AAMC

Tomorrow's Doctors, Tomorrow's Cures

Cultural Competence Education

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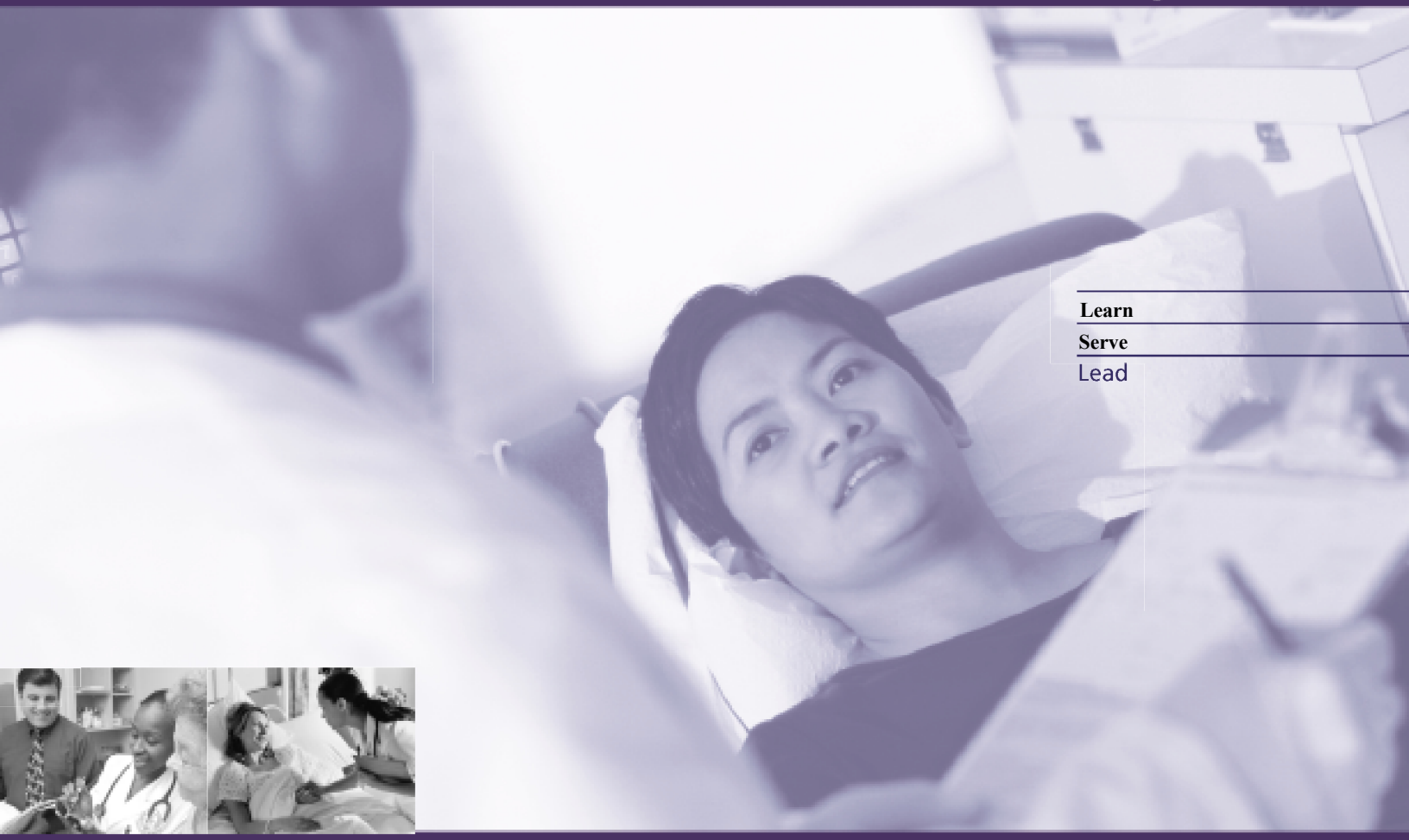

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What is Cultural Competence?

Many definitions of cultural competence have been put forward, but probably the most widely accepted is the following:

Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. "Competence" implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities.[1]

Cultural competence in health care combines the tenets of patient/family-centered care with an understanding of the social and cultural influences that affect the quality of medical services and treatment. With the ever-increasing diversity of the population of the United States and strong evidence of racial and ethnic disparities in health care, it is critically important that health care professionals are educated specifically to address issues of culture in an effective manner. Bodies such as the National Academies of Sciences' Institute of Medicine[2] and the American Medical Association have recognized this.

In 2000, the Liaison Committee on Medical Education (LCME) introduced the following standard for cultural competence:

"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 should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient."

This standard has given added impetus and emphasis to medical schools to introduce education in cultural competence into the undergraduate medical curriculum (or, in some cases, specifically identify it).

[1] Cross, T L et al. Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children, National Center for Cultural Competence, Georgetown University, 1989.
[2] Smedley, B, Ed. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine: The National Academies Press, 2003.

Cultural Competence Curriculum

A cultural competence curriculum cannot be an add-on to the present medical school curriculum. If issues such as culture, professionalism, and ethics are presented separately from other content areas, they risk becoming de-emphasized as fringe elements or of marginal importance. The intent of a cultural competence curriculum is to enhance the patient-physician interaction and assure that students have the knowledge, skills, and attitudes that allow them to work effectively with patients and their families, as well as with other members of the medical community. Cultural competence is complicated: Health-care professionals must be educated to avoid stereotyping, but to also be aware of normative cultural values that can affect informed consent and can have serious consequences.[3]

For a cultural competence curriculum to be effectively put in place, there are certain institutional requirements:

- The curriculum must have the institutional support of the leadership, faculty, and students.
- Institutional and community resources must be committed to the curriculum.
- Community leaders must be sought out and involved in designing the curriculum and providing feedback.
- The institution and its faculty need to commit to providing integrated educational interventions appropriate to the level of the learner.
- A cultural competence curriculum must have a clearly defined evaluation process that includes accountability and evaluation (for example, evidence of a planning process to assure appropriate inclusion of material throughout the curriculum, details on curriculum process and content [including duration and types of educational experiences], specific student feedback, and consideration of outcomes assessment).

Assessing Students in Cross-Cultural Education

Mixed-methods of evaluation that include both quantitative and qualitative strategies are required to appropriately assess the impact of cross-cultural curricula. Betancourt[4] provides a model of how students who have completed cross-cultural curriculum might be evaluated, based on a framework of changes in attitudes, knowledge, and skills (see table following):

[3] Paasche-Orlow, M. The Ethics of Cultural Competence. *Academic Medicine* vol. 79, no. 4, April 2004, pp. 347-350.

[4] Betancourt, J.R. Cross-cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation. *Academic Medicine* vol. 78, no. 6, June 2003, pp. 560-569.

Table 1. Assessing Students in Cross-Cultural Education

Educational Approach Focusing On:	Evaluation Strategy
ATTITUDES **Examples:** Has the student learned the particular importance of curiosity, empathy, and respect in cross-cultural encounters? Does the student exhibit these attitudes, as corroborated by evaluation?	Standard Surveying Structured Interviewing Self-Awareness Assessment Presentation of Clinical Cases Objective Structured Clinical Exam Videotaped/Audio-taped Clinical Encounter
KNOWLEDGE **Examples:** Has the student learned the key core cross-cultural issues, such as the styles of communication, mistrust/prejudice, autonomy vs. family decision-making, the role of biomedicine for the patient, traditions and customs relevant to health care, sexual/gender issues, and so on? Does the student make an assessment of the key core cross-cultural issues, as corroborated by evaluation?	Pretest-Posttests (multiple choice, true-false, and so on) Unknown Clinical Cases Presentation of Clinical Cases Objective Structured Clinical Exams
SKILLS **Examples:** Has the student learned how to explore core cross-cultural issues and the explanatory model? Has the student learned how to effectively negotiate with a patient? Does the student explore the explanatory model and negotiate with a patient, as corroborated by evaluation?	Presentation of Clinical Cases Objective Structured Clinical Exam Videotaped/Audio-taped Clinical Encounter

Evaluating Students in Cross-Cultural Education

To assist medical schools in their efforts to integrate cultural competence content into their curricula, the AAMC, supported by a Commonwealth Fund grant[5], has developed the Tool for Assessing Cultural Competence Training (TACCT). The TACCT reflects the input of experts in cultural competence and medical education. The instrument provides validated recommendations on curriculum content and should be used in conjunction with materials that identify optimal educational methods and evaluation strategies.

The activities that led to the development of the TACCT instrument included:

1. Creating three commissioned papers, published in the June 2003 issue of *Academic Medicine,* that established a basis for deliberations on the domains of cultural competence.
   - Betancourt, J.R. (2003). Cross-cultural Medical Education: Conceptual Approaches and Frameworks for Evaluation. *Acad Med,* 78(6), 560-569.
   - Tervalon, M. (2003). Components of Culture in Health for Medical Students' Education. *Acad Med,* 78(6), 570-576.
   - Kagawa-Singer, M. & Kassim-Lakha, S. (2003). A Strategy to Reduce Cross-cultural Mi scommuni cation and Increase the Likelihood of Improving Health Outcomes. *AcadMed,* 78(6), 577-587.

2. Identifying the major areas or domains of cultural competence that need to be incorporated into medical education programs. A panel with expertise in medicine, anthropology, and other fields was convened for this purpose.

3. Developing a curriculum assessment tool to identify and monitor cultural competence educational experiences throughout the medical school curriculum. The panel tasked with this responsibility included some members of the initial panel charged with delineating the major domains of cultural competence training, as well as experts in curriculum development and evaluation. The panel developed the TACCT instrument, which identifies a location for the potential cultural competence curriculum (year, course, course element).

4. Receiving feedback on the overall areas as well as the structure and utility of the TACCT instrument from medical students, educators, and minority health experts. This is in progress.

[5] *Medical Education and Cultural Competence: A Strategy to Eliminate Racial and Ethnic Disparities in Health Care*, supported by The Commonwealth Fund. Project Director: Ella Cleveland, Ph.D., Director, Pipeline Projects, Division of Diversity Policy and Programs, AAMC.

Using TACCT

The TACCT will assist schools in meeting the stated LCME (www.lcme.org) objectives and clarifications of:

1. *ED-21.* 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.
   Clarification: The objectives for clinical instruction should include student understanding of demographic influences on health care quality and effectiveness, such as racial and ethnic disparities in the diagnosis and treatment of diseases. The objectives should also address the need for self-awareness among students regarding any personal biases in their approach to health care delivery.

2. *ED-22.* Medical students must learn to recognize and appropriately address gender and cultural biases in themselves and others, and in the process of health care delivery.
   Clarification: All instruction should stress the need for students to be concerned with the total medical needs of their patients and the effects that social and cultural circumstances have on their health. To demonstrate compliance with this standard, schools should be able to document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to such material, and demonstrate the extent to which the objectives are being achieved.

A cultural competence educational program that is effectively integrated throughout all years of medical school requires identification and assessment of all components of the cultural competence domains. The TACCT provides a framework for building an effective educational program.

The TACCT is a self-administered assessment tool that can be used by medical schools to examine all components of the entire medical school curriculum. Schools can identify areas in the curriculum where specific aspects of culturally competent care are currently taught, including previously unrecognized educational elements. The TACCT permits gaps to be identified, as well as planned and unplanned redundancies that will allow schools to make the best use of opportunities and resources. The TACCT may be used for both traditional and problem-based learning curricula.

There are two parts to the TACCT grid. The first part (Domains) allows monitoring of overall curricular offerings **(where** teaching is occurring). The second part (Specific Components) provides a framework for identification of education for detailed knowledge, skills and attitudes **(what** learning objectives are being met). In both parts, the evaluation grid should show all required courses listed on the horizontal axis. Each school should use the Excel spread sheets to modify the names of courses, blocks, or clerkships to reflect their own curricular structure. All course, block, or clerkship directors should be asked to complete the TACCT for their course/block/clerkship, even if they believe that cultural competence teaching is not occurring in their course/block/clerkship (in which case their responses should be ‘not taught’ or ‘NT’).

The sample TACCT document identifies courses in the preclinical and clinical segments of the curriculum using standard discipline specific terminology *(e.g.,* physiology, internal medicine clerkship). Each school will have individual or interdisciplinary courses that cover the areas indicated. In completing the grid it is recommended that the school's appropriate course/unit/block names be substituted for the generic terms.

Domains Grid

Completion of the Domain evaluation grid will provide an overall curriculum blueprint. Patterns that emerge may include: absence of content material, content in a single domain through multiple courses and/or a single course/clerkship where the majority of domains are covered.

Specific Components Grid

The use of the TACCT Specific Components grid provided higher fidelity information on educational objectives. It can be used to evaluate the quality of curricular offerings as well as identify teaching and student assessment methods. Effective teaching about cultural competence requires a solid knowledge base, which can be developed in lectures, assignments, and small-group activities. Skill building is most effectively accomplished in interactive, experiential learning settings. Exploring attitudes and developing effective communication strategies require an opportunity for reflection and discussion. The information from the TACCT Specific Components grid can form the basis for a strategic plan to modify and/or enhance the curriculum to assure that medical students receive an appropriate educational experience.

To facilitate accurate and complete curriculum evaluation the following steps are recommended:

1. This assessment should be initiated from the office of the dean or associate dean for medical education.
2. A TACCT (or LCME self-review) committee should be tasked with overseeing this activity. The membership of this committee should have expertise in cultural competence and medical education. In addition, this committee should include individuals who represent each year/segment of the curriculum (year representatives).
3. As an initial step in the process, course, block, or clerkship directors and department chairs should receive an explanatory letter or an electronically communicated message for the process of completing the TACCT from the dean with planned deadlines.
4. The year representatives should arrange face-to-face information meetings with representatives from each course, block, or clerkship to explain the process, provide background information, indicate their availability to serve as a resource for analysis of course content, and so on.
5. Course, block, or clerkship directors (or their designee) should be asked to complete the domain template with the assumption that they are most familiar with what content is being taught in their courses/blocks/clerkships.
6. The TACCT committee can then summarize the collected data and provide an overall blueprint for the medical school curriculum from which to make revisions, deletions or additions.
7. Following completion of the Domains template, course or block directors may then be asked to undertake a more detailed analysis using the TACCT part 2 (Specific Components).

What the TACCT Does NOT Do

While the TACCT provides an overview of where curricula pertinent to cultural competence are offered (which year or which courses, blocks, or clerkships) in the medical school, it may not allow in-depth analysis of the teaching strategies (for example, lecture vs. discussion vs. role-play vs. self-reflection vs. standardized patient practice formats) or actual learning outcomes achieved. Careful examination of what teaching strategies (how learning is occurring) are currently offered, student responses to the teaching (how teaching is being evaluated), and student assessment (what learning outcomes are achieved) appropriate to the objectives, is strongly encouraged. This will allow systematic development of appropriate new or revised curricula to address cultural competence.

The TACCT does not make recommendations for the optimal number of hours to be devoted to each domain or the entire formal cultural competence curriculum. It is intended that each school will derive its own recommendations based on the collective findings of the TACCT administration.

Most importantly, the TACCT does not address the 'informal curriculum' that may influence student learning or achievement of desired cultural competency. To enrich the TACCT approach, schools may opt to conduct focus groups and other alternative evaluations to add depth to their planning process.

Following completion and discussion of the results of the TACCT administration, an examination of the evaluation methods for assessing student performance in the different domains, by the TACCT (or LCME self-study) committee, is highly recommended.

Eliminating racial and ethnic disparities in health care is a complex, multifactor process. It is recognized that one cornerstone of this is assuring that medical education supports the development of culturally competent physicians. The AAMC has developed the TACCT process as a resource to assist in this activity. Staff of the AAMC look forward to working with all the medical schools on this critically important initiative.

TACCT Content Domains

Domain I: Cultural Competence—Rationale, Context, and Definition

A. Definition and understanding of the importance of cultural competence; how cultural issues affect health and health-care quality and cost; and, the consequences of cultural issues
B. Definitions of race, ethnicity, and culture, including the culture of medicine
C. Clinicians' self-assessment, reflection, and self-awareness of own culture, assumptions, stereotypes, biases

Domain II: Key Aspects of Cultural Competence

A. Epidemiology of population health
B. Patient/family-centered vs. physician-centered care: emphasis on patients'/families' healing traditions and beliefs [for example, ethno-medical healers][6]
C. Institutional cultural issues
D. Information on the history of the patient and his/her community of people

Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making

A. History of stereotyping, including limited access to health care and education
B. Bias, stereotyping, discrimination, and racism
C. Effects of stereotyping on medical decision-making

Domain IV: Health Disparities and Factors Influencing Health

A. History of health-care design and discrimination
B. Epidemiology of specific health and health-care disparities
C. Factors underlying health and health-care disparities—access, socioeconomic, environment, institutional, racial/ethnic
D. Demographic patterns of health-care disparities, both local and national
E. Collaborating with communities to eliminate disparities—through community experiences

Domain V: Cross-Cultural Clinical Skills

A. Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class
B. Dealing with hostility/di scomfort as a result of cultural discord
C. Eliciting a culturally valid social and medical history
D. Communication, interaction, and interviewing skills
E. Understanding language barriers and working with interpreters
F. Negotiating and problem-solving skills
G. Diagnosis, management, and patient-adherence skills leading to patient compliance

[6] Pachter, L.M. Etlmomedical (folk) Remedies for Childhood Asthma in a Mainland Puerto Rican Community. *Arch. Pediatr Adolesc Med* vol. 149, no. 9, September 1995, pp. 982-988.

Developing and Implementing A Cultural Competence Curriculum

The five TACCT domains provide a framework for considering the components of a cultural competence curriculum. For each of these domains, there are specific knowledge (K), skills (S), and attitudes (A) that need to be taught and evaluated. The following material provides details on the components for each domain. The individual education experience developed to achieve these goals will be determined by a number of factors including, but not limited to, the level of the learner, available educational resources and other curricular experiences.

Domain I: Cultural Competence—Rationale. Context, and Definition

At the end of medical school, students will:

Kl. Define—in contemporary terms—race, ethnicity, and culture, and their implications in health care.
K2. Identify how these factors—race, ethnicity, and culture—affect health and health-care quality, cost, and consequences.
K3. Identify patterns of national data on health, health-care disparities, and quality of health care.
K4. Describe national health data in a worldwide immigration context.
51. Discuss race, ethnicity, and culture in the context of the medical interview and health care.
52. Use self-assessment tools, asking:
What is my culture? What are my assumptions/stereotypes/biases?
53. Use Healthy People 2010[7] and other resources to make concrete the epidemiology of health-care disparities.
Al. Describe their own cultural background and biases.
A2. Value the importance of the link between effective communication and quality care.
A3. Value the importance of diversity in health care and address the challenges and opportunities it poses.

[7] U.S. Department of Health and Human Services. *Healthy People 2010.* 2nd ed. With Understanding and Improving Health and Objectives for Improving Health. 2 vols. Washington, DC: U.S. Government Printing Office, November 2000.

Domain II: Key Aspects of Cultural Competence

At the end of medical school, students will:

K1. Describe historical models of common health beliefs and health belief models (for example, illness in the context of "hot and cold," Galen and other cultures).
K2. Recognize patients'/families' healing traditions and beliefs, including ethno-medical beliefs.
K3. Describe common challenges in cross-cultural communication (for example, trust, style).
K4. Demonstrate basic knowledge of epidemiology and biostatistics.
K5. Describe factors that contribute to variability in population health.
51. Outline a framework to assess communities according to population health criteria, social mores, cultural beliefs, and needs.
52. Ask questions to elicit patient preferences and respond appropriately to patient feedback about key cross-cultural issues. Elicit additional information about ethno-medical conditions and ethno-medical healers.
53. Elicit information from patient in context of family-centered care.
54. Collaborate with communities to address community needs.
55. Recognize and describe institutional cultural issues.
Al. Exhibit comfort when conversing with patients/colleagues about cultural issues.
A2. Ask questions and listen to patients discuss their health beliefs in a nonjudgmental manner.
A3. Value the importance of social determinants and community factors on health and strive to address them.
A4. Value the importance of curiosity, empathy, and respect in patient care.

Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making

At the end of medical school, students will:

Kl. Describe social cognitive factors and impact of race/ethnicity, culture, and class on clinical decision-making.
K2. Identify how physician bias and stereotyping can affect interaction with patients, families, communities, and other members of the health-care team.
K3. Recognize physicians' own potential for biases and unavoidable stereotyping in a clinical encounter.
K4. Describe the inherent power imbalance between physician and patient and how it affects the clinical encounter.
K5. Describe patterns of health-care disparities that can result, at least in part, from physician bias.
K6. Describe strategies for partnering with community activists to eliminate racism and other bias from health care.
51. Demonstrate strategies to assess, manage, and reduce bias and its effects in the clinical encounter.
52. Describe strategies for reducing physician's own biases.
53. Demonstrate strategies for addressing bias and stereotyping in others.
54. Engage in reflection about their own cultural beliefs and practices.
55. Use reflective practices in patient care.
56. Gather and use local data as examples of Healthy People 2010.
Al. Identify their own stereotypes and biases that may affect clinical encounters.
A2. Recognize how physician biases impact the quality of health care.
A3. Describe/model potential ways to address bias in the clinical setting.
A4. Recognize importance of bias and stereotyping on clinical decision-making.
A5. Recognize need to address personal susceptibility to bias and stereotyping.

Domain IV: Health Disparities and Factors Influencing Health

At the end of medical school, students will:

K1. Describe factors other than bio-medical—such as access, historical, political, environmental, and institutional—that impact health and underlie health and health-care disparities.
K2. Discuss social determinants on health including, but not limited to, the impact of education, culture, socioeconomic status, housing, and employment.
K3. Describe systemic and medical-encounter issues, including communication, clinical decision-making, and patient preferences.
K4. Identify and discuss key areas of disparities described in Healthy People 2010 and the Institute of Medicine's Report, Unequal Treatment.[8]
K5. Describe important elements involved in community-based experiences.
K6. Discuss barriers to eliminating health disparities.
51. Critically appraise the literature as it relates to health disparities, including systems issues and quality in health care.
52. Describe methods to identify key community leaders.
53. Develop a proposal for a community-based health intervention.
54. Actively strategize ways to counteract bias in clinical practice.
Al. Recognize the existence of disparities that are amenable to intervention.
A2. Realize the historical impact of racism and discrimination on health and health care.
A3. Value eliminating disparities.

[8] Smedley, B, Ed. Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care. Institute of Medicine: The National Academies Press, 2003.

Domain V: Cross-Cultural Clinical Skills

At the end of medical school, students will:

K1. Identify questions about health practices and beliefs that might be important in a specific local community.
K2. Describe models of effective cross-cultural communication, assessment, and negotiation. (See following pages for some models.)
K3. Understand models for physician-patient negotiation.
K4. Describe the functions of an interpreter.
K5. List effective ways of working with an interpreter.
K6. List ways to enhance patient adherence by collaborating with traditional and other community healers.
51. Elicit a culture, social, and medical history, including a patient's health beliefs and model of their illness.
52. Use negotiating and problem-solving skills in shared decision-making with a patient.
53. Identify when an interpreter is needed and collaborate with interpreter effectively.
54. Assess and enhance patient adherence based on the patient's explanatory model.
55. Recognize and manage the impact of bias, class, and power on the clinical encounter.
Al. Demonstrate respect for a patient's cultural and health beliefs.
A2. Acknowledge their own biases and the potential impact they have on the quality of health care.

Models of Effective Cross-Cultural Communication and Negotiation

Models	Sources
BATHE Background (What is going on in your life?) Affect (How do you feel about what is going on?) Trouble (What troubles you most?) Handling (How are you handling that?) Empathy (This must be very difficult for you.)	Stuart, M.R., Leibermann. J.R. (1993). The fifteen-minute hour: applied psychotherapy for the primary care physician. New York: Praeger.
BELIEF Beliefs about health (What caused your illness/problem?) Explanation (Why did it happen at this time?) Leam (Help me to understand your belief/opinion.) Impact (How is this illness/problem impacting your life?) Empathy (This must be very difficult for you.) Feelings (How are you feeling about it?)	Dobbie, A.E., Medrano. M.. Tysinger. J.. Olney, C. (2003). The BELIEF instrument: a preclinical teaching tool to elicit patients' health beliefs. *Family Medicine,* 35:316-319.
Eliciting Patient Information and Negotiating Identify core cross-cultural issues Explore the meaning of the illness Determine the social context Engage in negotiation	Carrillo, J. E., Green, A. R,, & Betancourt, J. R. (1999). Cross-cultural primary care: a patient-based approach. *Ann Intern Med, 130(10*), 829-834.
ESFT model for communication and comnliance Explanatory model Social risk for noncompliance Fears and concerns about the medication Therapeutic contracting and playback	Betancourt, J.R., Carrillo, J. E.. & Green. A. R. (1999). Hypertension in multicultural and minority populations: linking communication to compliance. *Curr Hy pertens Rep, 1(6),* 482-488.
ETHNIC Explanation (How do you explain your illness?) Treatment (What treatment have you tried?) Healers (Have you sought any advice from folk healers?) Negotiate (mutually acceptable options) Intervention (agreed on) Collaboration (with patient, family, and healers)	Levin. S.J.. Like. R. C.. Gottlieb. J.E. (2000). ETHNIC: A framework for culturally competent ethical practice. *Patient Care* 34 (9). 188-189.

Models of Effective Cross-Cultural Communication and Negotiation

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,, Eisenberg, L., Good, B. (1978). Culture, Illness, and Care: Clinical lessons from anthropologic and cross-cultural research. *Annals of Internal Medicine,* 88:251-258.
LEARN Listen with sympathy and understanding to the patient's perception of the problem Explain your perceptions of the problem Acknowledge and discuss the differences and similarities Recommend treatment Negotiate treatment	Berlin, E.A., Fowkes, W.C. (1983). A teaching framework for cross-cultural health care. *The Western Journal of Medicine,* 139, 934-938.
Model for Cultural Competency in Health Care Nonnative cultural values Language issues Folk illnesses Patient/parent beliefs Provider practices	Flores, G (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. J Pediatr 136, 14-23.
"Review of Systems" domains of the Social Context Social stressors and support network Change of enviromnent Life control Literacy	Green, A. R,, Betancourt, J. R., & Carrillo, J. E. (2002). Integrating social factors into cross-cultural medical education. *Acad Med,* 77(3), 193-197.

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