



Policy Brief

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DIVERSITY EDUCATION AND CULTURAL COMPETENCY IN THE HEALTH PROFESSIONS SCHOOL CURRICULUM

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Overview

This brief investigates the subject of diversity education and cultural competency and asks the question: “Should health professions schools be required to provide cultural competency training for their students as a condition of accreditation?”

The conclusion reached here is that, while cultural competency courses may be somewhat helpful in producing sensitive clinicians, the best way to ensure a culturally competent workforce is to graduate health care providers from underrepresented racial and ethnic groups. Realizing this goal requires an increase in the enrollment of students who belong to one or more of these underrepresented groups.

What Clinicians Can Do:

- Understand that cultural competency can be taught and learned, but that there is no substitute for clinician-patient concordance
- Find out about the policies and practices of the health professions schools in your state regarding admission of underrepresented racial and ethnic groups and the incorporation of cultural competency in the curricula
- Encourage both the teaching of cultural competence and the recruitment and retention of underrepresented racial and ethnic groups among both the faculty and student body of health professions schools
- Contact your Congressional representatives and encourage them to maintain or increase funding of programs (e.g., Titles VII, VIII) that support health professions training for minority groups
- Do your part to become a more culturally-competent caregiver by learning about the practices of the unique patient mix you serve in your local area

Background

In its report, *Unequal Treatment*, the Institute of Medicine concluded that cultural factors can contribute to racial disparities in health irrespective of insurance status, income, or education level, by prejudicing providers and altering patients’ perceptions of illness and their attitudes toward health and health care. By contrast, culturally competent physicians (especially those who are the same race as their patient) increase patient

satisfaction and improve health outcomes,¹ suggesting a desire by patients for racial concordance and a need for physicians who deliver high quality care “to every patient regardless of race, ethnicity, culture, or language proficiency.”²

Yet, only 7% of physicians are minorities,³ and with minority populations expected to grow to over 50% of the U.S. population by 2056, the need for culturally competent physicians will only increase.⁴ As Congress considers proposals to make cultural competency training a condition of medical school accreditation, many schools have already increased the amount of cultural and linguistic issues covered in their curricula. “As of 2000, 87% of U.S. medical schools addressed cultural competence in 3 or fewer lectures during the preclinical years, and 8% of schools offered separate courses on the topic. This compares with only 13% that included any such material in 1991.”⁵ However, adding cultural competence courses presents difficulties with scheduling, hiring qualified faculty, and assessing students’ attitudes about the subject’s relevance.⁶

Despite few established links between cultural competency and the reduction of racial disparities, experts in academia, government, and health care embrace the connection.⁷ The Association of American Medical Colleges supports cultural competency via increased minority enrollment,⁸ while the Liaison Committee on Medical Education, which accredits medical schools, requires cultural competence to be integrated into the curriculum.⁹

Some medical students also consider training in cultural competency an essential part of a medical education, citing that an entire clinical skill set can become useless without the ability to understand or communicate.¹⁰ Other students, however, consider cultural differences a non-issue, and for them, cultural competency courses can be completely ineffective.¹¹

The federal government addresses cultural competency in health care by very limited administrative regulations. In 2001, President Bush renewed an executive order requiring any entities receiving federal funding to provide reasonable access to services

¹ L.J. Lee, H.A. Batal, J.H. Maselli, and J.S. Kutner. Effect of Spanish interpretation method on patient satisfaction in an urban walk-in clinic. *Journal of General Internal Medicine*, 17(8): 641-5

² Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo, and Elyse R. Park. Cultural competence and health care disparities: Key perspectives and trends. *Health Affairs*, 24(2): 499-505.

³ Joseph R. Betancourt, Alexander R. Green, and J. Emilio Carrillo. Cultural competence in health care: Emerging frameworks and practical approaches. *Commonwealth Fund*, Field Report, October 2002.

⁴ Manish Champaneria and Sara Axtell. Cultural competence training in U.S. medical schools. *JAMA* 291(17): 2142.

⁵ *Ibid.*

⁶ Renee C. Fox. Cultural competence and the culture of medicine. *NEJM*, 353(13): 1316-9.

⁷ Joseph R. Betancourt, Alexander R. Green, and J. Emilio Carrillo, *op cit.*

⁸ Grutter v. Bollinger et al. *Amicus Curiae Brief* of the AAMC. No. 02-241

⁹ Joseph R. Betancourt, Alexander R. Green, J. Emilio Carrillo, and Elyse R. Park, *op cit.*

¹⁰ Kristen C. Ochoa, Michele A. Evans, Scott A. Kaiser. Negotiating care: The teaching and practice of cultural competence in medical school. A student perspective. *Medical Education Online* 2003.

¹¹ Brenda L. Beagan. Teaching social and cultural awareness to medical students: “It’s all very nice to talk about it in theory, but ultimately it makes no difference.” *Academic Medicine*. 78(6): 605-14.

to persons of limited English proficiency. The Department of Health and Human Services and its agencies have also issued policy guidance and provided funding for cultural competency initiatives.¹² Organizations in the health care industry also support cultural competency as a way of appealing to various minority populations, thus increasing the organization's market share.

Recommendations

Support Cultural Competency Curriculums but not as an Accreditation Standard

Direct costs of providing cultural competency in the health professions curriculum include the cost to health professions schools of hiring faculty who are well-qualified to teach cultural competency skills, and the cost of evaluating new courses to determine if they improve outcomes and reduce disparities. An indirect cost of this option is the opportunity cost of removing current subjects to make room in the curriculum. While care would be taken to minimize the detriment of any substitution, it is highly likely that substantive knowledge and skills might be reduced, which could negatively affect patients' care.

This option has high political feasibility given the strong push for such standards by government, the current accreditation standards of the LCME, the support of professional organizations, and the number of health professions schools already voluntarily offering cultural competence courses. The technical feasibility of this option, however, leaves much to be desired, and is its most challenging aspect, as it requires hiring new faculty, designing new courses, evaluating the effectiveness of new courses and improving them through trial-and-error.

Many clinicians feel that cultural competency involves skills and personality traits that are inherent to certain individuals, and cannot be taught. If students are unmotivated, courses will be ineffective, and if done incorrectly, teaching cultural competence can lead to the reinforcement of racial and ethnic stereotypes by over-generalizing attributes on the basis of race and ethnicity.

Support Increased Minority Enrollment in Health Professions Schools

The best way to ensure a culturally competent clinician workforce and reduce health disparities is to graduate health professionals who come from different cultures. Increasing minority enrollment in health professions schools is an easily implemented, politically feasible, and cost-free approach that will do far more to ensure a culturally competent workforce and reduce racial disparities in health both now, and in the future, than will making cultural competence a condition of accreditation. While adding cultural competency to the health professions school curriculum is encourage, such courses alone cannot be guaranteed to reduce or eliminate racial disparities in health care. In essence, mandating cultural competence training simply sets a bar that clinicians-in-training must hurdle, without establishing the rigor of that curriculum, the degree to which it is taught, understood, adhered to, and enforced. Health professions students may be required to

¹² Courtney Rees and Sonia Ruiz, *op cit*.

take courses, but unless they truly want to learn the material, they will not become culturally competent.

By contrast, increasing minority representation in medical schools will eventually increase patient-physician racial concordance, leading to higher patient satisfaction, and may also encourage non-minority physicians to become more culturally-sensitive, through interactions with a diverse group of peers. Research has shown high levels of patient satisfaction and better outcomes when there is clinician-patient racial concordance. Minority clinicians are also more likely to work in underserved areas, which may reduce health disparities. There have also been suggestions that increasing minority enrollment in health professions schools, at least passively, improves the cultural sensitivity of non-minority health professions students. One slight downside is that minority physicians are not necessarily more culturally competent when it comes to caring for patients of other races or ethnicities not their own, and race alone is not always a particularly good indicator of culture, as in the case of blacks from the Caribbean, Africa, and North America, which have very distinct cultures. Still, the more diverse the physician workforce is, the more likely it will be to provide culturally competent care.