

Cross-cultural Integrative Medicine at BUSM [CCIM]

Report and recommendations to the Clinical Curriculum Subcommittee.

Presented: February 8, 2005.

Executive summary:

Attitudinal goals such as those heavily weighted in a curriculum of this type must be addressed early during medical education and readdressed regularly.

Trainees as well as faculty can be expected to evolve along a **developmental continuum** [see Bennett]; progress should be should be serially revisited.

In some clerkships “**an aura of cultural sensitivity is engendered and expressed within our clerkship without any expressed designated instruction unit or time.**” This aura is invaluable and should be nurtured even as more formal activity is added.

In *ICM* and *IP* many cases have “**built-in**” features that might evoke dialogue related to ethical, psychosocial, or cross-cultural dimensions of patient care, but not all small group leaders are equally comfortable with facilitating these types of sessions.

Current availability of well-intentioned **faculty with proper skills and motivation** may not be sufficient to achieve educational goals.

In some clerkships, **cultural competence is not part of the formal curriculum.**

Although the **clinical exposure on the wards affords a remarkable opportunity to address cross-cultural issues, all such discussions are currently of an ad hoc nature and are at the discretion of course faculty and ward attendings.**

With few exceptions, this exposure to linguistic, racial, ethnic, and other related dimensions of **our special patient population is dealt with in no systematic way during the years of clinical training.**

An ongoing program of **faculty development** and ongoing learning may be required to fully realize the **rich potential we have at BUSM** for cross-cultural medical education.

Like-minded faculty are often working without the benefit of an **organizational infrastructure that cross-fertilizes their efforts, supports and encourages concrete teaching projects, and minimizes duplicated effort and competition.**

BUSM has no mechanism in place as yet to provide an overview of educational goals and the means chosen to achieve them in the area of CCIM.

An expanding literature exists on cross-cultural education in general with recent work on conceptual models for medical education specifically [see Appendix A].

National experts have codified the **key elements of a curriculum** for cross-cultural undergraduate medical education [see Appendix C].

Evaluation strategies for cultural competency are becoming available [see Appendix B].

The purpose of this report is neither to review the literature on the teaching of *Cross-cultural Integrative Medicine* nor to propose a specific model or guiding philosophy for use here at BUSM, but to suggest that we **establish a mechanism** by which our curriculum evolves in a manner consistent with established educational goals.

BUSM is ready to begin the process of **gradual implementation of strategies for cross-cultural education that will be of high quality, realistic, cost-contained, and integrated with existing elements and structures within the curriculum.**

Table of Contents:

- I. The Committee's charge
- II. Committee members
- III. Definition of Cross-cultural and Integrative Medicine [CCIM]
- IV. Current status of cross-cultural education at BUSM
- V. Background
- VI. Recommendations
- VII. Potential consultants
- VIII. Potential resources
- IX. References

I. The Committee's charge:

Dr. Ben Siegel charged **Dr. Eric Hardt**, Clinical Director of Geriatrics, to chair a committee to:

- 1] explore how Cross-cultural Integrative Medicine [CCIM] is taught in the clinical years and review what students are exposed to in the preclinical years.
- 2] make recommendations for a Cross Cultural Integrative Medicine curriculum addressing these issues to be integrated into the clinical years.
- 3] suggest resources necessary for faculty and curriculum development to sustain these efforts.

Committee members and other informants agreed that **attitudinal goals** such as those heavily weighted in a curriculum of this type must be addressed early during medical education and readdressed regularly. As related knowledge and skills are developed later in the curriculum, attitudes of trainees can be expected to evolve along a **developmental continuum [see Bennett]**; progress for students, faculty, and courses themselves should be serially revisited. Perhaps more than in other curricular areas, the availability of well-intentioned faculty and proximity to good teaching cases may not be sufficient to achieve educational goals. An ongoing program of **faculty development** and ongoing learning may be required to fully realize the unusually rich potential we have at BUSM for cross-cultural medical education.

II. Committee members:

Eric J. Hardt MD, Chairman; **Linda L. Barnes MTS, MA, PhD**; **Karen Bryant MD**; **Kenneth C. Edelin MD**; **Benjamin Siegel MD *ex officio***. This faculty was complemented by three students: **Joyce Yang M05**, **Tiffany Mosley M06**, and **Chinenye Adimora M07**. The Chairman has found widespread and increasing enthusiasm for this work among many students and faculty alike for many years. A group of committed faculty has been meeting for several years as **The Diversity Curriculum Taskforce of the Boston University Residency Training Program in Internal Medicine**; their contributions are noted in this report. Impressions and recommendations have been influenced by many informal discussions with students for whom dialogues about cross-cultural issues have typically begun in the context of IP and ICM courses. Many students seem eager to have input into curriculum planning. This report was also very helpfully informed by the **survey of the BUSM curriculum conducted by Dr. Kenneth Edelin and presented in 2002 as: "Health Disparities: The Role of Medical Students in Closing the Gap."**

III. Definition of Cross-cultural Integrative Medicine [CCIM]

The intellectual domains of “**Cross-cultural Medicine**” [CCM] and “**Complementary and Alternative Medicine**” [CAM] are both commonly victimized by intellectual stereotyping. Discussions of CCM are often restricted to issues of immigrant health and medical interpretation implying that cultural differences are present only in a minority of special encounters typically involving foreign-born patients. CAM is often discussed as a set of esoteric health-related practices that lie outside of the experience of the typical patient that we see. In this report we offer the notion of **Cross-cultural Integrative Medicine [CCIM]** that sees cultural and interpersonal dimensions of medical care as critical to the success of every provider in virtually every encounter. We see the care of most patients as interfacing, if not including, issues of the spiritual and cultural meaning of illness and the use of community-based remedies and practices that offer help.

Cross-cultural Integrative Medicine is an emerging medical paradigm that encompasses three core principles: **culturally-grounded patient-centered care**, **relationship-centered care**, and the **coexistence of evidence-based biomedicine with complementary and alternative medicine**. The CCIM paradigm also holds to the notion that current biomedical methods of defining and assessing data and evidence may not adequately capture the full scope of efficacy as understood within the many culturally and religiously based versions of CAM. CCIM seeks methods of care, research, and training that more adequately addresses this potentially broader range of meaning.

Culturally grounded patient-centered care sees the patient as a complex individual with biological, psychological, social, economic, cultural, and spiritual dimensions. With this approach the practitioner seeks to understand the cultural sources of strength and resilience that serve the patient and family. Also considered are the various structural forces that may impose barriers to optimum access and quality of care: race, ethnicity, class, gender, sexual orientation, religious identity, immigration status, and others. The practitioner also attempts to understand the patient’s unique goals, expectations, belief systems, worldviews, and strengths. Disease and illness are seen as distinct: disease is the biomedical entity; illness is the individual’s unique experience of the disease, often shaped by cultural and/or religious explanatory models.

Relationship-centered care sees the human interaction as a critical component of any treatment or healing activity. The relationship between the clinician and patient itself can have therapeutic potential above and beyond the specific therapeutic modality employed. The clinician brings to this relationship respect, compassion, and positive regard for the patient along with the intention to earn the patient’s trust. The relationship-centered clinician is committed to reflective practice that attempts to identify personal and institutional perceptions and attitudes that may contribute to health disparities. As a self-identified patient advocate, he resolves to address these problems with an eye to social justice. This clinician attempts to understand how each patient is situated as a decision-maker within a network of relationships potentially including family, friends, and co-workers, faith communities, along with biomedical and other healing professionals. All parties are seen as potential allies in the therapeutic process.

Lastly, CCIM seeks to combine appropriately and responsibly the widely accepted biomedical modalities with any **safe, evidence-based CAM** modalities that may be important to the patient. This concept may generalize to include respect for culturally and/or religiously-based practices that may relate to a patient’s more broadly defined understanding of health and well-being.

IV. Current status of cross-cultural education at BUSM:

A reasonable inventory has been completed of the ongoing efforts to teach CCIM at BUSM. With few exceptions, formal efforts seem to have arisen from the work of interested faculty working alone or with a few supportive colleagues. As has been said in the case of medical ethics, efforts have been largely *ad hoc*, incomplete, and uneven. In the preclinical years, the effectiveness of the curriculum is often dependent of the performance of a single lecturer, preceptor, or group leader. If evaluation is unsatisfactory, material may be displaced from the curriculum. Like-minded faculty are often working without the benefit of **an infrastructure that cross-fertilizes their efforts and minimizes duplicated effort and competition**. In the clinical years approaches to cross-cultural issues are very uneven. Some clerkships have no organized activity. There seems to be a prevalent assumption that proximity to a diverse patient population and, in some cases, to a diverse faculty will suffice to achieve some type of valid educational experience in CCIM. In other cases, optional readings or bibliographic material is provided to students with no required or even available venue for dialogue and discussion. **There seems to be no location as yet for the maintenance of an overview of educational goals and the means chosen to achieve them in the area of CCIM over the four years of training at BUSM.**

Most of the overt structured teaching of CCIM at BUSM occurs during the preclinical years and seems concentrated in a very few locations. ***Introduction to Clinical Medicine , ICM I and II*** [Nanette Harvey MD, course director], offer the most direct invitation for students to **consider their own level of cultural competency and to consider issues of cultural differences, language barriers, and health care disparities based on racial and other biases**. Students have offered very positive feedback on the single lecture on “Cross-cultural Medicine” given most recently by a panel of three faculty [Dr. Sheila Chapman, Dr. Eric Hardt, and Dr. Thea James, all members of the Diversity Curriculum Task Force]. This four week module also includes patient contact sessions in which the student uses the RESPECT Model [developed by the Diversity Curriculum Taskforce, see Appendix 4 and Bigby 2004] to guide their subsequent clinical exercises. Student input suggests the need for faculty development here as some preceptors seem to “have no clue” about this material and have trouble even finding “appropriate patients.” The final small group meetings afford a critical opportunity for working with CCIM materials, but **not all small group leaders are equally comfortable with facilitating these types of sessions**. Some faculty have already expressed interest in having some form of written guidance in this area [e.g. in the form of an expanded “facilitators’ guide”]. Additionally, discussions may be stimulated or suppressed by the interactions among group leadership and group members in terms of racial and ethnic composition. Left to random, the **racial, ethnic and cultural makeup of the student group** may determine some of the potential issues addressed or may affect the tone and feeling involved in the discussion. This approach may have some merit, but may fail in some cases. Most importantly, these sessions must leave the student with the feeling that cultural competency, as it contributes to the ability to promote healthy doctor-patient relationships, is a **necessary skill for all medical professionals in all encounters**. This core competency is not analogous to other skill sets relevant to only certain clinical situations like “Taking the Sexual History” or “Taking the Substance Abuse History.” It needs to be established early that our expectation is for students to become involved in lifelong personal development in this area.

Integrated Problems I and II [Dr. Adrienne Rogers and Peter Shaw, course directors] offers another two year longitudinal venue for teaching CCIM. Cased-based discussions are driven by carefully constructed case studies as written by a case-writers group. Cases are designed to recall or foreshadow course material from preclinical studies. Additionally they invite students to develop intellectual habits that promote individual and group learning and inquiry, critical thinking, hypothesis generation, and evidence-based medical practice [EBM]. Many cases have “**built-in**” features that might evoke dialogue related to **ethical, psychosocial, contextual, or cross-cultural dimensions of patient care**. For example, one scenario in the EBM portion of the course challenges student groups to critically review data on the use of a common herbal remedy. Unfortunately, in this format these aspects compete with the “hard” biomedical aspects of the case that students are so eager to learn. Once again, not all preceptors are equally equipped and interested in facilitating discussions of this type of material; student experience seems variable. Still, small modifications in case material and **orientation/training/selection of group leaders** might allow important progress in this important course.

Essentials of Public Health [Dr. Michael Grodin, course director] offers students another series of potential exposures to issues of CCIM. One lecture in this course has been devoted to “**Race, Ethnicity, Culture, and Health.**” This lecture has been given by three different faculty members over the past four years; it has been given most recently by another member of the Diversity Curriculum Taskforce [Dr. Julie Crosson]. As in many other courses, issues related to CCIM may be referenced in other lectures, but no others claim to address them formally.

Students interviewed informally mention a variety of teaching moments that relate to CCIM in a variety of preclinical courses including ***Psychiatry, Genetics, Infectious Disease, Pharmacology, Pathology, and Biology of Disease.*** In ***Psychiatry I*** one weekly session has been devoted to “Culture and Development.” One student mentioned exposure in ***Psychiatry*** to common terms used by patients although this material was not extended into clinical contexts in the clinical years. Beyond ***Psychiatry I***, it seems unlikely that a coordinated effort to teach CCIM would be efficient in these settings, but one might conceive an infrastructure that would inventory the concepts and illustrative details to which students have been exposed.

With some exceptions, during the **years of clinical training** discussions of issues specifically related to CCIM are largely **afterthoughts and curiosities** as students face the huge body of knowledge and complex skill set of clinical medicine:

YEAR 3:

Family Medicine: Under the direction of a group including **Drs. John Wiecha, Lana Habash, and Peter Shaw** the Family Medicine clerkship has specifically developed a **cross-cultural curriculum including learning objectives over a range of knowledge, skills, and attitudes**. At the core of the methodology is web-based learning involving families into which a variety of cross-cultural issues have been programmed. Issues include those related to the use of medical interpreters, end-of-life issues, impact of spirituality, culturally determined values, and maternal-child health issues. This work has been grant-funded and is ongoing. Efforts are active to **coordinate educational goals with those of other clerkships** including *Pediatrics* and *Geriatrics*. This group is likely to continue to develop as a potential location for grant supported work and as a **source of interested faculty** who would benefit quickly from faculty development activity.

Pediatrics: The structured cross-cultural educational work within the third year *Pediatrics* clerkship primarily involves activities developed by the Boston Healing Landscape Project led by **Linda Barnes, PhD**. These include an introduction to the clerkship given by **Drs. Seigel and Barnes** during which cross-cultural issues are introduced. This is supplanted by a Core Conference on **Culture and Spirituality** led by Linda Barnes which reviews students personal cultural backgrounds, experience with complementary and alternative therapies, and religious worldviews and practices. These interacting aspects are then applied to student case experience. Finally, the clerkship includes a required weekly session entitled the **Humanism in Medicine Seminar** led by **Benjamin Seigel MD, Linda Barnes PhD, and Patricia Moffat MD**. Its purpose is to generate discussion of aspects in the process of becoming a physician that do not always receive attention in clinical training, such as interpersonal dynamics, cross-cultural issues, ethical dilemmas, emotional struggles, spiritual challenges, and other issues that arise either in this rotation or previous ones.

Obstetrics/Gynecology: Per the comments of **Drs. Phillip Stubblefield and Richard Brown**, the course director, this rotation quietly attempts to weave the thread of cultural sensitivity into the fabric of its teaching. Students are taught to manage each patient in the context of her culture, race, and religion and her current circumstances. This practice location seems to offer many examples of cases where cultural elements in the lives of patients have obvious clinical impact. A highly **diverse faculty** working closely with students provides many informal opportunities for sharing of cultural insights. **Formal seminars relating to cross-cultural issues were planned additions to the scheduled lecture series nearly three years ago but have not yet been developed**. Still, the course director feels that **“an aura of cultural sensitivity is engendered and expressed within our clerkship without any expressed designated instruction unit or time.”**

Surgery: Per course director, **Dr. Erica Brotschi, cultural competence is not part of the formal curriculum**. Attempts are made to teach students how to communicate with patients respectfully and in clear language. The course director is open to suggestions about what more might be done.

Psychiatry: Some introduction to issues of CCIM related to Psychiatry have been presented to students during the preclinical years before they enter the third year clerkship

according to clerkship director **Dr. Douglas Hughes**. During the actual rotation the students are exposed to a broad diversity of clinical material and have ample time for one on one discussions with precepting staff. Neither the 40 page introductory summary nor the six weekly lectures contain material specifically identified as “cross-cultural,” but all psychiatric content is presented with sensitivity to issues of minority health, refugee health, women’s health, sexual preference, and life cycle. No specific readings, discussions, lectures, or experiences are designed to emphasize or highlight issues of CCIM.

Medicine: The third and fourth year rotations in Medicine [clerkship director, Dr. Warren Hershman] have no special cross-cultural components or stated learning objectives. Weekly “**Clinical Topics Talks**” are all based on standard topics in Internal Medicine. Weekly “**Physical Diagnosis**” sessions typically underrepresent or exclude patients who don’t speak English; other potentially interesting cross-cultural issues are typically not addressed. None of the structured clinical case discussions have been designed to bring out cross-cultural issues. Of the 32 intricately designed “**Clinical Problem-solving Cases,**” a total of five mention race or ethnicity in any way: one is a “white” 62 year old diabetic; one is a 78 year old of “Scandinavian ancestry” with B12 deficiency; one patient with “Mediterranean Anemia” has family origins in Southern Italy; one patient is a homeless Russian immigrant with alcoholism; and the final and perhaps most upsetting case in the series, the only case identified as “African-American,” is a 21 year old black man with heroin addiction, noncompliance, violent and assaultive behavior who receives hemodialysis while in prison and eventually arrives in the ED as a DOA. Clearly a case such as this last one has the potential either to reinforce established stereotypes and biases or to direct a group toward new ways of thinking about patients for whom clinicians are expected to have positive regard. **Although the clinical exposure on the wards affords a remarkable opportunity to address such issues, all such discussions are currently of an ad hoc nature and are at the discretion of course faculty and ward attendings.**

YEAR 4:

Geriatrics: The rotation on *Geriatrics* [Dr. Lisa Norton, clerkship director] offers a rich opportunity for the teaching of cross-cultural issues as students have historically spent considerable **time in the community visiting patients in their homes as well as at community nursing homes, adult day health, and other settings.** Over the years the reactions of students have varied from anxiety and fear to amazement over the value they see in understanding the context of patients’ illnesses. The interdisciplinary faculty all have some degree of comfort in teaching about these issues; two faculty members have developed specific career interests in related issues [**Drs. Karen Bryant and Eric Hardt**]. Issues of race, culture, and language are dealt with in individual discussions with students in the course of managing specific patients as in other clerkships. Some issues are addressed as cross-cultural issues involve other content issues in the lecture schedule [e.g. **End-of-Life Issues: Hospice and Palliative Care, Dr. Eric Hardt**]. Interestingly to date formal sessions on cross-cultural medicine have been directed only at geriatric fellows and others participating in the Center for Excellence in Geriatrics and at students attending the Summer Institute in Geriatrics [**Cross-cultural Geriatrics: Issues of Race, Culture, and Language, Dr. Eric Hardt**]. A small amount of funding currently exists to

plan the development of an Ethnogeriatrics curriculum similar to those that have been well-developed elsewhere.

Neurology: [Dr. **Janice Wiesman**, clerkship director]. The “**Neurology Curriculum in Cultural Competency**” currently consists of a handout that includes five nicely designed cases that illustrate points and invite thinking about cultural issues as they affect a number of common clinical situations in Neurology. There is no suggested bibliography, websites, or related articles for further reading. “The cases are for you to read. There will be no formal discussion.” The reasons for the lack of a session devoted to such a discussion are unclear. Perhaps there is no time in the curriculum to devote to these interesting cases; perhaps the issue is the identification of faculty with sufficient time, motivation, interest, and skills to facilitate these discussions.

Radiology: [Dr. **William Cranley**, clerkship director]. No current or planned educational activity in the areas of CCIM.

Fourth Year Electives: During his comprehensive 2002 survey of cultural competency education at BUSM, Dr. Edelin found many groups reporting approaches similar to some of those noted earlier. Some electives, like **Otolaryngology** have developed reading lists that are distributed to students. Others like **Anesthesia, Dermatology, Ophthalmology, and Physical Medicine and Rehabilitation** rely on the students’ proximity to a diverse faculty and patient population to provide *de facto* cross-cultural medical education. This committee found no evidence of any substantive change since these courses were last reviewed.

Other Electives:

1] Race, Ethnicity and Health Seminar. This seminar introduces **Early Medical School Selection Program** students to the pathophysiology of diseases which disproportionately affect racial and ethnic minorities. It explores the role that race or ethnicity have in the occurrence, diagnosis, and treatment of these diseases. Faculty: **Dr. Kenneth Edelin** of Ob/Gyn.

2] Cultural Formation of the Clinician: Its Implications in Clinical Practice. This elective for first and second year students helps them examine cultural biases they might unintentionally bring into their future practices. Faculty includes **Linda Barnes** of Pediatrics, **Lana Habash** of Family Medicine, **Karen Bryant** of Geriatrics, and **Michael Paasche-Orlow** of General Internal Medicine.

3] Cultural Competence and Community-Based Complementary/Alternative Medicine. This fourth year elective for medical students offers an opportunity to gain an understanding of cross-cultural approaches to complementary/alternative therapies. It includes weekly seminars, case discussions, meetings with traditional healers, and field trips. Faculty includes **Linda Barnes** of Pediatrics.

OSCEs: Observed Structured Clinical Examinations have recently become a part of the training and evaluation program at BUSM. These exercises seem to have been well-received by students so far; some effort is being made to recruit more faculty to be involved in providing

supervision and feedback during these exercises. Thus far the programmed patients involved have not been designed to highlight issues of cross-cultural medicine although the possibility remains to use these exercises to provide feedback to students on their skills in working with medical interpreters, in dealing with racial and cultural differences, etc. Attention will need to be paid to the **staff development issues** along with the development of scripts and actors appropriate to a specific set of trainees. Issues of developmental variation among trainees and faculty alike may make the “Cross-cultural OSCEs” particularly challenging.

V: Background:

A survey of all US and Canadian medical schools conducted in 1996-1998 revealed that very few schools [8% of US, 0 % of Canadian] had separate courses specifically addressing cultural issues. Schools in both countries usually addressed cultural issues in one to three lectures as part of larger, mostly preclinical courses [Flores 2000]. As mandates for cultural competency have proliferated along with funding opportunities for program and curriculum development, we can assume that many institutions have made progress since the time of the study. Progress has been made at BUSM in recent years, but the notion of a few isolated learning experiences mostly occurring in the preclinical years still largely describes what we do here at BUSM. Interestingly, our students responses to the AAMC GQ2004 Graduation Questionnaire repeated cite the diversity of the patient populations we see a one of our major strengths; they also cite diversity of clinical exposure and training as a major strength. Still, with few exceptions, this exposure to linguistic, racial, ethnic, and other related dimensions of our special patient population is dealt with in no systematic way during the years of clinical training.

The purpose of this report is neither to review the literature on the teaching of *Cross-cultural and Integrative Medicine* nor to propose a specific model or guiding philosophy for use here at BUSM. An expanding literature exists on cross-cultural education in general with considerable recent work on medical education specifically. Clear conceptual models are now ready to implement [see **Appendix A: Three Conceptual Approaches to Cross-cultural Education. Betancourt J. Acad Med 2003; 78 560-569**]. Evaluation strategies for cultural competency are becoming available. [see **Appendix B: Evaluating Students in Cross-cultural Education Betancourt J. Acad Med 2003; 78 560-569**]. National experts have codified the key elements of a curriculum for cross-cultural undergraduate medical education. [see **Appendix C: Culture in Health: Core Components for Undergraduate Medical Education. Tervalon M. Acad Med 2003; 78 570-576**]. Perhaps the most important step we can take at this point in our institutional development is to establish a mechanism by which our curriculum evolves in a manner consistent with established educational goals in the area of cross-cultural education.

The following recommendations specifically attempt to avoid conflict for curricular time in favor of cross-cultural education over other areas of study. Like all other curricular areas involving humanism and professionalism in medical education, specific time devoted to “special curricula” may be seen as subtracting from time available for other required learning. **Above all else, the time devoted to this material must be well spent and rewarding for the students.** We must assure that we not only fulfill training mandates, but that we contribute to the stated goals of trying **to make our students better physicians by training them to understand the impact of context, family, generic issues of culture, linguistic challenges, and bias on the**

illnesses of their patients. These goals would not be best served by an abrupt and clumsy attempt to expand this curriculum beyond our capacity to do it with the highest quality of pedagogy. Like any other new or expanded curriculum, material should be introduced in phases to ensure highest quality. We need to avoid duplication of material that may produce a negative attitudinal response among our trainees; on the other hand, content and skills-training needs to be reinforced in ways that build on earlier experience. Early exposures may involve large groups, but most attitudinal change is likely to occur in smaller groups that are designed to have some continuity as well as some internal diversity, that are felt by students and faculty to be safe environments for the sharing of very personal experience, and that are led by qualified facilitators. Subsequent exposure to new case material in the clinical years can be dealt with again in larger groups perhaps designed to capture motivated students as they cluster efficiently in various sites [e.g. combined Cross-cultural Rounds].

On the other hand, we have an **unusual wealth of relevant clinical teaching material** here at BUSM and many faculty attitudinally and experientially well-equipped to be teachers and role models for the culturally competent physician. Some of the curriculum already present here is occult and implicit. This approach may be very effective and efficient, but without ongoing tracking and evaluation may be highly vulnerable to small changes like changes in precepting staff. In this area effective teaching can become counterproductive teaching based on the knowledge, skills, or attitudes of a single instructor. In the same way that we must evaluate students developmentally as they are exposed to this material, we must understand, evaluate, support, and develop faculty according to their skill and comfort levels across a range of dimensions within the larger area of cultural competence. Curricular development in the area of CCIM may have an **initial heavy emphasis on faculty development** and the organizing of accessible teaching material and resources. We might anticipate a need for an initial bolus of funding to accomplish this faculty development with the assistance of outside consultants and formal training for our faculty. A variety of potential grant funders exist for this type of highly leveraged faculty development activity. Other activities, e.g. field trips into the community for first year students, will require some type of permanent budgetary support. The items listed below are listed more in temporal order than in order of priority.

VI: Recommendations:

- **Introductory remarks to and experiences** for new first year students should continue to highlight the proximity to diversity that they will have with us at BUSM. Of course, this exposure is a special positive of our program and not merely a challenge that must be endured. This experience is an opportunity to begin a process of personal and professional growth that will last a lifetime. The growth process during the preclinical years may be reflected in **how students relate to and understand each other**; this provides the underpinning for rewarding and effective relationships with patients later in training.
- Each **Department** should be encouraged to plan for an annual **Grand Rounds** presentation that somehow features or includes material designed to advance cultural competency. Presentations might include data from researchers on health disparities, presentations by those with expertise in advocacy/policy/law/regulation, demonstrations by clinician-educators of effective methods for addressing issues of racial/ethnic/cultural/linguistic differences, and so on. Specific evaluation of these sessions should be fed back to a central group that helps plan such events across disciplines.
- The first year student body should be provided with a **physical introduction to the City of Boston** including its diverse communities and neighborhoods. Fourth year students on home visits regularly reveal to us that they have never seen many of the neighborhoods in which our patients live. With some careful planning and some funding we might arrange “**Cultural Duck Tours**” during which our students spend a day on the streets of Boston including a narration carefully scripted to entertain, educate, reassure, and invite students to get to know our city. Such a tour should include brief stops to visit cultural highlights with introductions to appropriate community members and leaders. The tour might serve to introduce students to the concept of neighborhood health centers and specifically to the **Health Net**. This experience will be reinforced when students make home visits during clerkships in *Geriatrics, Pediatrics, and Family Medicine*.
- **Site-specific** [e.g. **BMC, VA**] monthly case-based **Cross-cultural Grand Rounds** should be developed and integrated into existing required sessions for third and fourth year students based at a facility. **Cases might be drawn from material on any service** including Medicine, Surgery, Ob/Gyn, Neurology, and so on and will be designed to be relevant to students on all rotations. Mechanisms will need to be developed and supported for identifying cases and discussants. These sessions might be most easily phased in a part of a “**Professionalism in Medicine**” series that

alternates with or includes cases and discussants/discussions from disciplines like **Medical Ethics, Health Law, Medical Interviewing**, and so on. Intellectual support for initial sessions might emerge from currently ongoing sessions like **Schwartz Rounds** or **Geriatrics Ethics Conference**. Initial funding might facilitate inclusion of local outside experts as discussants such as **Arthur Kleinman** or **Joseph Betancourt**.

- The current range of **electives offered in CCIM** should be gradually expanded as motivated faculty emerge with enthusiasm about what they have to share. These might be modeled after those recently developed by **Linda Barnes** within the context of the Boston Healing Landscape. They might also include more individualized clinical experiences with patients from particular racial, ethnic, or cultural groups that might be organized for particular students by particular faculty; these might be community or institutionally based. They might include **rotations at other institutions** where experiences in cross-cultural medicine have been more developed [e.g. U Mass]; they might include **rotations abroad** as they seem to be of ongoing interest to students. Rotations abroad should attempt to provide a cross-cultural curriculum along with a medical one; evaluation should be designed to include both dimensions.
- Modest, but expanded efforts should continue to **reference cross-cultural issues in each and every course during the preclinical years** [Anatomy, Pharmacology, Microbiology, Psychiatry, BOD, etc]. These items should be consistent with the overall educational goals of the courses and not inappropriately emphasized. Still they must be addressed in order to reinforce their validity.
- **Individual clinical clerkships should be considered developmentally in much the same way that students are faculty might be [see Bennett]:**

For example, those for which CCIM is not currently part of the curriculum [e.g. **Surgery**] should be encouraged/supported to develop a single monthly session and/or suggested readings designed to address material and issues that have direct content connections to the clinical issues seen during the clerkship [e.g. the impact of violence on minority communities, history of medical experimentation, disparities in access/utilization of surgical procedures, etc]. Identification of appropriate faculty interested in developing skills in facilitating such discussion may be critical in these cases.

Clerkships in which cross-cultural education is active, but not highly formalized [e.g. **Ob/Gyn**] might be encouraged to develop a single session of some type that presents material and allows discussion with direct content connections to the clinical issues seen or addressed during the clerkship [e.g. cultural issues in conception, pregnancy, childbearing, prenatal care; cultural stigmatization of STDs, etc.]. Again, faculty will have to be identified to lead these sessions.

Clerkships that already have formalized cross-cultural education for example by providing cases/readings related to CCIM [e.g. **Neurology**] might be encouraged to develop a faculty member who might lead a discussion group based on this material.

Clerkships that have special characteristics that offer particular opportunities for learning in CCIM [e.g. **Geriatrics**] should be encouraged to generate relevant formal sessions or experience [e.g. monthly talk on Ethnogeriatrics], should establish specific educational goals related to CCIM and include related evaluation, and should encourage faculty development with an eye to providing support to faculty development throughout BUSM.

Clerkships that offer intense proximity to clinical issues wrapped in cross-cultural context should be offered collaboration with identified, experienced faculty in an attempt to gently remodel existing teaching material in a manner consistent with the educational goals of cultural competence. For example, the existing well-designed **Clinical Problems Cases** discussed by third and fourth year students on *Medicine* might be rewritten to add sufficient details of context to encourage discussion of issues of CCIM. Existing detail that might support subconscious stereotyping or bias should be revised and the rationale for the revisions discussed.

Clerkships that have already provided leadership in areas of cross-cultural work [e.g. **Family Medicine** and **Pediatrics**] should be looked to for guidance and leadership. Such work cannot always be expanded within a clerkship without giving learners a sense that things are being overdone. On the other hand, faculty that have developed within these areas can be helpful in guiding faculty development elsewhere. Such faculty can be helpful to others looking for funding for curriculum and faculty development.

- **Preclinical courses** like ICM and *IP* and *EPH* where CCIM are already actively being taught should be supported. In particular, these locations provide sites for ongoing **faculty development along a continuum**. Some preceptors come to these courses with considerable experience and expertise, others with less. Course Directors should develop mechanisms by which more faculty are involved and by which the involved faculty are continuously addressing their own personal issues of cultural competency. The **case writers groups** for such courses should be working directly with others looking downstream within the CCIM curriculum to optimize incremental learning and to minimize duplication of effort [e.g. what if the *ICM* case with ALL were to be recast as a Jehovah's Witness; how might we introduce the Schulman study and similar data on health care disparities into an *IP* scenario; etc]. More attention might be paid to the **racial/ethnic/cultural composition of the groups** as it is already paid to issues of gender. Finally we might consider whether ***ICM* might be continued for all or part of the clinical years** in a format that facilitates small group discussions of issues of humanism, professionalism, ethics, cultural competency, and the like. If done, this should be done in a manner that complements rather than duplicating or competing with the educational goals of the **Academies of Advisors Program**.

- Those responsible for the *OSCE* program might consider the potential value of and resources necessary for developing one or more OSCEs that specifically address issues of CCIM including challenges posed by language barriers, the politics of immigrant health, and distrust based on racial/ethnic differences. Such a proposal needs to interface with issues of faculty development and would only be appropriate once we are assured that students being exposed had had documented adequate educational experiences that might predict success on the *OSCE*.
- **This strategic plan should be frontloaded with efforts at faculty development.** We are rich with gifted and motivated faculty who might easily be trained to become increasingly comfortable and effective in addressing issues of CCIM. On the other hand, many busy faculty may be reluctant to try something new or expanded without support, training, and recognition of effort. The medical school needs to deal directly with issues of support/recognition/compensation for time and effort spent in these activities. Such support need not be monetary, but might rather be provided in terms of academic recognition or other negotiable rewards. Examples might include time off and support for attendance in CME activity related to CCIM; we might consider developing a customized version of the **Foundations in Cross-cultural Health** course formerly given by HPHC. Such a three day intensive course could be given here at BUSM thus limiting cost; no better faculty development course of its type has yet been given in the USA.
- A venue or mechanism might be developed for **ongoing interaction** of interested faculty including a core group that may have participated in the Foundations course. This group might meet periodically [e.g. quarterly] and encourage its members to develop **teaching projects** that relate to BUSM clerkships and courses. Ultimately this group might evolve into one capable of sponsoring a **national annual CME offering in CCIM** that could help fund ongoing efforts.
- **Libraries of educational resources** related to CCIM must be made available to faculty in a centralized and controlled location. This collection should include articles, texts, videotape, role plays, and other potential teaching and learning aids.
- A **website** related to the Course Info system might be developed with appropriate links to related resources and similar activities at other institutions. A major head start in this plan could be the website under development by the **Boston Healing Landscape Project** under the direction of **Linda Barnes**. Another suggestion for the website would develop a **chat session** facilitated by experienced facilitators; students on any clerkship might go there to discuss issues relevant to CCIM that they have encountered in clinical settings.
- Evaluation specific to the educational goals of CCIM needs to be integrated into ongoing evaluation activity. Additional venues for feedback and group evaluation

might be considered, e.g. annual **Town Meetings** at which students can provide input into directions for future curriculum development.

- **Collaborative efforts at education in CCIM should be pursued with appropriate local, regional, and national medical schools.** Collaborators should be carefully chosen for their expertise and for their potential to promote collective development among our faculty. Interinstitutional grant proposals and other work might be evaluated and coordinated by a centralized body to ensure that the benefit to BUSM is maximized.
- **Finally, BUSM needs to institutionalize a centralized location to which a variety of functions can be assigned.** At a minimum these functions should include: **annual inventory of CCIM related activity** within BUSM, **review of all feedback and evaluation** related to educational goals in CCIM, provision of an **overview** of the trajectory for CCIM development at BUSM, **facilitation of faculty development activity**, coordination of resource acquisition and availability, facilitation of intrainstitutional and interinstitutional **collaboration** in CCIM, identification and **support** for established and emerging core faculty, and facilitation of funding support. The size, shape, and costs of such an entity may depend more on available resources than on an ideal model; but the quality and quantity of progress in our curricular development in CCIM may depend on the details of those decisions.

VII: Potential Consultants:

Warren Ferguson MD. Consulting Family Physician. Family Health Center of Worcester. Associate Professor, Dept Family Medicine and Community Health University of Massachusetts Med School [Small group session: Patient Care in a Diverse Society]

Joseph Betancourt MD, MPH. Senior Scientist, Institute for Health Policy, Dept of Medicine and Health Policy, Mass General Hospital

Melanie Tervalon: Mueller J, Schor W. Foundations of Patient Care. UCSF School of Medicine Essential Core Curriculum, (<http://www.som.ucsf.edu>).

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Appendix A:

Three Conceptual Approaches to Cross-cultural Education
[Betancourt J. Acad Med 2003; 78 560-569]

Approach A: Awareness/Sensitivity Approach

The primary focus is on provider *attitudes*.

The goal is to increase provider awareness of the impact of sociocultural factors on individual patients' health values, beliefs, and behaviors, and ultimately on the quality of care and outcomes.

Students explore and reflect on culture, racism, classism, sexism, etc.

These factors are discussed as they relate to the provider and the patient culture, and how they may have an impact on clinical decision making.

The importance of curiosity, empathy, and respect in the medical encounter are highlighted.

This approach is primarily taught in early in the first and second years of medical school.

Approach B: Multicultural/Categorical Approach

The primary focus is on increasing provider *knowledge* of cross-cultural issues.

Point out limits of previous focus on teaching unifying cultural characteristics of cultural groups (patients of culture x believe...and behave...).

New focus is to teach methods of community assessment and evidence-based factors.

These include disease incidence/prevalence among groups, ethnopharmacology, and historical factors that might shape health behaviors.

This approach is taught throughout undergraduate medical education.

Approach C: Cross-cultural Approach

The primary focus is on developing *tools* and *skills* for providers.

Process-oriented instruction is used to meld medical interviewing and communication skills with sociocultural and ethnographic tools of medical anthropology. These include

approaches to elicit patient's explanatory model (patient's conceptualization of illness), methods to assess patient's social context, and

strategies for provider-patient negotiation and facilitation of participatory decision making.

A foundation to care for diverse populations is laid through the development of interviewing frameworks.

This is a practical approach for the clinical years.

Appendix B:

Evaluating Students in Cross-cultural Education

[Betancourt J. Acad Med 2003; 78 560-569]

Educational Approach	Evaluation Strategy
Focusing on attitudes	Standard surveying
	Structured interviewing
	Self-awareness assessment
	Presentation of clinical cases
	Objective structured clinical exam
	Videotaped/audiotaped clinical encounter
Focusing on knowledge	Pretest–posttests (multiple-choice, true-false, etc)
	Unknown clinical cases
	Presentation of clinical cases
	Objective structured clinical exams
Focusing on skills	Presentation of clinical cases
	Objective structured clinical exam
	Videotaped/audiotaped clinical encounter

Appendix C:

Culture in Health: Core Components for Undergraduate Medical Education

[Tervalon M. Acad Med 2003; 78 570-576]

Rationale	Why learn about culture in health care?
Culture basics	Definitions, terms, language, concepts Basis in social sciences, especially anthropology Relationship to health and health care Health systems as cultural systems
Health status	Demographics Epidemiology Health disparities Historical context
Clinical encounter: knowledge, Tools and skills	Core cultural issues in context Interviewing skills Interpreters
Provider focus: attitudes and behaviors	Identity Bias, prejudice, discrimination, stereotyping Self-reflection
Community participation: relationships and power	Expert teacher Partnerships Learning environment

Institutional culture and policies

Leadership, goals, vision

Parallel educational process

Workforce composition

Appendix D

The RESPECT Model

[Diversity Curriculum Work Group, BMC 2001]

- **Respect - a demonstrable attitude involving both verbal and non-verbal communications.**
- **Explanatory model - What is patient's point of view?**
- **Sociocultural context - class, race, ethnicity, education, sexual norms and orientation, family and gender roles for example**
- **Power - power differential between patients and providers**
- **Empathy - putting into words the significance of the patient's concerns so the patient feels understood**
- **Concerns and fears - eliciting the patient's emotions and underlying concerns of her/his symptoms**
- **Therapeutic Alliance/Trust - a measurable outcome that will enhance adherence and compliance**

