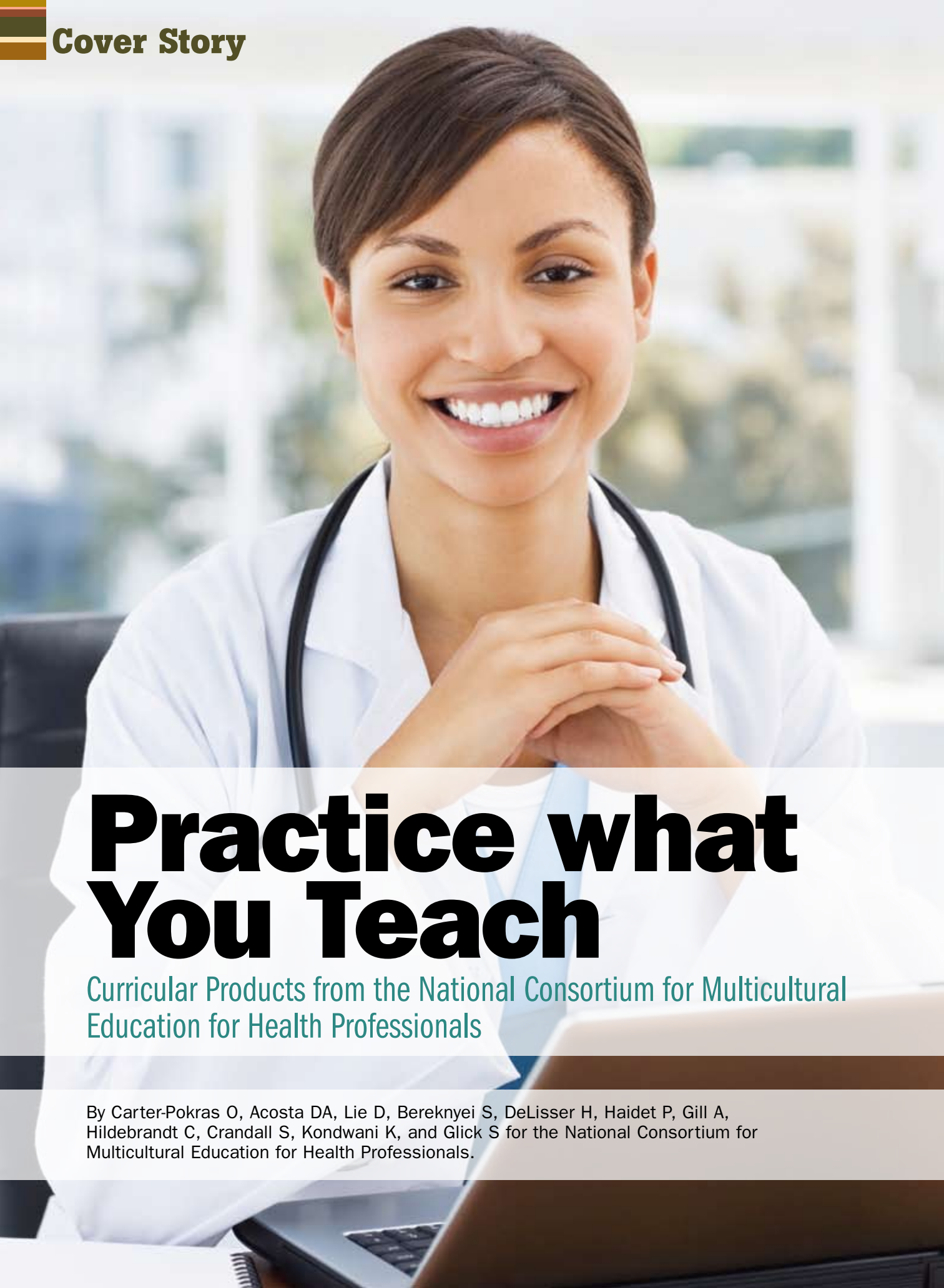

Practice what You Teach

Curricular Products from the National Consortium for Multicultural Education for Health Professionals

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There is growing evidence linking cultural competency training to better patient outcomes (http://tinyurl.com/nhflp7). Continuing medical education laws in California, New Jersey, New Mexico, and Washington now require practitioners to take cultural competency training, and an increasing number of states are expected to impose similar obligations based on lobbying efforts. Regulatory bodies are requiring demonstrated evidence of this training in both health and allied health professionals (LCME, ACGME, and JCAHO). As a result, cultural competency education is becoming standard curricula in most medical schools. The National Consortium for Multicultural Education for Health Professionals (NCME) is creating curricular products for medical students, residents, and physicians. Since 2004, the National Heart, Lung, and Blood Institute (NHLBI) has charged our 18-member consortium with enhancing training on ethnic, cultural, religious, socioeconomic, linguistic, and other factors that contribute to health disparities. NCME's four goals for health professional education are to: (1) support curriculum development, implementation, and evaluation of health professional education; (2) widely disseminate curriculum; (3) provide support and leadership to other programs; and (4) provide support to others for advocacy. NCME members advance the field through individual projects while collaborating with other members and providing technical assistance to medical education stakeholders.

Overview of curricular products

Drawing upon the collective experience of physicians, epidemiologists, medical educators, researchers, course directors, medical education deans, and policy advocates, NCME offers a comprehensive perspective. Initiatives include Cultural Competence Online for Medical Practice, an online clinician's guide to reduce cardiovascular disparities (www.c-comp.org); cultural competency-specific edits to Bates' Guide to Physical Examination & History Taking, the premiere textbook for pre-clinical medical students (http://tinyurl.com/lnubz5); and Physician Update: Cultural Competency, a versatile CME activity teaching physicians about cultural competency issues (http://tinyurl.com/myl4fd). NCME members have partnered with California Newsreel to develop discussion guides for the award-winning documentary series, *Unnatural Causes* (http://tinyurl.com/lh8jsf). NCME members are continually developing and expanding their curricular products (for more information, visit http://culturalmeded.stanford.edu). Several NCME curricular products are discussed in detail below.

Tool for Assessing Cultural Competency Training (TACCT)

Several medical schools engaged in a collaborative effort to define areas of greatest educational need in medical schools by using the Tool for Assessing Cultural Competency Training (TACCT), a curricular assessment tool first developed and recommended by the Association of American Medical Colleges (AAMC). The TACCT (www.aamc.org/meded/tacct/start.htm) was originally designed with five domains encompassing 67 learning objectives relevant to cultural competency training. A subgroup of seven schools sought to simplify the tool and reorganize the domains to recognize areas not well addressed by medical educators. In a multisite study of student and faculty perceptions of domains addressed in cultural competency training, these schools found that three of six domains of the revised TACCT were under-addressed and needed more attention. The three under-addressed domains were health disparities, bias/stereotyping, and community strategies. The remaining three domains of cross-cultural communication skills, use of interpreters and reflection were found to be relatively well addressed by both students and faculty with some cross-site differences (http://tinyurl.com/m9zr9n). These six (revised) TACCT domains have been used in settings other than medical student training—such as Physician Update: Cultural Competency, a CME program for practicing physicians (http://tinyurl.com/myl4fd)—and are an excellent starting point for designing educational programs, not only for medicine, but also for other health professions, such as dentistry, nursing, and pharmacy. A five-page online resource guide is available for educators (www.aamc.org/meded/tacct/tacctresourceguide.pdf).

Achieving Cultural Competency: A Case-Based Approach to Training Health Professionals

The University of Pennsylvania School of Medicine developed a broad portfolio of 15 cases on cultural competency. Each case was written to promote self-awareness, enhance cross-cultural communication and negotiation skills, and provide knowledge of cultural norms and health-related disparities. The cases have been integrated into the humanism and professionalism modules of the medical student curriculum and have served as vehicles for internal medicine residents' training in culturally appropriate care. In addition, two of the cases have been developed into online, Web-based videos for continuing medical education for physicians. Taking advantage of the expertise and relationships within NCME, members served as co-editors and prepared an additional 10 cases. All of these cases have been assembled into a forthcoming book titled, *Achieving Cultural Competency: A Case-Based Approach for Training Health Professionals*, edited by Lisa Hark, PhD, RD, and Horace DeLisser, MD (www.lisahark.com/Learnmore.shtml). The book includes contributions from many of the top educators in cultural competence in the United States and provides a rich and diverse set of cases for teaching and learning.

Implicit Association Test (IAT)

A growing body of literature demonstrates that providers' unconscious biases contribute to healthcare disparities. Educators interested in promoting cultural proficiency recognize the importance of educational experiences that help learners understand their own biases and develop strategies to manage these when making clinical decisions.

The computer-based Implicit Association Test (https://implicit.harvard.edu/implicit), introduced in 1998, is a useful tool for measuring unconscious biases about a number of social and group constructs, including race, ethnicity, gender, obesity, disability, and others. Through a series of simple matching exercises, the IAT measures average response latencies as a measure of one's implicit biases. To date, more than 200 studies have been conducted using various versions of the IAT, and data from more than 5 million tests has been accumulated.

The IAT is an innovative approach to employ as a consciousness raising experience for medical students and other learners (residents, nurses, physician assistants, physicians) and serves as a trigger for reflection and discussion about unconscious bias and its effects on patient care in a way that is quite different from the discussions of explicit types of biases. At our institutions, IATs have been used with medical students in small group discussion settings, and for self-assessment accompanied by journaling. In addition, IATs have been used by our institutions with physician assistant students as part of a problem-based case, and as a self-reflective exercise by dental and public health students.

The RESTORE Mnemonic: A Framework for Relationship-centered Care

The concept of the explanatory model for illness was developed by Kleinman et al (www.annals.org/cgi/content/short/88/2/251; http://tinyurl.com/nrxqkc), and has been used as a tool for understanding patients' perceptions of their illnesses and effective methods of negotiating acceptable treatment. A number of other models have since been developed (see callout box), each intended to serve as a framework to facilitate communication during clinical encounters.

In an effort to restore the importance of relationship-centered care and promote the delivery of culturally responsive care to all of the patients we serve (especially those patients from different cultural backgrounds), the RESTORE mnemonic (for more details, visit www.cc-prime.com and click on "Tools") has been developed at the University of Washington School of Medicine to provide an effective approach for good cross-cultural communication that can be used by all healthcare providers:

- **Respect the journey and/or the experiences of your patient**
- **Engage them–listen with the intent to be influenced**
- **Sensitivity–be sensitive to their perspective**
- **Teach them your perspective about their condition and common approaches to treatment**
- **Open-mindedness–be open to learning how your patient thinks about their own illness or condition, their fears and concerns, and how they think that their condition should be approached**
- **Reach common ground**
- **Exercise humility in your approach to the patient**

This tool can be used in any clinical encounter, but especially in those situations in which you may encounter a "cultural bump" (http://culturebump.com/Culturebumpbeyond.pdf) or a difficult cross-cultural challenge, or just need help in restoring a patient-provider relationship that's gone bad.

CRASH-Course in Cultural Compete Competency Training Program

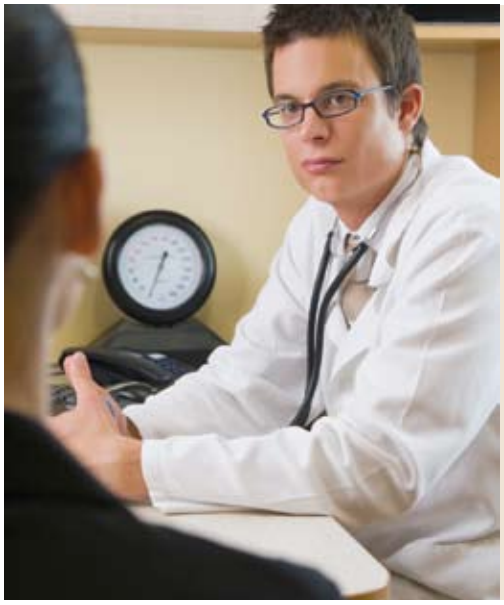
The goal of the CRASH-Course in Cultural Competency training program for medical professionals is to build confidence and competence in the clinician's ability to communicate effectively with diverse patient populations (http://tinyurl.com/n3u2b7). For more details, go to www.primarycareforall.org and click on "Cultural Competency Tools."

A result of combining an extensive literature review with the knowledge and experience of a culturally diverse medical team, the course can be taught in a wide range of formats, including one-hour introductory sessions, full-day workshops, and videoconferencing. CRASH is a mnemonic for the following essential components of culturally competent healthcare—consider Culture, show Respect, Assess/Affirm differences, show Sensitivity and Self-awareness, and do it all with Humility.

To date, more than 200 studies have been conducted using various versions of the IAT, and data from more than 5 million tests has been accumulated.

Curricula in Asthma Management

For some diseases such as asthma, racial disparities in care result from differences in the structure of care (eg, available resources including equipment) and process of care (eg, delivery of care including physician adherence to national guidelines) (www.chestjournal.org/content/132/5_suppl/810S.full). For these diseases, quality improvement efforts aimed at improving structure and/or process of care may reduce disparities in care. Several Consortium members have developed cultural competency curriculum to address asthma in emergency departments and primary care settings that incorporate recommendations of the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program—Expert Panel Report 3 (www.nhlbi.nih.gov/guidelines/asthma), asthma disparities data, communication models, and language and community resources. For example, the Curriculum in Asthma Management for Primary Care (CAMP-C) is a two-hour program at the University of Chicago to educate primary care physicians about asthma disparities and optimal clinical practice.



A Teaching Framework for Cross-cultural Healthcare
http://tinyurl.com/mlymmk

ETHNIC: A Framework for Culturally Competent Clinical Practice - Appendix: Useful clinical Interviewing Mnemonics
http://tinyurl.com/oade2d

The ETHNIC(S) Mnemonic: A Clinical Tool for Ethnogeriatric Education
http://tinyurl.com/r32rls

The BELIEF Instrument: A Preclinical Teaching Tool to Elicit Patients' Health Beliefs
http://tinyurl.com/pyl2wr

Hypertension in Multicultural and Minority Populations: Linking Communication to Compliance
http://tinyurl.com/mce6k2

Challenges and lessons learned

Developing and implementing cultural competency curriculum is not without challenges. NCME members were recently surveyed and asked about the specific challenges they have encountered. Issues cited were: obtaining additional funding to support faculty; finding a "voice" in the curriculum for cultural competency; integrating and embedding cultural competency into a curriculum already at capacity; developing exercises that safely and openly foster an examination of one's own internal biases (barriers include the unconscious nature of internal biases, and a culture of medicine that marginalizes, downplays, or denies the existence of subjective bias); sustaining momentum when you are feeling marginalized and isolated as the only educator doing this work; accessing communities and skills to engage communities; changing institutional climate; negotiating with difficult personalities in leadership positions; and disseminating our curricular products to a larger network base. Linking the curricular products to enhanced learner competencies is a challenge and more validated evaluation tools are needed. It remains to be proven whether improved competencies translate directly into improved patient-centered outcomes like satisfaction, greater adherence, and disease-based quality outcomes.

When asked how these challenges were dealt with, some of the NCME members stated that they found it useful to develop partnerships with key stakeholders (ie, curriculum committees, health professionalism and other course directors, and other institutional leaders). Another lesson learned was the realization that to fully achieve a culturally competent healthcare system, changes at patient, provider, and institutional levels will be required. As a result, NCME has partnered with organizations outside of our individual institutions, such as the AAMC, the California Endowment, and the US Department of Health and Human Services' Office of Minority Health to develop, implement, evaluate, and disseminate cross-institutional cultural competence education projects.

The work continues

This article highlights several of the cultural competency and health disparities curriculum products developed by the 18 members of the NCME, and provides examples of how existing resources can be used to supplement cultural competency education and training of current and future physicians and other health professionals. Although there are variations in how key concepts are taught in medical schools across the United States, the AAMC TACCT provides guidance on what should be taught. Our work has further identified three other curriculum content areas in medical education that have not received the attention they deserve: community strategies (eg, community participatory approach), health disparities (eg, critically appraise literature on health disparities), and bias/stereotyping (eg, strategic approaches to counteract bias). Featured resources in this article can help address these content areas. The NCME welcomes readers to provide feedback regarding these and other curricular products.

The National Consortium for Multicultural Education for Health Professionals (NCME) is a collaborative effort of 18 US medical schools, funded by the National Heart, Lung, and Blood Institute (NHLBI), working to educate future and current physicians in multicultural practice. Learn more about NCME projects and initiatives at http://culturalmeded.stanford.edu. mdng

Reference:

Lie DA, Boker J, Crandall S, et al. Faculty and Medical Student Perceptions of Cultural Competence Instruction: A Study in Seven Schools using the Tool for Assessing Cultural Competence Training (TACCT). *Medical Education Online*. 2008:13(11). Available at www.med-ed-online.org/volume13.php. Accessed March 22, 2009.