schools have achieved longitudinal integration of issues of culture into four-year curricula. The author makes the practical contribution of describing key themes and components of culture in health care for incorporation into undergraduate medical education. These include teaching the rationale for learning about culture in health care, ‘culture basics’ (such as definitions, concepts, the basis of ‘culture’ in the social sciences, relationship of culture to health and health care, and health systems as cultural systems), data on and concepts of health status (including demographics, epidemiology, health disparities, and the historical context), tools and skills for productive cross-cultural clinical encounters (such as interviewing skills and the use of interpreters); characteristics and origins of attitudes and behaviors of providers; community participation (including the use of expert teachers, community-school partnerships, and the community as a learning environment); and the nature of institutional culture and policies.

Global migration patterns have forever changed the racial, ethnic, cultural, and linguistic character of the United States. One consequence of the nation’s rapid multicultural transformation is that interpretations of contemporary health care experiences are often reflections of the different cultural viewpoints about health and the health care delivery system that exist among patients and providers. For example, patients’ opinions of the use of complementary and alternative healing practices, spiritual healers, and community-based support mechanisms as primary sources for health maintenance or healing can be at odds with the perspective of those US providers whose explanations and approaches to health and illness originate in training heavily infused with the principles of biomedicine and technology.

Fundamental mismatches in culturally-mediated health belief systems between patients and providers in the current health care system are occurring alongside the well-publicized differentials in health outcomes across racial and ethnic groups in the United States. Over the last decade, substantial research and educational efforts have been directed towards untangling the relationships between culture and health in order to reverse these differentials. Many health policy experts, and most recently the Institute of Medicine, suggest that a well-conceptualized focus on culture in medical education could serve as one of several important national strategies to eliminate racial and ethnic health disparities.

Responding to the call to teach about culture in the undergraduate medical curriculum requires creating learning materials and learning environments that equip students with
knowledge, skills, and experiences about culture and health that have clinical applicability for all patient populations. For example, part of this educational process includes providing students with information that deepens their understanding of the concept of culture in health, the power dynamics inherent in cultural interactions, and the reality that culture is ever-changing and thus cannot be reduced to stereotypic descriptions of population groups’ cultural health beliefs, norms, behaviors, and values. It also includes the difficult work of examining cultural beliefs and cultural systems of both patients and providers to locate the points of cultural dissonance or synergy that contribute to patients’ health outcomes.
Abstract
The author presents reflections from medical anthropology on the institutional culture of medicine and medical education, which sees itself as a ‘culture of no culture’ and which systematically tends to foster static and essentialist conceptions of ‘culture’ as applied to patients. Even though requirements designed to address cultural competence are increasingly incorporated into medical school curricula, medical students as a group may be forgiven for failing to take these very seriously as long as they perceive that they are quite distinct from the real competence that they need to acquire. To change this situation will require challenging the tendency to assume that ‘real’ and ‘cultural’ must be mutually exclusive terms. Physicians’ medical knowledge is no less cultural for being real, just as patients’ lived experiences and perspectives are no less real for being cultural. Whether this lesson can be effectively conveyed within existing curricular frameworks remains an open question. Cultural competence curricula will, perhaps, achieve their greatest success if and when they put themselves out of business – if and when, that is, medical competence itself is transformed to such a degree that it is no longer possible to imagine it as not also being ‘cultural’.

Efforts to promote cultural competence in medical education and practice that have blossomed over the past decade or so have thus far focused primarily on the task of providing cultural information about various specific immigrant communities. This focus has been fruitful, resulting in expanded and improved resources of many kinds – from courses to training seminars, translator services, highly informative websites, and more – to assist practitioners caring for patient populations that have created (especially in those regions where successive waves of immigrants have congregated most densely) an enormously complex tapestry of linguistic, religious, and other kinds of diversity. In the wake of these accomplishments, cultural competence has earned a secure place among the formal educational goals of medical school curricula, and the moment may now be ripe to pause and consider future directions. With that in mind, in this article I present reflections from medical anthropology on the institutional culture of medical education, and suggest some reasons why achieving the broader goals of cultural competence curricula may require broader institutional changes.

As cultural competence programs have matured, a number of parties involved in promoting them have warned against a too-simple understanding of ‘culture’. One obvious concern is that materials intended to help foster awareness of and openness to difference may – depending upon how they are presented and how they are received – have the contrary effect of perpetuating more or less rigid stereotypes about what members of a particular ‘culture’ believe, do, or want, and how they should be dealt with. Some authors stress that a ‘culture’ is not a state and timeless thing but is constantly changing as people make use of their cultural resources in creative and sometimes surprising ways. Others emphasize that ‘culture’ is multifaceted, encompassing linguistic, religious, educational, class, and many other dimensions of difference, which intersect in complex ways in the life experience and identify of any one individual. It has been proposed that the term cultural ‘humility’ ought to replace cultural ‘competence’ as
the goal of multicultural education in medicine. It is also argued that ‘culture’ must be situated in relation to ‘social’ factors such as literacy or socioeconomic class standing. The point has also been made repeatedly that not only patients and other communities have cultures, but that there is also a ‘culture’ of medicine.

It is tempting to remain at the level of theoretical discussions, and to imagine that what is needed are newer and better definitions for ‘culture’. This temptation is perhaps especially strong for those of us who discuss cultural competence from the discipline of sociocultural anthropology, because we use the same key term ‘culture’ differently. Coming from anthropology, where ‘culture is now viewed by many to consist of acts of competing discourses and practices, within situations characterized by the unequal distribution of power’ (and where, it must be added, one enjoys the luxury of reflecting on culture at some distance from the urgencies of clinical care), the literature on cultural competence can give one the slightly spooky sensation of having encountered the Ghost of Anthropology Past. Guarnaccia and Rodriguez note that:

in reviewing recent works on culturally competent health, writers have often turned to earlier writings by anthropologists to present a definition of culture. In general, these definitions have reflected a static view of culture as the distinctive set of beliefs, values, morals, customs and institutions which people inherit ..... [whereas] more recent approaches to culture in anthropology provide a more dynamic perspective ..... viewing culture as a process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships, and migrations.

Merely to argue about how one ought to define ‘culture’, however, is unlikely to be especially persuasive or helpful. The anthropologist, I am well aware, risks sounding a bit like Humpty Dumpty saying to Alice that ‘when I use a word, it means just what I choose it to mean, neither more nor less!’ A more interesting and useful approach is to ask of cultural competent programs the same question that anthropologists ask of any sociocultural phenomenon that they wish to understand: How do systems of thought relate to what anthropologists sometimes call ‘systems of social action’ (ie the observable patterns in the ways that people act and interact in society)? Specifically, in this case, how do particular ways of conceptualizing and talking about ‘culture’ relate to the sociocultural organization of the institutions of medicine and medical education? To put it very bluntly, are there features of the culture of medicine that might tend to lead those who inhabit it to think of ‘culture’ as a static set of ideas and beliefs that only other people possess?
Abstract
Given that understanding the sociocultural dimensions underlying a patient’s health values, beliefs, and behaviors is critical to a successful clinical encounter, cross-cultural curricula have been incorporated into undergraduate medical education. The goal of these curricula is to prepare students to care for patients from diverse social and cultural backgrounds, and to recognize and appropriately address racial, cultural, and gender biases in health care delivery. Despite progress in the field of cross-cultural medical education, several challenges exist. Foremost among these is the need to develop strategies to evaluate the impact of these curricular interventions. This article provides conceptual approaches for cross-cultural medical education, and describes a framework for student evaluation that focuses on strategies to assess attitudes, knowledge, and skills, and the impact of curricular interventions on health outcomes.

The 2000 Census confirmed what demographers had been predicting all along – our country has become more diverse than ever before. This expansion has been fueled by growth of our minority populations, in addition to significant immigrant influx. Our success as a nation hinges on how we meet the challenges diversity poses, while capitalizing on the strengths it provides. Many sectors have responded proactively to our demographic evolution, understanding there are financial and market imperatives to better understanding, communicating, servicing, and partnering with those from diverse backgrounds. This has resulted in the focusing of major educational efforts, through training and corporate development, on how to better ‘manage’ diversity at the workplace and in business/service relations.

A growing literature delineates the impacts of sociocultural factors, race, and ethnicity on health and clinical care. Clinicians aren’t shielded from diversity, as patients present varied perspectives, values, beliefs, and behaviors regarding health and wellbeing. These include variations in patient recognition of symptoms, thresholds for seeking care, ability to communicate symptoms to a provider who understands their meaning, ability to understand the prescribed management strategy, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to preventive measures and medications.

Sociocultural differences between patient and physician influence communications and clinical decision making. Evidence suggests that provider-patient communication is directly linked to patient satisfaction and adherence and subsequently to health outcomes. Thus, when sociocultural differences between patient and provider aren’t appreciated, explored, understood, or communicated in the medical encounter, patient dissatisfaction, poor adherence, and poorer health outcomes result. It is not only the patient’s culture that matters; the provider’s ‘culture’ is equally important. Historical factors for patient mistrust, provider bias, and their impacts on physicians’ decision-making have also been documented. Failure to take sociocultural factors into account may lead to stereotyping,
and, in the worst cases, biased or discriminatory treatment of patients based on race, culture, language proficiency, or social status.
Abstract
The author proposes a theoretical orientation for cultural competency that reorganizes common curricular responses to the study of culture in medical education. What has come to be known in medical education as cultural competency is theoretically truncated and many actually work against what educators hope to achieve. Using Giroux’s concept of insurgent multiculturalism, she suggests that the critical study of culture might be a bridge to certain aspects of professional development. Insurgent multiculturalism moves inquiry away from a focus on nondominant groups to a study of how unequal distributions of power allow some groups but not others to acquire and keep resources, including the rituals, policies, attitudes, and protocols of medical institutions. This approach includes not only the doctor-patient relationship but also the social causes of inequalities and dominance. Linked to professional development efforts, insurgent multiculturalism can provide students with more opportunities to look at their biases, challenge their assumptions, know people beyond labels, confront the effects of power and privilege, and develop a far greater capacity for compassion and respect.

Humility, and not so much the discrete mastery traditionally implied by the static notion of competence, captures most accurately what researchers need to model and hold programs accountable for evaluating in trainees under the broad scope of multicultural training in medical education.

Cultural competency, frequently addressed in many academic medicine publications and conference papers during the past decade, is perceived by medical educators and accrediting bodies as deficient in the curriculum, and by extension, in medical students. In this article, I develop a theoretical orientation for cultural competency that reorganizes common curricular responses to the study of culture in medical education. In fact, I contend that what has come to be known in medical education as cultural competency is theoretically truncated and may actually work against what educators hope to achieve. I explicate Henry Giroux’s idea of insurgent multiculturalism as a more useful orientation to cultural competency in medical education and then propose it as a bridge to critical aspects of professional development. But first, I offer a critique of prevailing concepts of cultural competency in medical education.
A Strategy to Reduce Cross-cultural Miscommunication and Increase the Likelihood of Improving Health Outcomes

Marjorie Kagawa-Singer PhD and Shaheen Kassim-Lakha MPH


**Abstract**

Encounters between physicians and patients from different cultural backgrounds are becoming commonplace. Physicians strive to improve health outcomes and increase quality of life for every patient, yet these discordant encounters appear to be a significant factor, beyond socioeconomic barriers, in creating the unequal and avoidable excess burden of disease borne by members of ethnic minority populations in the United States. Most clinicians lack the information to understand how culture influences the clinical encounter and the skills to effectively bridge potential differences. New strategies are required to expand medical training to adequately address culturally discordant encounters among the physicians, their patients, and the families, for all three may have different concepts regarding the nature of the disease, expectations about treatment, and modes of appropriate communication beyond language.

The authors provide an anthropological perspective of the fundamental relationship between culture and health, and outline systemic changes needed within the social and legal structures of the health care system to reduce the risk of cross-cultural miscommunication and increase the likelihood of improving health outcomes for all populations within the multicultural US society. The authors define the strengths inherent within every culture, provide a guideline for the clinician to evaluate disease and illness within the cultural context, and outline the clinical skills required to negotiate among potential differences to reach mutually desired goals for care. Last, they indicate the structural changes required in the health care setting to enable and support such practice.

In this article, we provide an anthropological perspective of the fundamental relationship between culture and health, and outline systemic changes needed within the social and legal structures of our health care system to reduce the risk of cross-cultural miscommunication and increase the likelihood of improving health outcomes for all populations within our multicultural US society.
Can Cultural Competency Reduce Racial and Ethnic Health Disparities?  
A Review and Conceptual Model

Cindy Brach, Irene Fraser, Agency for Healthcare Research and Quality  

Abstract
This article develops a conceptual model of cultural competency’s potential to reduce 
racial and ethnic health disparities, using the cultural competency and disparities 
literature to lay the foundations for the model and inform assessments of its validity. The 
authors identify nine major cultural competency techniques: interpreter services, 
recruitment and retention policies, training, coordinating with traditional healers, use of 
community health workers, culturally competent health promotion, including 
family/community members, immersion into another culture, and administrative and 
organizational accommodations. The conceptual model shows how these techniques 
could theoretically improve the ability of health systems and their clinicians to deliver 
appropriate services to diverse populations, thereby improving outcomes and reducing 
disparities. The authors conclude that while there is substantial research evidence to 
suggest that cultural competency should in fact work, health systems have little evidence 
about which cultural competency techniques are effective and less evidence on when and 
how to implement them properly.
Abstract
A sensitizing book that will bring you into a direct interface between the American health care system and the health care consumer. The consumers examined here are the ethnic people of color, including Blacks, Asians, Hispanics, and native Americans. You will find that the cultural issues of health and illness have been explored in four areas:

- provider self-awareness;
- consumer-oriented issues surrounding delivery and acceptance of health care;
- broad issues such as poverty (a barrier), and health care as a right (a bridge);
- examples and traditional health beliefs and practices among selected populations.
Effect of Spanish Interpretation Method on Patient Satisfaction in an Urban Walk-In Clinic

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JGIM(2002)17(8):641-646

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Abstract

Objective: To examine the effect of Spanish interpretation method on satisfaction with care.

Design: Self-administered post-visit questionnaire.


Participants: Adult, English- and Spanish-speaking patients presenting for acute care of non-emergent medical problems.

Measurements and Main Results: Satisfaction with overall clinic visit and with seven provider characteristics was evaluated by multiple logistic regression, controlling for age, gender, ethnicity, education, insurance status, having a routine source of medical care, and baseline health. ‘Language-concordant’ patients, defined as Spanish-speaking patients seen by Spanish-speaking providers and English-speaking patients, and patients using AT&T telephone interpreters reported identical overall visit satisfaction (77%, p = .57), while those using family or ad hoc interpreters were significantly less satisfied (54% and 49%, p < .01 and p = 0.007, respectively). AT&T interpreter use and language concordance also yielded similar satisfaction rates for provider characteristics (p > .2 for all values). Compared to language-concordant patients, patients who had family members interpret were less satisfied with provider listening (62% vs. 85%; p = .003), discussion of sensitive issues (60% vs. 76%, p = .02), and manner (62% vs. 89%, p = .005). Patients who used ad hoc interpreters were less satisfied with provider skills (60% vs. 83%; p = .02), manner (71% vs. 89%; p = .02), listening (54% vs. 85%; p = .002), explanations (57% vs. 84%; p = .02), answers (57% vs. 84%; p = .05), and support (63% vs. 84%, p = .02).

Conclusions: Spanish-speaking patients using AT&T telephone interpretation are as satisfied with care as those seeing language-concordant providers, while patients using family or ad hoc interpreters are less satisfied. Clinics serving a large population of Spanish-speaking patients can enhance patient satisfaction by avoiding the use of untrained interpreters, such as family or ad hoc interpreters.
Abstract

Objective: To describe the utilization of various methods of language interpretation by Spanish-speaking patients in an academic medical clinic and to determine patients’ and physicians’ satisfaction with these methods.

Methods: Survey administered to medical residents and Spanish-speaking patients asking about their experience and satisfaction with various methods of language interpretation.

Main Results: Both patients and residents had the highest level of satisfaction for professional interpreters (92.4% vs. 96.1% reporting somewhat or very satisfactory, \(p = .17\)). In contrast, patients were significantly more satisfied than residents with using family members and friends (85.1% vs. 60.8%, \(p < .01\)). Physicians and patients agreed that accuracy, accessibility, and respect for confidentiality were highly important characteristics of interpreters (> 90% of both groups reporting somewhat or very important). However, patients were more concerned than residents about the ability of the interpreter to assist them after the physician visit (94% vs. 45.1%, \(p < 0.01\)).

Conclusions: Using family members and friends as interpreters for Spanish-speaking patients should be more seriously considered; however, in order to optimize patient satisfaction, differences between patients and providers should be taken into account when using interpretation in medical settings.
Levels of Racism: A Theoretic Framework and a Gardener’s Tale

Camara Phyllis Jones MD, MPH, PhD

Abstract
The author presents a theoretic framework for understanding racism on three levels: institutionalized, personally mediated, and internalized. This framework is useful for raising new hypotheses about the basis of race-associated differences in health outcomes, as well as for designing effective interventions to eliminate those differences.

She then presents an allegory about a gardener with two flower boxes, rich and poor soil, and red and pink flowers. This allegory illustrates the relationship between the three levels of racism and may guide our thinking about how to intervene to mitigate the impacts of racism on health. It may also serve as a tool for starting a national conversation on racism.
Resident Physicians’ Preparedness to Provide Cross-Cultural Care

Joel S. Weissman PhD, Joseph Betancourt MD, MPH, Eric G. Campbell PhD, Elyse R. Park PhD, Minah Kim PhD, Brian Clarridge PhD, David Blumenthal MD, Karen C Lee MD, MPH, Angela W. Maina BS

JAMA(2005)Vol 294:9

Abstract

**Context**: Two recent reports from the Institute of Medicine cited cross-cultural training as a mechanism to address racial and ethnic disparities in health care, but little is known about residents’ educational experience in this area.

**Objective**: To assess residents’ attitudes about cross-cultural care, perception of their preparedness to deliver quality care to diverse patient populations, and educational experiences and educational climate regarding cross-cultural training.

**Design, Setting and Participants**: A survey was mailed in the winter of 2003 to a stratified random sample of 3435 resident physicians in their final year of training in emergency medicine, family practice, internal medicine, obstetrics/gynecology, pediatrics, psychiatry, or general surgery at US academic health centers.

**Results**: Responses were obtained from 2047 (60%) of the sample. Virtually all (96%) of the residents indicated that it was moderately or very important to address cultural issues when providing care. The number of respondents who indicated that they believed they were not prepared to care for diverse cultures in a general sense was only 8%. However, a larger percentage of respondents believed they were not prepared to provide specific components of cross-cultural care, including caring for patients with health beliefs at odds with western medicine (25%), new immigrants (25%), and patients whose religious beliefs affect treatment (20%). In addition, 24% indicated that they lacked the skills to identify relevant cultural customs that impact medical care. In contrast, only a small percentage of respondents (1-2%) indicated that they were not prepared to treat clinical conditions or perform procedures common in their specialty. Approximately one-third to half of the respondents reported receiving little or no instruction in specific areas of cross-cultural care beyond what was learned in medical school. Forty-one percent (family medicine) to 83% (surgery and obstetrics/gynecology) of respondents reported receiving little or no evaluation in cross-cultural care during their residencies. Barriers to delivering cross-cultural care included lack of time (58%) and lack of role models (31%).

**Conclusions**: Resident physicians’ self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas. Although cross-cultural care was perceived to be important, there was little clinical time allotted during residency to address cultural issues, and there was little training, formal evaluation, or role modeling. These mixed educational messages indicate the need for significant improvement in cross-cultural education to help eliminate racial and ethnic disparities in health care.
Use of Race and Ethnicity in Biomedical Publication

Judith B. Kaplan MS, Trude Bennett DrPH


Abstract
Researchers, clinicians and policy makers face three challenges in writing about race and ethnicity: accounting for the limitations of race/ethnicity data; distinguishing between race/ethnicity as a risk factor or as a risk marker; and finding a way to write about race/ethnicity that does not stigmatize and does not imply a we/they dichotomy between health professionals and populations of color. Journals play an important role in setting standards for research and policy literature. The authors outline guidelines that might be used when race and ethnicity are addressed in biomedical publications.
When nurses double as interpreters: a study of Spanish-speaking patients in a US primary care setting

Virginia Elderkin-Thompson, Roxane Cohen Silver, Howard Waitzkin


Abstract
The United States is experiencing one of its largest migratory waves, so health providers are caring for many patients who do not speak English. Bilingual nurses who have not been trained as medical interpreters frequently translate for these patients. To examine the accuracy of medical interpretations provided by nurses untrained in medical interpreting, we conducted a qualitative, cross-sectional study at a multi-ethnic, university-affiliated primary care clinic in southern California. Medical encounters of 21 Spanish-speaking patients who required a nurse-interpreter to communicate with their physicians were video-recorded. Encounters were transcribed by blinded research assistants. Transcriptions were translated and analyzed for types of interpretive errors and processes that promoted the occurrence of errors. In successful interpretations where misunderstandings did not develop, nurse-interpreters translated the patient’s comments as completely as could be remembered and allowed the physician to extract the clinically-relevant information. In such cases, the physician periodically summarized his/her perception of the problem for back-translation and verification or correction by the patient. On the other hand, approximately one-half of the encounters had serious miscommunication problems that affected either the physician’s understanding of the symptoms or the credibility of the patient’s concerns. Interpretations that contained errors that led to misunderstandings occurred in the presence of one or more of the following processes: (1) physicians resisted reconceptualizing the problem when contradictory information was mentioned; (2) nurses provided information congruent with clinical expectations but not congruent with patients’ comments; (3) nurses slanted the interpretations, reflecting unfavorably on patients and undermining patients’ credibility; and (4) patients explained the symptoms using a cultural metaphor that was not compatible with western clinical nosology. We conclude that errors occur frequently in interpretations provided by untrained nurse-interpreters during cross-language encounters, so complaints of many non-English-speaking patients may be misunderstood by their physicians.
An EM Residency Faculty/Resident Developmental Session on Diversity and Cultural Competence

Lou Binder, MD

Abstract

**Purpose:** As part of its long-term residency education and faculty development efforts, the Departments of Emergency Medicine (EM) and Office of Cultural Affairs developed and implemented a residency-wide half-day workshops (residents and faculty) in diversity and cultural competence. It was hoped that the curriculum would sensitize departmental residents and faculty to frequently-occurring and high impact issues in diversity and cultural competence that occur in EM practice, and would assist practitioners in their daily clinical and educational functions at the patient’s bedside.

**Methods:** The workshop was planned and taught by a working group consisting of EM faculty, and staff from our institution’s Office of Cultural Competency. Teaching session organization and pedagogy utilized an initial interactive lecture format (combining presentation of concepts with large group case discussion examples), followed by five subtopic concept and case presentations that were distributed and discussed in a combined large group and small group format. The cases reflected each of the course objectives, and required participants to identify impacting cultural issues, identify the full range of management options, and to decide upon a preferred course of action for each case. The cases served to reinforce the key didactic points and key learning objectives of the course via active learning and application of these concepts to real world situations.

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<tr>
<th><strong>Workshop Objectives:</strong></th>
<th><strong>Workshop Agenda:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Define &amp; relate importance of “cultural competency”</td>
<td>1. Welcome, purpose, and overview of agenda</td>
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<tr>
<td>2. Relate issues pertaining to spirituality &amp; health care</td>
<td>2. “GLBT issues in health care”, presentation/discussion</td>
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<tr>
<td>3. Relate issues pertaining to GLBT pts in health care</td>
<td>3. “Spirituality and health care”, case presented/discuss</td>
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<tr>
<td>4. Related issues pertaining to pain and culture</td>
<td>BREAK</td>
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<tr>
<td>5. Relate issues pertaining to bereavement and culture</td>
<td>4. “Pain and culture”, case presentations and discussion</td>
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<tr>
<td>6. Relate issues pertaining to interpreter services and health care delivery</td>
<td>5. “Bereavement and culture”, presentation/discussion</td>
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</tbody>
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**Results:** Attendance: 40 participants; 34 evaluation forms received.