Educating Students and Residents to Provide Culturally Competent Care: A Review of Models, Educational Methods

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Abstract

The disparities in health care and health outcomes between the majority population and cultural and racial minorities in the US are a problem likely influenced by the lack of culturally competent care. Emergency medicine and other primary care specialties remain on the front lines of this struggle due to the nature of their open door practice. In order to provide culturally appropriate care, health care providers must recognize the factors impeding cultural awareness, seek to understand the biases and traditions in medical education potentially fueling this phenomenon, and create a health care community open to individuals' "otherness," thus leading to better communication of ideas and information between patients and their health care providers. This article highlights the rationale for and current problems in teaching cultural competency and examines several different models implemented to teach and promote cultural competency. However, the literature addressing the true efficacy of such programs in leading to long-lasting change and improvement in minority outcomes remains insufficient.

Key words: minority groups, cultural competency, disparities, health outcomes, ethnocentrism, medical education, residency training.

Introduction

The Institute of Medicine was charged by Congress with assessing the extent of racial and ethnic health care disparities, evaluating the potential sources of disparities, and recommending interventions to eliminate disparities. In its landmark report in 2003, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare,* the IOM concluded, "Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled."[1] Additionally, one of the two overarching goals of Healthy People 2010 is to eliminate racial and ethnic health disparities.[2]

Disparities have been documented in physician recommendations for cardiac revascularization[3] rates of reperfusion therapy, coronary angiography, and in-hospital death after

myocardial infarction.[4] In emergency medicine, disparities have been shown in pain management[5,6] authorization for emergency visits by managed care organizations[7] and in emergency department management of asthma.[8]

The IOM study committee examined a number of areas in looking for the causes of these disparities. In "the clinical encounter itself, [they] found evidence that stereotyping, biases, and uncertainty on the part of health care providers can all contribute to unequal treatment".[1] Recent data by Weissman et al.[9] demonstrated that trainees felt our educational system had poorly prepared them to deliver culturally competent care. In a diverse sample of clinical specialties, one third to one half of respondents reported receiving little or no instruction in specific areas of cross-cultural care beyond what was learned in medical school. Residents in general surgery and emergency medicine were significantly more likely to report a lack of cross-cultural training during their residencies when compared with other specialties.

The increasing diversity of the US population, as well as documented health disparities, mandates that the health care workforce be trained to care for patients from different backgrounds and cultures. The purpose of this paper is to describe a selection of educational models currently used for cultural competency teaching in undergraduate and postgraduate medical education and identify assessment methods that can be used to measure cross-cultural skills acquisition.

Discussion

Culturally competent health care has been described as "sensitive to the health beliefs and behaviors, epidemiology, and treatment efficacy of different population groups."[10]

> The Office of Minority Health defines cultural and linguistic competence as follows: Cultural and linguistic competence is a set of congruent behaviors, attitudes and policies that come together in a system, agency or among professionals that enables effective work in cross-cultural situations…. 'Competence' implies having the capacity to function effectively as an individual and an organization within the

context of the cultural beliefs, behaviors and needs presented by consumers and their communities.[11]

These principles of cultural competence have been codified in the standards of the Liaison Committee on Medical School Accreditation (LCME) with the following criteria: "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."[12] Similarly, the Accreditation Council for Graduate Medical Education (ACGME) has defined its competency standards for patient care and interpersonal communication skills by requiring that residents are able to provide "patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health" and "communicate effectively and demonstrate caring and respectful behaviors while interacting with patients and their families."[13] Emergency medicine has also specifically defined its own standards for communication competency; emergency physicians must be able to "demonstrate respect for diversity and cultural, ethnic, spiritual, emotional, and age-specific differences in patients and other members of the health care team."[14] These standards make clear that cultural competence education must be integrated into our training programs at every learner level. In fact, they must be inculcated into the lifelong learning of every competent emergency physician.

Barriers to Implementation of Cultural Competency Education

Successful change within the educational environment mandates the exploration of current attitudes and practices that represent barriers to the implementation of more culturally sensitive care. We will briefly explore two major classes of barriers: 1) educational barriers, e.g., what and how we teach, and 2) professional barriers, e.g., how we model what we value by what we do.

Educational barriers take many forms and often start very early in medical school training. As one of the first acts of medical education, students are taught to perform the core clinical skills: history and physical examination. Becoming competent at this task implies learning and performing what Good calls "clinical narratives."[15] As students achieve the most basic skill level in the performance of the clinical narrative, they elicit all the information the

patient can provide and use this to discuss and diagnose. As they advance in skill and medical knowledge, the acquisition of advanced clinical material leaves little room for a focus on the "cultural" intricacies of patients' presentations.[15] Students are pushed to "[sharpen] their biomedical 'gaze' and [develop] their clinical reasoning," often at the expense of addressing "the 'psychosocial' aspects of patents' illnesses, social histories and emotional states, and their lives outside of the hospitals and clinics," leaving these chapters irrelevant and non-contributory to everyday rounds and presentations.[15] This method is continually reinforced throughout training. Because there is no reinforcement for evaluating and valuing all aspects of patients, including their culture and beliefs, students learn to diminish those parts of patients that are outside of the mainstream clinical narrative.

Anne Fadiman illustrates this in her book on medical multiculturalism, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, when she states, "Western medicine is one-sided. Doctors endure medical school and residency in order to acquire knowledge that their patients do not have…it would be asking a lot of them to consider, much less adopt, the notion that their view of reality is only a view, not reality itself."[16] This statement challenges the traditional perspective generated by medical training and forces the consideration of adopting a more culturally responsive, patient-centered focus for care.

Professional Barriers

In addition to what and how students and residents are taught, focus must be placed on the methods that inculcate and reinforce desired behaviors. Students often report receiving conflicting messages between what they learn in the classroom and what they observe in the clinical setting. This variance often leads to confusion about which values to uphold and appropriate behaviors to demonstrate.[17,18] Senior residents and attendings often reinforce behaviors that may be maladaptive to embracing cultural awareness. In a typical clinical training environment, the trainees' efforts are often focused on providing patient care that will impress and gain the approval of senior members of the team for the purposes of grading, evaluation, and career promotion. If the attending or senior residents do not place value on enhanced cultural awareness, then this appraisal-based focus may lead to the modeling and reinforcement of

negative traits at the expense of understanding the cultural components of the patient. Over time, these behaviors become established, and the student learns to evaluate patients' social-cultural aspects less and less.[19] Although much instruction may take place in settings with diverse patient populations, trainees, faculty, and senior members of the medical team may not see diversity as a priority.[20] When they present cultural information, educators may have too simple an understanding of "culture" and may inadvertently foster and perpetuate rigid stereotypes of what members of a particular culture believe, do, or want.[21] Faculty and senior residents who model cultural awareness and value culture from the perspective of the patient are strong professional models for the development of culturally-sensitive learners.

Summary of Representative Educational Models

To identify what educational models for teaching cultural competency currently exist, a computerized literature search of the National Library of Medicine was performed using the PubMed search engine. The following terms were included as both Medical Subject Headings (MESH) and as text words: cultural competency, cultural, cultural diversity, multicultural, mental competency, competence, clinical competence, ethnology, education, medical, medical education, internship, residency. Limits of the search were "English language," and "1995 to the present." Search results yielded 142 articles, which were reviewed for their applicability of the educational methods or curricula to cultural competency education. A full review of all articles is outside the scope of this article; however, we selected a representative sample of educational offerings that give educators an overview of the types of educational interventions that have addressed this topic. The following educational models were selected based on their illustrative nature and unique applicability to teaching cultural competency in the ED settings. Other selected educational models are listed in Table 1.

Culture of the Community Model: University of Massachusetts Medical School[20]

This is an ongoing cultural competency faculty development program adopted from the standards set by the university. The goal of the program is to directly and indirectly elevate the quality of faculty teaching through behavioral modeling. It integrates cultural diversity into the training of community preceptors from 13 medical schools in New England. The cornerstone of the program is a series of four two-day workshops that take place over 18 months. The

curriculum uses the GNOME (Goals, Needs, Objectives, Methods and Evaluation) concept throughout workshops utilizing interactive lectures, role-play exercises on cultural needs assessment, patient-centered interviewing, feedback on cultural issues, and the use of the community to enhance cultural understanding. This type of intermittent program which uses a variety of teaching methods can be applied to any learner type: students, residents, and faculty. It will also integrate well into traditional EM conference schedules or large regional or national meetings.

Culture and Diversity Course Model: Wake Forest University[22]

This course is a theoretically-based, year-long cultural competency training program for second-year medical students based on the 27 core competencies outlined in the American Medical Student Association's Promoting, Reinforcing and Improving Medical Education project (AMSA PRIME). The goals of the course include effective communication, self-directed independent learning, critical thinking and problem-solving, and facility with technology. The course incorporated interactive lectures, videos, simulation, demonstration, role plays, workshops, patient interviews (including those with interpreters), community-based service-learning, and online problem-based learning cases. The course was designed using Howell's levels of competence to move students from an unconscious incompetence (Level 1) to a conscious competence (Level 3), as well as Bennett's developmental model that includes six developmental stages.[23,24] This is another example of a mixed method educational intervention. This intervention's curriculum is grounded in specific competencies and a theoretical framework that make assessment and skill acquisition discretely measurable. It is an excellent structure for residency training programs to emulate as they are held accountable for the EM-specific competencies. The longitudinal nature of this curriculum could be integrated into a standing EM conference schedule.

Portfolio Model: University of Sydney[25]

Personal and Professional Development (PPD) is one of four key themes integrated throughout this longitudinal medical training program. The goals of the PPD program are to foster compassionate, ethical, and professional behavior; teamwork; rational decision-making; self-awareness; commitment to colleagues, and appropriate professional skills. This model is

specifically designed to promote self-directed learner awareness on multiple issues using prompts that are then translated into personal portfolios reflecting each student's explorations of the PPD goals and curriculum. Year-end interviews are conducted by faculty who have read the students' portfolios, allowing for a meaningful exchange between faculty and students to promote awareness and understanding. Some of the prompts used to stimulate students' self-reflection include: notes on ethical dilemmas and evidence of a systematic approach to resolving them, and notes on readings in the humanities, social sciences, or elsewhere. This type of self-reflection model could easily be incorporated into medical student rotations or residency training programs, as culturally challenging cases are seldom lacking in the ED. The model has the advantage of forcing residents and students to ask questions of culture for each of their clinical encounters as they search for their portfolio entries. It also forces an examination of personal biases, which are not often explored in the large group lecture-type setting.

Immersion Model: Wellington School of Medicine and Health Sciences[26]

The Immersion Model is designed to promote learning about other cultures and provide opportunities for students to learn some of the principles associated with cultural safety, which may in turn address the problem of unconscious inherited racism in medical training. The model is a one-week immersion program for third-year medical students in which they are placed in a remote region with one of the New Zealand tribes to learn about the culture and to assess health needs. As more and more residents seek international electives, this type of elective offering, if well-structured, could provide in-depth experiences with culture that may be difficult to replicate within the traditional hospital setting. Programs adopting this type of immersion method should carefully establish their learning objectives and goals for the experience in advance. Self-reflection, critical appraisal, and teaching others about the experience from the lens of culture and health care, rather than a travel log approach, will make immersion experiences more robust.

Cross-Cultural Communication and Negotiation Models

In addition to specific educational models, several cross-cultural communication and negotiation models exist to assist students, residents, and physicians in gaining important cultural information during a physician-patient interview. These critical skills underpin all successful cross-cultural clinical encounters. A summary of these models is cited in the Association of

American Medical Colleges' *Cultural Competence for Medical Students: Assessing and Revising Curriculum*[27] provided in Table 2.

Assessment Methods

The effectiveness of any educational intervention must be measured to insure success and give data for improvement. Several methods can be used to measure the acquisition of culturally competent knowledge, skills, and attitudes. Our literature review identified very few methods validated specifically to measure competency as a result of cultural training. Betancourt's notes in his article "Cross-Cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation"[28] state that to date, there are limited published assessment methods that measure student and resident cultural competency skills. He hypothesizes that the lack of evaluation and assessment tools may be due in part to a lack of consensus regarding what competencies should be achieved. Additionally, there are significant challenges that cross-cultural evaluation poses: social desirability bias and its influence on survey and interview responses when attempting to measure attitudes, the variability among different cultural groups, and the resistance among students and residents to discussing personal perceptions about race, ethnicity, and culture.

Betancourt suggests a three-legged-stool model of evaluating attitudes, knowledge, and skills. To assess attitudes, he suggests a variety of methods, including standard surveying and structured interviewing; however, he notes that these two methods are often lengthy, cumbersome, and labor-intensive and that to truly assess change in attitudes, certain "key questions" should be embedded within other kinds of evaluation or long surveys. He also suggests using self-awareness assessment via facilitated small group discussions and role plays to evaluate attitudes, as well as measuring attitudes as part of an objective structured clinical exam (OSCE) to allow standardized patients to comment on students' attitudes. Lastly, Betancourt suggests that the "gold standard" to evaluate attitudes would be video/audiotaped real clinical encounters between a student or resident and a patient, which would allow a faculty member to provide feedback to the learner.

To assess knowledge, Betancourt suggests using standard evaluation tools such as pre-and-post tests, unknown clinical cases, presentation of clinical cases, and OSCEs; however, he

cautions against testing knowledge of the behaviors and customs of certain cultural groups since this can lead to stereotyping and send the message that culture is static. Instead, Betancourt suggests evaluating students' knowledge of evidence-based cultural issues and knowledge of frameworks that promote patient-centered information-gathering.

Lastly, to assess skills, Betancourt suggests assessment through presentation of clinical cases, OSCEs, and through video/audiotaped clinical encounters.

Additionally, the ACGME's Toolbox of Assessment Methods[29] is an excellent resource for assessment methods. It includes a description of 13 assessment methods and references to articles where more complete and in-depth information about each method can be found. These methods include 360º evaluation, chart-stimulated recall oral examination, checklist evaluation, global rating of live or recorded performance, objective structured clinical examination, case logs, patient surveys, portfolios, record review, simulations and models, standardized oral examination, standardized patient examination, and multiple choice written examination. All of these methods can be adapted to assess cultural competency attitudes, knowledge, and skills.

Emergency Medicine Perspective

Emergency medicine educators must be leaders in cultural competency education. Our practice paradigm of 'any patient any time' demands that we be well-trained to handle diverse cultural expectations, practices, and perspectives on health care. In order to achieve this goal, both educators and trainees must acknowledge and address the current limitations of our educational systems and design and implement effective curricula to insure that every emergency physician is trained to deliver culturally competent care. This will be accomplished by a variety of curricular mechanisms, but all will be designed to foster the learners' ability to examine their personal values associated with culture and to examine how forms of ethnocentrism impact health and health care.

Conclusions and Recommendations

The disparity in health care and health outcomes between the majority population and cultural and racial minorities is a widespread and well-documented problem facing the United

States. To close this gap, emergency medicine educators can play a critical role. Educators and trainees alike must recognize these disparities as critical issues in medicine and focus specific training on the attitudes and knowledge gaps that perpetuate the problem. The development of effective cultural training and curricula in emergency medicine must provide our graduates the skills needed to be effective, culturally competent practitioners. The development and implementation of cultural training programs is an important means of enhancing our understanding and awareness of the importance of culture to all the patients we serve and improving the cultural appropriateness of our health care delivery.

Table 1: Representative Educational Methods Used to Teach Cultural Competency

Author	Specifically used for Cultural Competency	Description
Portfolios		
Gordon[25]	No	Longitudinal portfolio focused on self-reflection and self-evaluation. Faculty review for both formative and summative feedback.
Cultural Immersion		
Crampton[26]	Yes	Cultural immersion program with emphasis on health needs assessment and cultural exposure.
Kamaka[30]	Yes	5-day CME cultural immersion program focusing on cultural aspects of health, traditional healing and impact of culture on MD-Pt relationship.
Godkin[31]	Yes	Coordinated longitudinal curriculum of linguistic, cultural and clinical immersions.
Literary Models		
Shapiro[32]	No	Multi-session seminar series which uses poetry, short stories and other literary media to explore relationships and difficult patient interactions.
Clinical Experience		
Hatem[33]		Two educational programs for professionalism education: Resident as teacher and Bedside teaching.
Esfandiari[34]	Yes	Six-week classroom and clinical experience in tropical health and disease. Two weeks of classroom work followed by a four-week clinical immersion experience.
Takayama[35]	Yes	Pediatric residents receive 18 hrs of instruction in diversity training, cultural issues and field work sessions.

Simulation Models		
Brainin-Rodriquez[36]	Yes	Video prompts focus culture-based discussions and guides development of best practices for culturally sensitive interviews.
Altshuler[37]	Yes	Six-station standardized patient cultural OSCE administered to pediatric residents. Written formative feedback based on checklist evaluation instruments.
Didactic Models		
Goleman[38]	Yes	Four-unit curriculum focused on the development of knowledge, skills, and attitudes needed to span barriers of culture, economics, gender and education.
Nunez[39]	Yes	Defines educational milestones for women's health and cross-cultural objectives and identifies instructional methods and paired evaluation tools.
Kagawa-Singer[40]	Yes	Provides an anthropological perspective on culture and defines the RISK model (Resources, Identify, Skills, Knowledge) for decreasing miscommunication across cultures.
Rosen[41]	Yes	1.5-day workshop using lecture, teaching OSCEs, and small group discussion format. Use the CHAT (Culture and Health-Belief Assessment Tool) to elicit a patient's explanatory model.

Table 2: Models of Effective Cross-Cultural Communication and Negotiation[27]

Models	Sources
BATHE **B**ackground (What is going on in your life?) **A**ffect (How do you feel about what is going on?) **T**rouble (What troubles you most?) **H**andling (How are you handling that?) **E**mpathy (This must be very difficult for you.)	Stuart, M.R. Leibermann, J.R.[42]
BELIEF **B**eliefs about health (What caused your illness/problem?) **E**xplanation (Why did it happen at this time?) **L**earn (Help me to understand your belief/opinion.) **I**mpact (How is this illness/problem impacting your life?) **E**mpathy (This must be very difficult for you.) **F**eelings (How are you feeling about it?)	Dobbie, A.E.[43]
Eliciting Patient Information and Negotiating **I**dentify core cross-cultural issues **E**xplore the meaning of the illness **D**etermine the social context **E**ngage in negotiation	Carrillo, J.E.[44]
ESFT model for communication and compliance **E**xplanatory model **S**ocial risk for non-compliance **F**ears and concerns about the medication **T**herapeutic contracting and playback	Betancourt, J.R.[45]
ETHNIC **E**xplanation (How do you explain your illness?) **T**reatment (What treatment have you tried?) **H**ealers (Have you sought any advice from folk healers?) **N**egotiate (mutually acceptable options) **I**ntervention (agreed on) **C**ollaboration (with patient, family, and healers)	Levin, S.J., Like, R.C., Gottlieb, J.E.[46]

Models	Sources
Kleinman's questions What do you think has caused your problem? Why do you think it started when it did? What do you think your sickness does to you? How severe is your sickness? Will it have a short or long course? What kind of treatment do you think you should receive? What are the most important results you hope to receive from this treatment? What are the chief problems your sickness has caused for you? What do you fear most about your sickness?	Kleinman, A.[47]
LEARN **L**isten with sympathy and understanding to the patient's perception of the problem **E**xplain your perceptions of the problem **A**cknowledge and discuss the differences and similarities **R**ecommend treatment **N**egotiate treatment	Berlin, E.A.[48]
Model for Cultural Competency in Health Care Normative cultural values Language issues Folk illnesses Patient/parent beliefs Provider practices	Flores, G.[49]
"Review of Systems" domains of the Social Context Social stressors and support network Change of environment Life Control Literacy	Green, A.R.[50]

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