

MEDEDU 2240 Cultural Competence in Medical Education: Syllabus

Course instructors:

CULTURAL COMPETENCE IN MEDICAL EDUCATION

J.South-Paul and Others

Course Summary

Cultural differences have always been integral to American society and represent a dynamic mixture of races, ethnicities and beliefs. Indeed these differences are one of the characteristics most associated with Americans overseas. Only recently has there been recognition of the importance of these cultural differences in medical education. Therefore, there is still some confusion in medical academia regarding what the focus should be and why cultural competence (*definition*) is now of interest to the Liaison Committee on Medical Education, the accrediting body for allopathic medical schools, universities, managed care organizations, and various governmental bodies. This course is designed to explore the impact of diversity on the training of physicians and other health care providers.

Teaching objectives

1. To understand the definitions of culture and related concepts,
2. To recognize the role of historical context in current events,
3. To reflect on how one's individual world view affects personal relationships,
4. To describe the current demographic changes in the United States,
5. To recognize the behavioral and social factors related to culture and health,
6. To become familiar with the differing health status for culturally diverse groups,
7. To explore the role of diversity in medical education, and
8. To learn strategies for ensuring equity and health for the population.

Class Outline:

Topic	Students will be able to
1.Culture and History	Define cultural determinants; Recount historical events that shape how diverse populations interact with the health care system.
2. Individual World View	Recognize how personal worldview shapes relationships and encounters. Describe and use Bennett's Model of Intercultural Sensitivity.
3. Demographic Changes in the United States	Recount changes in family structure, racial/ethnic distribution, socioeconomic status, immigrant/refugee movements in the last 20 years.
4. Factors related to Culture and Health; Health Status Indicators	List the behavioral and social factors that influence population health; List differing health status for diverse groups.
5. Immigrant and Refugee Health	Describe the predominant immigrant groups, the impact of their journey on how they interface with the health care system, and common health issues they face.
6. Socioeconomics of Health Care Delivery	Recognize how SES and insurance influences access to care.
7. Discrimination	Understand the many faces of discrimination and how they influence health – e.g. racial/ethnic, age, gender, religious, national origin, sexual orientation, disability.
8. Diversity in Medical Education	Outline the representation of diverse groups at the faculty and students levels and describe the influence of public and legislative initiatives.

Course mechanics: 1 Credit; 2 hours/session for 8 sessions.

Course type: Seminar Format

Grading: H/S/U - Honors/Satisfactory/Unsatisfactory

Location: S216 BST

Prerequisites: No prerequisites

Cross-listing information: Not cross-listed

Texts (recommended or required): TBA

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Class sessions

Session 1 Culture and History

2/4/08

Instructors: J. South-Paul and A. Souidi

Discussions of culture in the United States traditionally revolve around descriptions of race. Race is a classification defined by physical characteristics such as skin color, facial features and hair type. Racial groups are presumed to have shared genetic traits. However, race is erratically assigned – often by an ill-informed observer – and has come to have little meaning. Ethnicity is a somewhat more specific term and relates to groups of people with shared racial, national, religious, linguistic heritage. Other cultural determinants are age, gender, family, language, religion, and nationality. More recently, sexual orientation, vocation, and disability have been included in discussions of culture, but do not impact on the individual from birth and tend to be more influential later in life.

Culture denotes knowledge, skills, and attitudes learned and passed on from one generation to the next. Cultural identity is a dynamic, life-long process. No living culture stands still. Cultural norms can be modified by education, language, cross cultural contact and socioeconomic status, and the number of generations an individual is removed from initial migration to the present location. Culture is a predominant force in shaping behavior, values and institutions. Cross-cultural and socio-pragmatic differences exist and impact health care access, delivery and management.

Recommended readings:

- ❑ Griffin, Paul R. *Seeds of Racism in the Soul of America*. Sourcebooks, Inc. Naperville, IL. 2000.
- ❑ Video – *In the Eye of the Storm*. 60 Minutes clip from 1968.
- ❑ Nelson, GL, Al Batal, M, El Bakary W. *Directness vs. indirectness: Egyptian Arabic and US English communication style*. International Journal of Intercultural Relations. 26(2002)39-57.
- ❑ Barrera I, Corso RM. *Cultural Competency as Skilled Dialogue*. Topics in Early Childhood Special Education. 22:2(103-113)2002.
- ❑ Edgar E, Patton JM, Day-Vines N. *Democratic Dispositions and Cultural Competency*. Remedial and Special Education. 23;4(July/August 2002), 231-241.
- ❑ Vincente B. *What pragmatics can tell us about (literal) meaning: A critical Note on Bach's theory of implicature*. Journal of Pragmatics. 34(2002)403-421.
- ❑ Davis KA, Henze RC. *Applying ethnographic perspectives to issues in cross-cultural pragmatics*. Journal of Pragmatics 30(1998)399-419.
- ❑ Coupland, N. *Introduction: Sociolinguistics and globalisation*. Journal of Sociolinguistics 7/4, 2003:465-472.

Class Exercise: 3 x 5 card self-identification exercise.

The impact of individual world-view on personal relationships is explored using the anthropologist Milton Bennett's Model of Intercultural Sensitivity. The approach presented serves as a foundation for a discussion of the cultural model of health care and its relationship to Engel's biopsychosocial model.

World view is an individual as well as a group phenomenon. It is also called cognitive culture in reference to the mental organization in each individual's mind of how the world works. Expressions of commonality in individual worldviews make up the cultural worldview of the group, which leads us to social culture.

Language is integral to developing, altering or perpetuating cognitive/cultural worldview. Language and thought, linguistic determinism/relativity will be discussed with reference to the Sapir-Whorf hypothesis and Wierzbicka (1986,1997) Chomsky (1965,1986a) linguistic/cultural universals.

Recommended readings:

- ❑ Tatum, Beverly D. *"Why Are All the Black Kids Sitting Together in the Cafeteria?" And Other Conversations About Race*. Basic Books/Perseus Books Group. New York 1997.
- ❑ Bennett MJ. A development Approach to Training for Intercultural Sensitivity. *International Journal of Intercultural Relations* 198;10:179-96.
- ❑ Rubin H. *The Princessa: Machiavelli for Women*. Dell Publishing. New York, 1997.
- ❑ Kleinman A, Eisenbery L, Good B. Culture, Illness and Care: Clinical Lessons From Anthropologic and Cross-cultural Research. *Annals of Internal Medicine* 1978;88:251-8.
- ❑ Ossorio P, *Race: The Power of an Illusion*. Washingtonpost.com May 1, 2003.
- ❑ Unnamed author. *Race – The Power of an Illusion*. Background Readings from the Public Broadcasting Service. http://www.pbs.org/race/00_About/002_04-background.htm.
- ❑ Ram P, Grol R, Rethans JJ, Schouten B, van der Vleuten C, Kester A. *Assessment of general practitioners by video observation of communicative and medical performance in daily practice: issues of validity, reliability and feasibility*. *Medical Education* 1999;33:447-454.
- ❑ Knudsen, S. *Scientific Metaphors going public*. *Journal of Pragmatics*. 35(2003)1247-1263.
- ❑ Altshuler L, Sussman NM, Kachur, E. *Assessing changing in intercultural sensitivity among physician trainees using the intercultural development theory*. *International Journal of Intercultural Relations*. 27(2003)387-401.
- ❑ Myhill J. *The native speaker, identity, and the authenticity hierarchy*. *Language Sciences* 25(2003) 77-97.
- ❑ Grandpierre A. *On the Fundamental Worldview of the Integral Culture*. *World Futures* 59:463-483, 2003.

Class Exercise: Iceberg model.

The largest segment of the population in history is now greater than 65 years of age. Women are becoming a growing majority. The ethnic heterogeneity of the nation is increasing. Census data from 2000 reflect only 69% of the current population as Caucasian. African Americans comprise 12.4% of the population, Hispanics of all races 12.8% of the population, and Asian Pacific Americans comprise 4% of the population. Native Americans remain less than 1% of the total U.S. population. Along with the racial, ethnic and gender changes in the nation have been profound changes in the family structure. Between 1970 and 1992, the percentage of single parent families grew from 14% of all families 22%. African American families with single parents grew from 36% to 53%, and Hispanic families from 22% to 32% of all families in those groups. In addition to differences in family structure among different ethnic groups, there are also major differences in socioeconomic status.

Readings:

- ❑ South-Paul JE, Grumbach K. How Does Changing a Country Change Family Practice? *Family Medicine* 2001.
- ❑ Lin-Fu JS. Asian and Pacific Islander Americans: an Overview of Demographic Characteristics and Health Issues. *Asian Pacific Islander Journal of Health* 1994;2:20-36.
- ❑ Komaromy M, Grumbach K, Drake M, et al. *The Role of Black and Hispanic Physicians in Providing Health Care for the Underserved Populations*. *New England Journal of Medicine* 1997; 334(20): 1305-1310.
- ❑ de la Cruz GP and Brittingham A, *The Arab Population:2000 Census 2000 Brief*, US Census Bureau, December 2003.
- ❑ Unnamed author, *Race – The Power of an Illusion, What Does the Census Tell Us about Race?* Public Broadcasting Service. http://www.pbs.org/race/000_About/002_04-background-03-01.htm.
- ❑ Unnamed author. *Racial and Ethnic Data: Why We Collect It; How We Use It in Public Policy*. ASA News Media Advisory – Congressional Briefing – May 28, 2003. <http://www.asanet.org/media/racebriefing.html>.
- ❑ Jussawalla F. *Are Cultural Rights Bad for Multicultural Societies?* *South Atlantic Quarterly* 100:4, Fall 2001, 967-990.
- ❑ Parks, FM. *The Role of African American Folk Beliefs in the Modern Therapeutic Process*. *Clinical Psychology: Science and Practice*. 10:4, winter 2003 (457-467)
- ❑ Kulwichi AD, Miller J. *Domestic Violence in the Arab American Population: Transforming Environmental Conditions Through Community Education*. *Issues in Mental Health Nursing*, 20:199-215, 1999.
- ❑ Hatahet, W, Khosla P, Fungwe TV. *Prevalence of risk factors to coronary heart disease in an Arab-American population in Southeast Michigan*. *International Journal of Food Sciences and Nutrition* (2002) 53, 325-335.
- ❑ Hall, DE. *When clinical medicine collides with religion*. *The Lancet Extreme Medicine*: 362, December 2003; s28-s29.
- ❑ Holme R. *Carrying a Baby In the Back: Teaching with an Awareness of the Cultural Construction of Language*. *Language, Culture and Curriculum*; 15:30, 2002(210-215).
- ❑ Drees WB. *“Playing God? Yes!” Religion in Light of Technology*. *Zygon*, 37;3 (September 2002) 643-664.

Class exercise: Village of 100 exercise. (with video).

Factors influencing health vary from genetic and physiologic to behavioral and social factors such as those related to socioeconomic status, environment, religion, LANGUAGE and family. Health status indicators vary widely from one group across a wide range of conditions. Major differences are seen in cardiovascular risk among ethnic groups, even when looking at women alone. Cardiovascular risk factors are higher among ethnic minority women than among white women – even after controlling for education. Mental illness has been diagnosed more frequently in African Americans and Hispanics than in for more than 100 years. Infant mortality in African Americans is more than twice that of non-Hispanic whites even though that of the overall population has improved in the past 20 years. There has also been a growing evidence of domestic violence in the Arab American Population among other social issues.

Discussions of these will also focus on some theoretical and philosophical issues around Multiculturalism! Should we/or should we not implement a fully-fledged unconditional multiculturalism approach? Is there a limit to diversity in a multicultural context? Should society maintain a position whereby “anything goes” in the name of respect for other cultures?

Readings:

- ❑ Helman CG. *Culture, Health, and Illness*. Butterworth/Heinemann. Oxford, UK, 1994.
- ❑ Kugler JP, Connell FA, Henley, CE. *Lack of Difference in Neonatal Mortality Between Blacks and Whites Served by the Same Medical Care System*. *Journal of Family Practice* 1990;30(3):281-7.
- ❑ Brooks, Linda. *Type A, Race, Anger, Forgiveness, Plus Stroke, HRT, and Hydralazine – The Bad, the Good, and the To-Be-Avoided*. *Medscape Cardiology* 7(2), 2003.
- ❑ Corbie-Smith G, Thomas SB, St. George DM. *Distrust, Race and Research*. *Archives of Internal Medicine* 2002;162.
- ❑ Duster T, *Unlikely Mix – Race, Biology, and Drugs*. *San Francisco Chronicle*, 3/17/2003.
- ❑ Mulsant BH, Shear KM, Duffy JN, Brown C, Cruz M, Houck PR, Thomas SB, South-Paul JE, Pincus, HA, Reynolds III, CF, *Racial Differences in Treatment of Late-life Depression*. Submitted to the *American Journal of Psychiatry*. 19 pages.
- ❑ Thompson, JW, *Quality of Care for Children in Commercial and Medicaid Managed Care*, *Journal of the American Medical Association*, 9/17/2003.
- ❑ NIH, *Prevalence of self-reported heart failure among US adults: results from the 1999 National Health Interview Survey*, *American Heart Journal*. 146(1):121-8, 2003 July.
- ❑ Srikameswaran, A. *Should Health Care For Minorities Be Based on Race or Ethnicity?* *Post-Gazette.com*, September 24, 2002.
- ❑ Unnamed author. *UPMC's International Patient Relations Center Smooths Cultural Differences*. www.globalpittsburghNEWS, March 2003.
- ❑ Putsch RW, *Language access in healthcare: Domains, Strategies and Implications for Medical Education (Concept Paper)*. *Language Access Services*. Undated, 1-32.
- ❑ Thompson-Elderkin V, Silver RC, Waitzkin H. *When nurses doubles as interpreters: a study of Spanish-speaking patients in a US primary care setting*. *Social Science and Medicine*: 52(2001) 1343-1358.
- ❑ Hagell P, McKenne SP, *International use of health status questionnaires in Parkinson's disease: translation is not enough*. *Parkinsonism and Related Disorders* 10(2003) 89-92.
- ❑ Yang W. *Communication slips and their sociocultural implications*. *Language and Communication* 22(2002) 69-82.
- ❑ Sireci SG, Allalouf A. *Appraising item equivalence across multiple languages and cultures*. *Language Testing* 2003(2) 148-166.
- ❑ Haque A. *Religion and Mental Health: The Case of American Muslims*. *Journal of Religion and Health*, 49, 1, Spring 2004, 45-58.

During the 1970's and 1980's, the two largest groups entering North America were refugees from Southeast Asia and Central America. Those immigrating to escape physical privation recovered more rapidly and completely than those suffering from emotional trauma and loss. Children may show minimal distress when faced with armed conflict until the violence reaches their nuclear family. Then the psychological effects are more serious.

When Cambodian high school students living in the U.S. who had witnessed violence were studied, almost half met the criteria for Post-Traumatic Stress Disorder (PTSD) and half met the criteria for other clinical problems – most notably anxiety and depression. Much of the vulnerability of Latino children to mental health problems stems from the numerous challenges faced by their families with respect to acculturation and poverty. Most of the problems these children face relate to depression and social withdrawal. Experiences subsequent to immigration such as discrimination, loneliness, unemployment, and isolation from mainstream society also negatively affect levels of anxiety and depressive symptoms.

At the midst of these large migratory waves, one of the major challenges faced by our healthcare providers is when they have to work through a language barrier.

Ineffective ways of communicating healthcare to patients with LEP-Limited English Proficiency- is very frequent In health systems.

Discussion will also revolve around the Socio-pragmatic and technical challenges of Translation and Interpreting, Preferred strategies to Implement an I/T in the medical encounter, guidelines for working with an interpreter, interpreter code ethics and medical areas where translation should be avoided at all costs.

Other issues relate to some Immigrants reluctance to learn English stemming from fear of cultural contamination implicit in the learning of a dominant language such as the BANA's Ige-British, Australasian and North America).

Activities include a visit/stop at the International Patient Relations Center at UPMC HEALTH SYSTEM and Interacting/interviewing two international patients from Saudi Arabic and a Syrian refugee female.

Recommended readings:

- ❑ South-Paul J, Katsufakis, P, Matheny S, Care of Special Populations, Association of Family Practitioners Monograph, Kansas City, 2001. This monograph is not available from the aafp.org website.
- ❑ Culhane-Pera KA, Vawter, DE, Xiong P, Babbitt B, and Solberg, MM, *Healing by Heart: Clinical and Ethical Case Studies of Hmong Families and Western Providers*, Vanderbilt University Press (ISBN 0-8265-1431-6) \$34.95
- ❑ Unnamed authors, <http://www.Medscape.com> series on “Geographic Diseases” September 2003.
- ❑ *Language Services Action Kit*, developed by the Access Project and the National Health Law Program (with support from the Commonwealth Fund). The kit has been developed to help people with limited English proficiency gain better access to health care. To receive a kit send your contact information to: LEPactionkit@accessproject.org.
- ❑ California Medical Association, *Need an Interpreter?* 2002. Available to order at this website www.calphys.org/html/bb008.asp.
- ❑ Rorie, JL, Paine LL, Barger MK; *Primary Care for Women*. Journal of Nurse-Midwifery:41,2 (March/April 1996)92-100.
- ❑ Ensign J, Panke Aileen. *Barriers and Bridges to care: voices of homeless female adolescent youth in Seattle, Washington USA*. Issues and Innovations in Nursing Practice. 37(2), 166-172.
- ❑ Drew P, Chatwin J, Collins S. *Conversation Analysis: a method of research into interactions between patients and health-care professionals*. Blackwell Science, 2001 (4)58-70.

The foreign-born populations are twice as likely as the U.S.-born population to be uninsured – i.e. without any form of health coverage including public insurance (Medicaid) (26.2% vs. 13.0%) [8]. The administrative criteria for public programs and extensive paperwork that must be completed may explain the high rates of uninsured status among recent immigrants. Recently enacted federal legislation further restricting Medicaid eligibility could substantially increase the number of uninsured among the U.S. foreign-born population, with profound public health implications. Past injustices may cause minority patients to distrust their health care carriers/providers. For example, some “Illegal Aliens” may be hesitant to fill out forms because of deportation fears and choose to remain uninsured.

Recommended readings:

- ❑ Bodenheimer TS, Grumbach K, *Understanding Health Policy*, Lange Medical Books/McGraw-Hill, New York 1998
- ❑ Ginzberg E, and others? Improving Healthcare for the Poor: Lessons from the 1980s. *Journal of the American Medical Association* 1994;27:464-467.
- ❑ Short and Graefe *Battery-Powered Health Insurance? Stability in Coverage of the Uninsured*, 2003;22:244-255.
- ❑ No author, *Cross-Cultural Challenges: Improving the Quality of Care for Diverse Populations*, QualityHealthCare.org. Note: This article includes citations for 10 publications in this subject area.
- ❑ Fairbrother G, Gusmano MK, Park HL, Scheinmann R, *Care for the Uninsured in General Internists' Private Offices*, *Health Affairs* 2003;22:6.217-224.
- ❑ Berney ML, *Addressing Racial and Ethnic Disparities in Health Care Delivery: The Purchaser's Role*, October 2003, Issue 20.
- ❑ Short PF, Graefe DR, Schoen C, *Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem*, *The Commonwealth Fund Issue Brief*, November 2003, 1-16.
- ❑ Glied S and Little SE, *The Uninsured and the Benefits of Medical Programs*, *Health Affairs*, July/August 2003.
- ❑ Gonzalez P and Stoll B, *The Color of Medicine: Strategies for Increasing Diversity in the US Physician Workforce*, April 2002.
- ❑ Sheets RH. *Competency vs. good intentions: diversity ideologies and teacher potential*. *International Journal of Qualitative Studies in Education*. 2003, Vol. 16(1) 111-120.
- ❑ Clarke-Tomlinson S. *Assessing outcomes in a multicultural training course: a qualitative study*. *Counselling Psychology Quarterly*(13), 2, 2000, 221-231.
- ❑ Abbas A, McLean Monica. *Communicative Competence and the Improvement of University Teaching: insights from the field*. *British Journal of Sociology of Education* (24), 1, 2003, 69-81.
- ❑ Palafox, NA, Buenconsejo-lum, Riklon S, Waitzfelder B. *Ethnicity and Health*, 2002;7(4): 279-285.
- ❑ Chur-Hansen A, Vernon-Roberts J. *Clinical teachers' perceptions of medical students English language proficiency*. *Medical Education* 1998, 32, 351-356.
- ❑ Gillotti C, Thompson T, McNeillis K. *Communicative competence in the delivery of bad news*. *Social Science and Medicine*, 54(7) April 2002, Pages 1011-1023.
- ❑ US Health and Human Services websites for Asian Americans and Native Americans: www.healthfinder.gov/justforyou and <http://asianamericanhealth.nim.nih.gov>.
- ❑ Unnamed author. *Minority Health and Health Care Disparities*, January 23, 2004, www.Kaisernetwork.org

Discrimination towards both health care providers and patients continues to exist and relates to a variety of cultural determinants – race, ethnicity, language, gender, age, religion, national origin, disability, and sexual orientation. Data from recent research confirm that many health disparities relate not only to patient preferences and choices, but also to race and gender bias in the choice of diagnostic procedures, processes for evaluation, and therapies prescribed by clinicians. Medical educators are challenged to identify discrimination when observed and develop strategies to ensure equitable treatment of all patients and colleagues.

The cultural norms of migrants to the US can profoundly affect their beliefs about disease and treatment options. The beliefs of healthcare providers can be at times different from that of Migrants and so there can be difficulties in understanding and barriers which inhibit effective clinical management and leads then to discrimination. Cultural incompetence of medical leadership and hence issues in cross-cultural health management and supervision can contribute largely to disparities in health status and access to health care services.

Recommended readings:

- Brooks, Linda. *Type A, Race, Anger, Forgiveness, Plus Stroke, HRT, and Hydralazine – The Bad, the Good, and the To-Be-Avoided*. Medscape Cardiology 7(2), 2003. [Note: This article is included under Session 4.]
- Fraser, Ross, *AMA, NMA Oppose California’s Proposition 54*, AMA Bulletin, 10/3/2003, accessible from www.ama-assn.org/ama/pub/article/1616-8073.html
- Schmidt, P, *College Leaders Discuss Ways to Preserve Affirmative Action*, Chronicle of Higher Education, 7/15/2003.
- Schmidt P, *Friends and Foes of Affirmative Action Claim Victory in Rulings on Michigan Cases*, Chronicle of Higher Education, 6/24/2003.
- Selingo J, *Decisions May Prompt Return of Race-Conscious Admissions at Some Colleges*, Chronicle of Higher Education, 6/24/2003.
- Maddox K and Gray S, *Cognitive Representations of Black Americans: Re-exploring the Role of Skin Tone”* Personality and Social Psychology Bulletin. 2002.
- Bell Derek, *Faces From the Bottom of the Well*
- Cooper-Patrick L. *Race, Gender, And Partnership in the Patient-Physician Relationship*. Journal of the American Medical Association 1999; 282(6):583-9.
- Ayanian JZ, Udvarhelyi IS et al. *Racial Differences in the Use of Revascularization procedures After Coronary Angiography*. Journal of the American Medical Association 1993; 269:2642-2646.
- LaVeist TA, Nickerson KJ, Bowie JV. *Attitudes About Racism, Medical Mistrust, and Satisfaction with Care Among African American and White Cardiac Patients*. Medical Care Research and Review 2000;57(Supplement 1):146-161.
- Schulman KA, Berlin JA, et al. *The Effect of Race and Sex on Physicians’ Recommendations for Cardiac Catheterization*. New England Journal of Medicine 1999;340:618-626.
- Institute of Medicine. *Unequal Treatment; Confronting Racial and Ethnic Disparities in Health Care*. National Academy Press, Washington, DC, 2002.
- No author ADS Center: Resource Center to Address Discrimination and Stigma. U.S. Department of Health and Human Services. <http://www.adscenter.org>
- Garcia, Richard, *The Misuse of Race in Medical Diagnosis*, The Chronicle of Higher Education, May 9, 2003, Volume 49, Issue 35, Page B15.
- Wise T, *Whites Swim in Racial Preference*, AlterNet, February 20, 2003.
- AMA, NMA oppose California’s Proposition 54, October 3, 2003. www.ama-assn.org/ama/pub/article/1616-8073.html.
- Unnamed author. *Hospital Pledges No Further Discrimination*. October 11, 2003. www.blackmystory.com.
- Szaro, J. *Hospital Conforms to Racial Demands*. January 22, 2004. www.thecowl.com (Published by Providence College in Rhode Island).
- Mitchell, Mary. *We’ve Talked About Sex, But I forgot About Racism*. Chicago Sun-Times, June 28, 2003.

MEDEDU 2240 Cultural Competence in Medical Education: Syllabus

Session 8 Diversity in Medical Education
Instructors: J. South-Paul and A. Souidi

3/24/08

Women and minorities have been underrepresented in medical educational institutions for more than 30 years. Though numbers of women have increased dramatically in recent years, they continue to face a glass ceiling in achieving leadership positions. Minorities have not fared as well, being increasingly disadvantaged by recent legislative and state ballot initiatives. Strategies to understand and address this area will be discussed during this session.

The relevance of communicative competence to increasing cultural competency in medical education and cross-cultural research and the need to incorporate cross-cultural issues in the syllabus will also be addressed

Recommended readings:

- ❑ Unnamed author, *College Leaders Discuss Ways to Preserve Affirmative Action*, Chronicle of Higher Education, 8/15/2003.
- ❑ Schmidt P, *Friends and Foes of Affirmative Action Claim Victory in Rulings on Michigan Cases*, Chronicle of Higher Education, 6/23/2003.
- ❑ Selingo J, *Decisions May Prompt Return of Race-Conscious Admissions at Some Colleges*, Chronicle of Higher Education, 6/24/2003.
- ❑ Potter W, *Texas Admissions Plan Has Not Increased Diversity at Flagship Campuses Study Finds*, Chronicle of Higher Education, 1/24/2003.
- ❑ Surendran, Aparna. *A Diversity of Doctors*. www.philly.com (The Philadelphia Inquirer), November 25, 2002.
- ❑ Terrell C, *Diversity Lags in Doctor Education*, Philadelphia Inquirer, 12/13/2002.
- ❑ Lowell LB and Suro R, *The Improving Educational Profile of Latino Immigrants*, Pew Charitable Trust and the Annenberg School for Communication, December 4, 2002.
- ❑ COGME Minorities in Medicine Report
- ❑ Borkan JM, Neher JO. *A Developmental Model of Ethnosensitivity in Family Practice Training*. Family Medicine 1991;23-23:212-217.
- ❑ Lum CK, Korenman SG. *Cultural Sensitivity Training in US Medical Schools*. Academic Medicine 1994;69:239-241.
- ❑ Like RC, Steiner P, Rubel AJ. *Recommended Core Curriculum Guidelines on Culturally-sensitive and Competent Health Care*. Family Medicine 1996;27:291-297.
- ❑ Berlin E, Fowkes Jr. WC. *A Teaching Framework for Cross-cultural Health Care – Application in Family Practice*. Western Journal of Medicine 1983;934-938.
- ❑ Gonzalez P and Stoll B, *The Color of Medicine: Strategies for Increasing Diversity in the U.S. Physician Workforce*. Community Catalyst written with support from the W.K. Kellogg Foundation, April 2002.

Class exercise:

- ❑ AAFP Racial and Ethnic Bias in Medicine Videotape – vignette #1.
- ❑ AAFP Quality Care for Diverse Populations Videotape.

Problem set due:

Read articles for next class:

Evaluation	Essay
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Students will be required to write an editorial on an area in their own discipline that relates to the topics covered in the course. The editorial should analyze the problem and suggest strategies for solutions in the medical educational environment. This exercise is designed to assist the student in applying the course material and stimulate its ongoing applicability.