EM Faculty Caring for Multicultural Patients

Georges Ramalanjaona MD, DSc, Marcus L. Martin MD

Abstract

Emergency Medicine (EM) Faculty caring for multicultural patients traditionally serve dual roles: as role models for EM Residents and as practitioners involved in clinical encounters, decisions and outcomes for these culturally diverse patients.

The objectives for this chapter are to define the concept of culturally competent faculty, review the current literature and delineate educational interventions aimed at improving cultural competency skills.

Results of our literature search show that there are only limited publications dealing with the role of EM Faculty caring for multicultural patients. Current educational interventions consist of implementation of cultural competency curricula for Faculty, and establishment of Faculty development programs specific for cultural diversity.

Recommendations for improving EM Faculty's skills on cultural competency include the following: expand the role of EM Faculty as patient advocate interfacing with local community; incorporate cultural competency curricula as an integral part of EM Residency training by the Accreditation Council for Graduate Medical Education, and implement a special Faculty Development Program to integrate cultural competency training across all EM Residency Training Programs.

Finally, a Federal Law which mandates cultural competency training as a requirement for certification for State Medical Licensure should be enacted.

Introduction

The 2000 US census reports that our population has become more diverse than previous decades due to the rapid growth of our minority population and significant influx of immigrants(1): in 1940, 70% of immigrants came from Europe compared to 15% in the 1990s, and demographic trends show that ethnic minorities - which constitute 25% of our current population - will be the majority of our population by 2050. The current US population consists of more than 100 ethnic groups and 500 American Indian groups, and published articles document that all US ethnic minorities lag behind their European

counterparts on almost every health indicator, including access to care, health care coverage, and life expectancy while surpassing white groups in all acute and chronic diseases rates(2). The accepted rationale for these health care disparities include barriers to routine access to preventive care, lower cultural competency skills among health care practitioners, and insufficient proportional representation of minorities in our health professions(3). Furthermore, a growing body of literature shows the impact of sociocultural factors, race and ethnicity on health care decisions, and that patient-provider communication is directly linked to patient satisfaction and health outcomes(4).
The Accreditation Committee for Undergraduate and Graduate Medical Education has recently recognized cultural diversity training as a necessary skill for delivering effective patient care(5). Therefore, Medical Educators in different specialties have developed effective training models to integrate sociocultural factors in patient care(6).
Unfortunately, there are only a few specific references in the current literature(7,8) addressing the role of EM Faculty caring for the multicultural patient population.
Traditionally, EM Faculty serves a dual purpose: as teachers and role models for EM residents and medical students, and as practitioners. Recently, an expert panel review of the American Medical College reports the beneficial impact of Faculty involvement for cultural competency exposure(9).

It is important to define the role of the culturally competent EM Faculty, delineate a cultural competency curriculum aimed at improving EM Faculty's skills, devise a Faculty Development Program specific for EM Faculty, and integrate these functions in a clinical setting as well as in academic life.

Discussion

Cultural competency is defined as learned skills that help to understand cultural differences and facilitate communication between populations who have different ways of understanding health, disease and body(10). Thus, cultural competency extends beyond simple awareness or sensitivity and should be defined as the ability to effectively use cultural knowledge and skills in cross-cultural encounters. The EM Faculty should then

be skilled at understanding their patients' cultural values within this context of medical practice and their own belief system.

Several educational interventions have been advocated to improve cultural competency for Faculty, including implementation of a cultural competency curriculum, and establishment of Faculty Development Programs specific for cultural diversity. Recently, the Agency for Healthcare Research and Quality published nine major cultural competency techniques which can reduce health disparities(11). These techniques include interpreter services, recruitment and retention policies, training, coordinating with traditional healers, use of community health workers, culturally competent health promotions, inclusion of family and community members, immersion into another culture, and administrative and organizational accommodation. However, these techniques are only general approaches to the problem and do not address outcomes in EM.
The Liaison Committee on Medical Education (LCME) recently set standards for the development of cultural competency training as part of the Medical School Curriculum(12). These new standards require a cultural diversity curriculum to be taught as part of undergraduate medical education and can be divided into three interdependent conceptual approaches focusing on attitudes, knowledge and skills:

- Cultural sensitivity/awareness approach: It is taught in the first year and second years of Medical Schools and its goal is to improve the provider's awareness of the impact of socioeconomic factors on the individual patient's health values, beliefs and behaviors as well as on the quality of care and outcome.
- Multicultural /categorical approach: It is taught throughout the undergraduate medical education and its primary focus is to increase the student's knowledge of cross-cultural issues by teaching relevant methods of community assessment and evidence-based factors (i.e. historical and epidemiological factors) that may influence health behaviors.
- Cross-cultural approach: It focuses on acquiring skills and is taught during clinical years, and its primary goal is to integrate medical interviewing and communication skills with sociocultural and ethnographic tools of medical anthropology. this approach lays the foundation to care for a culturally diverse patient population.

Although these new LCME standards constitute an excellent start to solving this cultural diversity gap in Medical Education, they do not apply to Graduate Medical Education. Flores and colleagues' recent survey of all US and Canadian Medical Schools reported that only 8% of schools have established a separate course on cultural competency(13). Moreover, while many of the existing cultural competency curricula target medical students, only a few studies report such curricula among Medical School Faculty(14,15), who will in turn shape Residents and Medical Students' attitudes and behavior toward these issues. Recently, Welch evaluated a three-part workshop on cultural competency designed for department chairs and course directors of an academic institution(16). The conceptual design and workshop content are based on a well-known experiential approach for training in cross-cultural sensitivity and awareness(17): individuals change attitudes toward cultural-ethnic differences if they are first aware of their own inherent values and biases. After they gain this awareness, training focuses on knowledge and skills of diverse groups, and attitudinal changes will follow as individuals question previously-held beliefs and biases. Based on this concept, a series of three workshops is developed: first, building knowledge and personal awareness of differences, then building knowledge and skills (focus on individual), and last building knowledge and skills (focus on organization). The workshop series are evaluated by both Faculty's verbal and written feedback. A total of 35 Faculty members participate, and based on a 5-point Likert scale (5 high to 1 low), the overall score for content is 4.10; the organization score 4.32; teacher effectiveness was 4.26 and usefulness of exercise videos 4.86. The written and verbal feedbacks recommend offering this workshop annually, continuing the use of role playing and experiential activities and requesting more workplace specific activities. Although these results are encouraging, baseline evaluation and follow-up measures of Faculty members toward diversity are not done, thus limiting the evaluation of the efficacy of this training. Furthermore, no EM Faculty members are involved in this study, thus questioning the application of its results in EM.

Addressing the need of teaching cultural competency curricula in Graduate Medical Education (GME), the specialty of Family Practice (FP) publishes Core Curriculum

guidelines on cultural sensitive and competent health care following the results of two national surveys of FP Residency programs in 1985 and 1998(18). In 1985, a national survey of all FP residency training programs with a 71% response rate, indicates that only 3% had a written curriculum (defined as having a bibliography, course objectives); 22% had a non-written curriculum for a total of 25% of FP residencies having a curriculum devoted to cultural competency(19). In 1998, the Society of Family Medicine conducted a national mail survey of all FP residency programs to determine the status and educational content of multicultural curricula, to identify the impending and facilitating factors to the implementation of such curricula, as well as activities that could help residency programs improve their multicultural training(20). The survey yielded a 595 response rate, with 58% of responding programs having an informal curriculum, 28% with a formal curriculum and 14% with no curriculum on cultural diversity. Programs with a formal curriculum taught more content ($p<0.050$, employed more educational methods ($p<0.05$), used more evaluation techniques ($p<0.05$) and felt more successful ($p<0.001$) than those with an informal curriculum. The top three factors that facilitated implementation of multicultural curricula were presence of culturally diverse patient population, and Faculty's and Residents' multicultural interests. Conversely, a lack of Faculty's interest and expertise in cultural diversity were cited as major problems for programs with informal and no curricula. Therefore, Faculty's expertise and interest in cultural diversity played an important role in facilitating and implementing multicultural curricula in Family Practice. Other specialties such as Internal Medicine and Pediatrics have reportedly started formal cultural diversity curricula(21, 22).

Regarding our own specialty of EM, the leadership of EM organization has taken an essential first step in recognizing cultural competency as an integral part of EM curricula and residency program accreditation. SAEM recently established a two-year task force in conjunction with CORD to develop a model curriculum on cultural diversity. It includes a case-based discussion, standardized curriculum, didactic sessions on cultural competency, bedside teaching and mentorship and educational exchange programs to improve experiences with cultural diversity (7).

Ferguson et al recently described a unique Faculty Development Program (FDP) designed to improve the skills of clinical Faculty to integrate cultural competency and advocacy education into clinical training(9). This training, known as " teaching the culture of the community", is integrated into the training of community preceptors from 13 Medical Schools in New York and New England. It consists of four 2.5 hour modules which include interactive lectures followed by large group exercises culminating in small group exercises on cultural needs assessment, patient-centered interviewing, participant feedback, review evaluation and self-reported change data from the first two years of the program (1999-2001). The 137 participants include family physicians as a majority (42%), with the remaining preceptors being internists and pediatricians. 60% of trainees are female, 52% had been in practice less than 10 years, 47% had less than 3 years of teaching experience, and 53% are involved in the care of the underserved population as defined in a federally-funded community health center. Results display an overall high level of participant satisfaction (averaged above 4.0 on a Likert scale of 5 -1 low, 5 excellent). Also, there is a statistically significant ($p< 0.05$) improvement in the overall rating of the program and the clarity of the objectives in 2000-01 compared to 1999-2000. Furthermore, with the intention of changing analysis before the curriculum, 5.4% of participants planned to change their teaching practice or behavior compared to 30.2% after the last workshop. Therefore, in this short-term study, cultural competency training has been successfully integrated into an existing FDP for community-based preceptors. Limitations of this study included limited involvement of medical specialties without representation of EM Faculty, difficulty in selecting an appropriate control group, lack of an accepted standard for evaluation of cultural competency of Faculty, the intention to change questionnaires' reliance on self-reported rather than objective criteria of behavior change, and lack of reported measures to address the impact of the community preceptors on residents at various stages of their training.

Integration of cultural competency curricula in clinical practice and medical education leads to redefining the role of Faculty. First, role modeling is an integral part of Graduate Medical Education (GME), crucial in shaping attitudes, behavior, values and ethics of medical trainees and an important influence on the career choices of residents (23).

Recent studies report that attending physicians who are considered role models differ from their other colleagues: using a multicenter case-control study of attending physicians (N=197), and IM house staff (N= 151) of four teaching hospitals, Wright et al(24) identified 5 attributes associated with being an excellent role model. These attributes included spending more than 25% of one's time teaching (OR=5.12, 95% CI, 1.81 to 14.47), spending 25 or more hours per week teaching and conducting rounds (OR=2.48, 95% CI, 1.15 to 5.37), stressing the importance of the Doctor-Patient relationship (OR=2.58, 95% CI, 1.03 to 6.43), teaching psychological aspects of medicine (OR=2.31, 95% CI, 1.23 to 4.35), and having served as a chief resident (OR=2.07, 95% CI, 1.07 to 3.98). These attributes represent acquired or modifiable behavior which is under the control of the individual Faculty member, meaning that with the appropriate advice, training and environment, more attending physicians may become excellent role models. Limitation of this study included involvement of a single specialty (IM), reliance on self-reporting and the inability to assess other attributes of role models such as clinical proficiency and teaching skills. Second, a new role of Faculty as patient advocate emerged and included interfacing with local community leaders to improve the cultural competency curriculum. Therefore, culturally competent Faculty is redefined as Faculty who acquired clinical and sociocultural skills necessary to effectively eliminate racial disparities in health outcomes(25). Interestingly, a recent article points out that prior exposure to cultural diversity education emerges as a significant predictor for sociocultural attitude dimensions, not whether a physician is a Faculty or a resident(26). Thus, from a social learning perspective, Faculty members previously exposed to diversity training can be culturally competent and transform their own experiences into training cases for other colleagues. This new concept, albeit important, may increase Faculty responsibilities at a time when they are already under great pressure to generate more revenue rather spending more time acquiring sociocultural skills. In summary, key elements for a successful FDP include Institutional commitment to develop policies and procedures that integrate cultural competency curriculum, recruit and retain ethnically diverse Faculty , establish an FDP which emphasizes mentoring and role modeling, and implement a formal means of consultation with the local community to be served for the needs and appropriateness of the intervention.

Conclusion

Given the current trend and future demographic changes in the US population, sociocultural diversity in health care and medical education will be a priority for our health care policy makers as well as for our medical educators. The best approach yet to achieve this goal is to integrate cultural competency training into our GME and FDP. EM Faculty as part of educational leadership has the moral obligation and opportunity to educate our future leaders about the benefits of cultural competency curricula. However, there is a paucity of literature (which should be reversed) on the role of EM Faculty to enhance cultural diversity curricula, to serve as role models and mentors for EM residents and to embrace the new role as patient advocate.

Despite reported progress in cultural diversity education, several challenges remain:

- Do trainees learn and apply what is taught ?
- Lack of development of valid strategies to evaluate the impact of a cultural competency curriculum on EM Faculty and GME(27).
- Lack of evidence showing effectiveness of these programs on patient satisfaction, health outcome and quality of care(28).

Recommendations

These recommendations should be carried out at multiple levels of our educational and governmental institutions and include:

- Incorporate cultural competency as a formal part of EM residency curricula. This process will require fundamental changes in Accreditation and Certification policies by the Accreditation Council for Graduate Medical Education. This program requirement for diversity training will be integrated at the FDP and Continuous Quality Improvement levels(29).
- Accept cultural competency as an essential part of the EM curriculum program accreditation sponsored by leadership of EM organizations (SAEM, ACEP, CORD). SAEM initiated a task force in collaboration with CORD to establish a model curriculum in cultural competency.

- Conduct a national survey of all EM residency programs sponsored by SAEM/CORD to determine current status and educational content of cultural competency and identify impending factors to the implementation of such curricula.
- Implement a special FDP to integrate cultural competency training across all levels of leadership which can change the institutional climate and specifically target Faculty who have not been exposed to such curricula in the past. Evaluation of the effectiveness of such a program should be done by objective, evidence-based criteria.
- Adopt cultural competency training as a prerequisite for certification for State Medical Licensure in all 50 States, sanctioned by the Federal State of Medical Boards. Several states have enacted such laws, including New Jersey.

References

1. Census bureau releases data on people who chose more than one race. Public Health Rep. 2001; 116: 626-7.
2. Institute of Medicine. Examining unequal treatment in American Health Care. Washington DC: National Academy of Sciences, 2002.
3. Gabriel BA. Confronting "unequal treatment": The Institute of Medicine weighs in on health care disparities. AAMC Reports 2002; 11(9):6-7.
4. Kagawa-Singer, Kassim-Lakha. A strategy to reduce cross-cultural miscommunication and increase the likelihood of improving health outcome. Acad .Med. 2003; 78: 577-87.
5. Tang Ts et al. Implementation and evaluation of an undergraduate sociocultural medicine program. Acad. Med. 2002; 77: 578-85.
6. Like RC et al. STFM Core Curriculum guidelines: recommended core curriculum guidelines on culturally sensitive and competent health care. Fam. Med. 1996; 28:291-7.
7. Hamilton G, Marco CA. Emergency Medicine education and health care disparities. Acad. Emerg. Med. 2003;10(11):1189-92.

8. Wear D. Insurgent multiculturalism: rethinking how and why we teach culture in medical education. Acad. Med. 2003; 78:549-54.
9. Ferguson WJ et al. Developing culturally competent community faculty: a model program. Acad. Med. 2003; 78: 1221-8.
10. Kai J et al. Learning to value ethnic diversity - what, why and how. Med. Educ. 1999; 33: 616-23.
11. Brach C, Faser I. Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. Med. Care Res. Rev. 2000;57:181-217.
12. Liaison Committee on Medical Education – Accreditation Standards - Available at www.lcme.org/standard.hcm # multicultural diversity. Accessed 3/7/03.
13. Flores G. et al. The teaching of cultural issues in US and Canadian medical schools. Acad. Med. 2000; 74: 451-5.
14. Robins LS et al. Improving cultural awareness and sensitivity training in medical schools. Acad. Med. 1998; 73 (10 sup): s31-s34.
15. Baronders J. The GPEP report III. Faculty involvement. Ann. Inter. Med.1985; 103: 454-5.
16. Welch M. Enhancing awareness of diversity and cultural competence; a workshop series for department chairs and course directors. Acad. Med. 1997; 72; 461-2.
17. Nile LN. National multicultural training institute. Developing diversity training for the workplace - A guide for trainers. Washington DC: NMCI publications, 1995.
18. Culhane-Pura KA et al. Multicultural curricula in family practice residencies. Fam. Med. 2000; 32(3): 167-73.
19. McConarty PC, Farr F. Culture as content in family practice residencies. Presented at the 1986 Society of Teachers of Family Medicine annual Spring meeting in San Diego.
20. STFM Group on multicultural health care and education. Theme day: Enhancing cultural competency education in family medicine. Presented at the 1999 STFM annual Spring meeting in Seattle.
21. American Academy of Pediatrics. Culturally effective pediatric care: education and training issues. Pediatrics 1999; 103(1): 167-70.

22. Bobo L et al. Principles of inter-cultural medicine in an internal medicine program. Am. J. Med. Sci.: 1991; 302: 244-8.
23. Wright SM, Carrese JA. Serving as a physician role model for a diverse population of medical learners. Acad. Med. 2000; 78: 623-8.
24. Wright SM et al. Attributes of excellent attending physician role models. NEJM 1998; 339: 1986-93.
25. Chin J. Culturally competent health care. Public Health Rep. 2,000; 115:25-33.
26. Tang TS et al. Are residents more comfortable than faculty members when addressing sociocultural diversity in medicine? Acad. Med. 2003; 78: 629-33.
27. Betancourt, J. Cross-cultural medical education; conceptual approaches and frameworks for evaluation. Acad. Med. 2003; 78: 560-69.
28. Quirk ME et al. Evaluation of primary care futures; a faculty development program for community health center preceptors. Acad. Med. 1998; 73: 705-7.
29. Whitcomb ME. Assisting medical educators to foster cultural competence. Acad. Med. 2002; 77:191-2.