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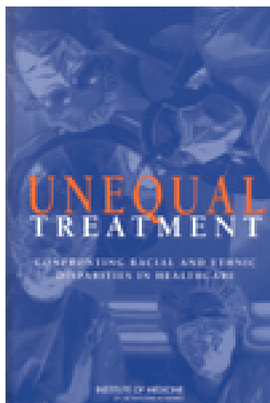

Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (with CD)

Brian D. Smedley, Adrienne Y. Stith, and Alan R. Nelson, Editors, Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care

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6

Interventions: Cross-Cultural Education in the Health Professions

BACKGROUND

The 2000 U.S. Census confirmed what demographers had been predicting all along—our country has become more diverse than ever before (U.S. Census, 2000). Our expansion has been fueled by growth of our minority populations, in addition to significant immigrant influx (Immigration Statistics, 2001). How will the United States respond to this increasing diversity? Ultimately, our success as a nation hinges on how we meet the challenges diversity poses, while capitalizing on the strengths it provides. Many sectors have responded proactively to our demographic evolution, understanding that there are financial and market imperatives to better understanding, communicating, servicing, and partnering with those from diverse backgrounds. This has resulted in major educational efforts, through training and corporate development, as to how better to "manage" diversity at the workplace and in business/service relations (Chin, 2000).

How will one of our largest industries—healthcare—respond? There is a growing literature that delineates the impact of sociocultural factors, race, and ethnicity on clinical care (Berger, 1998; Hill et al., 1990). Clinicians aren't shielded from diversity, as patients present varied perspectives, values, beliefs, and behaviors regarding health and well-being. These include variations in patient recognition of symptoms, thresholds for seeking care, ability to communicate symptoms to a provider who understands their meaning, ability to understand the management strategy, expectations of care (including preferences for or against diagnostic

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and therapeutic procedures), and adherence to preventive measures and medications (Einbinder and Schulman, 2000; Flores, 2000; Betancourt et al., 1999; Denoba et al., 1998; Gornick, 2000; Coleman-Miller, 2000; Williams and Rucker, 2000).

CROSS-CULTURAL COMMUNICATION: LINKS TO RACIAL/ETHNIC DISPARITIES IN HEALTHCARE

Sociocultural differences between patient and provider influence communication and clinical decision-making (Eisenberg, 1979). Evidence suggests that provider-patient communication is directly linked to patient satisfaction, adherence, and subsequently, health outcomes (Figure 6-1) (Stewart et al., 1999). Thus, when sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated in the medical encounter, the result is patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care (Flores, 2000; Betancourt et al., 1999; Stewart et al., 1999; Morales et al., 1999; Cooper-Patrick et al., 1999; Langer, 1999). And it is not only the patient's culture that matters; the provider "culture" is equally important (Nunez, 2000; Robins et al., 1998b). Historical factors for patient mistrust, provider bias, and its impact on physician decision-making have also been documented (Gamble, 1997; Schulman et al., 1999; van Ryn and Burke, 2000). Failure to take sociocultural factors into account may lead to stereotyping, and in the worst cases, biased or discriminatory treatment of pa-

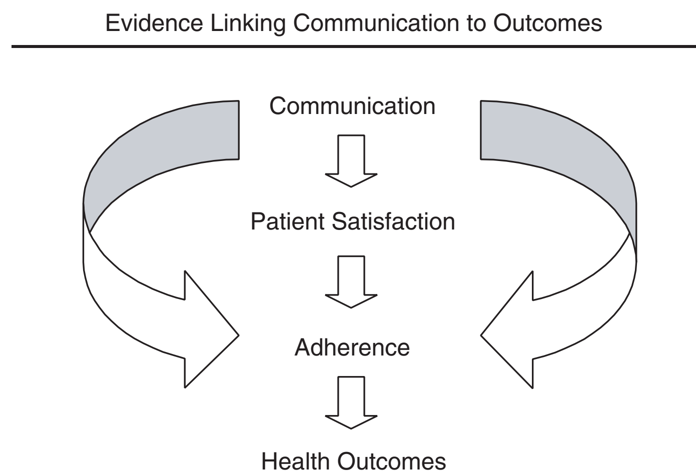

FIGURE 6-1 Evidence linking communication to outcomes.

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tients based on race, culture, language proficiency, or social status (Schulman et al., 1999; van Ryn and Burke, 2000; Donini-Lenhoff and Hedrick, 2000). Two studies for physicians highlight these points.

First, Schulman et al. (1999) showed that differential referral to cardiac catheterization was based on race and gender. Second, van Ryn and Burke (2000) illustrated that physicians have different attitudes about patients based on race, as well. Similarly, one study involving 116 nursing students found that negative attitudes about racial/ethnic minorities was related to the absence of prior exposure, suggesting that these issues are not limited to physicians (Eliason, 1998).

THE FOUNDATION AND EMERGENCE OF CROSS-CULTURAL EDUCATION

The meaning of "culture" has been widely debated and broadly defined, with certain common themes emerging. To summarize, culture can be seen as an integrated pattern of learned beliefs and behaviors that can be shared among groups and include thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs (Robins et al., 1998b; Donini-Lenhoff and Hedrick, 2000). Culture shapes how we explain and value our world, and provides us with the lens through which we find meaning (Nunez, 2000). It should not be considered "exotic" or about "others" (Shapiro and Lenahan, 1996; Like et al., 1996), but as part of all of us and our individual influences (including socioeconomic status, religion, gender, sexual orientation, occupation, disability, etc.). We all are influenced by and belong, to multiple cultures that include, but go beyond, race and ethnicity.

Sociocultural factors are critical to the medical encounter, yet cross-cultural curricula have been incorporated into undergraduate, graduate and continued health professions education only to a limited degree (Carrillo et al., 1999). Their goal is to enhance learners' awareness of sociocultural influences on health beliefs and behaviors, and to equip them with skills to understand and manage these factors in the medical encounter (Carrillo et al., 1999; Culhane-Pera et al., 2000; Zweifler and Gonzalez, 1998). This includes understanding population-specific disease prevalence and health outcomes and ethnopharmacology (Lavizzo-Mourey, 1996; Zweifler and Gonzalez, 1998).

Although cross-cultural medicine has gained recent attention, it has been discussed in the literature since the 1960's during the advent of the community health and civil rights movement. There was a clear call then for responsiveness to cultural differences in health attitudes, beliefs, behavior, and language (Chin, 2000). In the 1970's, the seminal work of Kleinman et al. solidified the important link between culture, illness and

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healthcare (Kleinman et al., 1978). In the 1980's and 1990's, the focus shifted from "cultural sensitivity" to a demand for "cultural competence," a more skill-focused paradigm (Rios and Simpson, 1998; Welch, 1998; Lavizzo-Mourey 1996). Early work in the field is found in the literature of nursing, mental health, and family medicine (Shapiro and Lenahan, 1996; Kai et al., 1999; Kristal et al., 1983). An international interest in the intersection between culture and health has arisen, with work done in Australia, Great Britain, and Canada, among others (Louden et al., 1999).

Looking at undergraduate medical education over this time, we see interesting parallels. Since 1978, four surveys/literature searches have been conducted to determine whether medical schools were teaching cross-cultural issues in their curriculum (Louden et al., 1999; Wyatt et al., 1978; Lum and Korenman, 1994; Flores et al., 2000) (Table 6-1). Although each study was limited by not determining curriculum specifics (whether a course was required, contact hours, approaches, etc.), the trend shows a decrease in specific cross-cultural courses, and an increase in incorporation of these issues into the overall curriculum. This last finding is deceiving, as it's unknown to what extent cross-cultural issues are dealt with in other courses. This could simply mean that there are optional noon lectures or electives that cover cross-cultural issues during some part of the standard health professional academic year. Experts in the field remain skeptical about the results, which show a "mainstreaming" of cross-cultural education, and are concerned about how effectively these issues are addressed during medical education (Kai et al., 1999; Flores et al., 2000). There is no literature to document the extent to which these issues are covered in graduate or continuing medical education for either residents or practicing providers. The literature in nursing education is similarly sparse. Although material related to cultural diversity is considered an

TABLE 6-1 Cross-Cultural Curricula in Undergraduate Medical Education

1978 (Wyatt):
20% med schools offered specific "sociocultural courses"
40% covered issues within other courses, 40% offered none
1992(Lum):
13% offered separate "sociocultural course" (only 1 required)
60% integrated sociocultural factors into broader curriculum
1998(Flores):
8% offered separate course
87% integrated sociocultural factors into curriculum
1999(Loudon)
17 programs teaching "cultural diversity" identified (US, UK, Canada, Australia).

NOTE: Cultural competence or cross-cultural medicine not used as search terms.

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important part of baccalaureate curricula, there is virtually no information published on the extent to which cultural competence is included in undergraduate courses or the specifics of the material that is included (Clinton, 1996; Janes and Hobson, 1998).

Cross-cultural education for health professionals has emerged because of three major factors. First, cross-cultural education has been deemed critical in preparing our providers to meet the health needs of our growing, diverse population (Welch, 1998). Second, it's been hypothesized that cross-cultural education could improve provider-patient communication and help eliminate the pervasive racial/ethnic disparities in medical care seen today (Einbinder and Schulman, 2000; Williams and Rucker, 2000; Brach and Fraser, 2000). Third, in response to the Institute of Medicine Report on Primary Care which states that "there should be an understanding of cultural belief systems of patients that assist or hinder effective healthcare delivery," and in response to the Pew Health Professions Commission, which states that "cultural sensitivity must be a part of the educational experiences of every student," accreditation bodies for medical training (i.e., Liaison Council on Medical Education, Accreditation Council on Graduate Medical Education) now have standards that require cross-cultural curricula as part of undergraduate and graduate medical education (Liaison Committee on Medical Education, 2001; Accreditation Council for Graduate Medical Education, 2001; Committee on the Future of Primary Care, 1994; Pew Health Professions Commission, 1995). Although these standards are general in their language, they are being expanded in detail and remain enforceable. Similarly, leaders in nursing education recognize the importance of culture in the health of populations and patients. As early as 1977, the National League for Nursing required cultural content in nursing curricula and in 1991, the American Nursing Association published standards specifically indicating that culturally and ethnically relevant care should be available to all patients.

APPROACHES TO CROSS-CULTURAL EDUCATION

Training in cross-cultural medicine can be divided into three conceptual approaches focusing on *attitudes*, *knowledge*, and *skills*. Like the proverbial three-legged stool, each approach plays a crucial role, but is unable to support any weight when not fully supported by the other two.

A Focus on Attitudes: The Cultural Sensitivity/Awareness Approach

The foundation of cross-cultural care is based in the *attitudes* central to professionalism—humility, empathy, curiosity, respect, sensitivity, and awareness of all outside influences on the patient (Bobo et al., 1991;

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TABLE 6-2 Conceptual Approaches to Cross-Cultural Education

Sensitivity/Awareness Approach

- Primary focus on provider **attitudes**
  - Goal is to increase provider awareness of impact of sociocultural factors on individual patients' health values, beliefs, behaviors, and ultimately quality of care and outcomes
- Exploration and reflection on culture, racism, classism, sexism, etc.
  - Discussion of these factors as they relate to the provider and the patient culture, and what impact they may have on clinical decision-making
  - Importance of curiosity, empathy and respect in the medical encounter highlighted
- Approach primarily taught in early in medical school and in certain residencies

Gonzalez-Lee and Simon, 1987). The added importance of these attitudes in cross-cultural medical encounters, where the desire to explore and negotiate divergent health beliefs and behaviors is paramount, has given rise to curricula designed to build or shape them within providers. The cultural sensitivity/awareness approach (see Table 6-2) incorporates educational exercises and techniques that promote self-reflection, including understanding one's own culture, biases, tendency to stereotype, and appreciation for diverse health values, beliefs, and behaviors (Culhane-Pera et al., 1997). Examples include open conversations exploring the impact of racism, classism, sexism, homophobia, and other types of discrimination in healthcare; determining how providers have themselves dealt with feeling "different" in some way; attempting to identify, using patient descriptors or vignettes, hidden biases we may have based on subconscious stereotypes; determining our reaction to different visuals of patients of different races/ethnicities; and discussing ways in which our family members have interacted with the healthcare system (Berlin, 1998; Donnini-Lenhoff, 2000; Tervalon and Murray-Garcia, 1998).

From a practical perspective, efforts to change attitudes are labor intensive, difficult, charged, complex to evaluate, and can seem abstract to those who are more clinically oriented (Kai et al., 1999). Nevertheless, attitudes such as curiosity, empathy, respect, and humility are critical to engaging in effective communication during the clinical encounter, whether the patient is from a similar or a distinct cultural background.

A Focus on Knowledge: The Multicultural/Categorical Approach

Traditionally, cross-cultural education has focused on a "multicultural" or "categorical approach," providing *knowledge* on the attitudes, values, beliefs, and behaviors of certain cultural groups (Paniagua, 1994). For

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example, methods to care for the "Asian" patient or the "Hispanic" patient would present a list of common health beliefs, behaviors, and key practice "do's and don'ts." With the huge array of cultural, ethnic, national, and religious groups in the United States, and the multiple influences such as acculturation and socioeconomic status that lead to intragroup variability, it is difficult to teach a set of unifying facts or cultural norms (such as "fatalism" among Hispanics, or "passivity" among Asians) about any particular group (Chin, 2000; Hill et al., 1990). These efforts can lead to stereotyping and oversimplification of culture, without a respect for its fluidity (Donini-Lenhoff and Hedrick, 2000; Carrillo et al., 1999). Research has shown that teaching "cultural knowledge" can be more detrimental than helpful if it is not done carefully (Shapiro and Lenahan, 1996).

There are two instances where focusing on a knowledge-based approach can be effective. First, following the basic tenets of community-oriented primary care and community assessment, students and practitioners can learn about the surrounding community in which they train or practice. Some important factors include the social and historic context of the population (new immigrants or longstanding residents), the predominant socioeconomic status, the immigration experience (was the immigration chosen or forced), nutritional habits (diet high in protein, fiber, or fat), common occupations (i.e., blue collar or service industry), patterns of housing (i.e., housing development), folk illnesses and healing practices (i.e., *empacho*, "coining"), and disease incidence and prevalence. Several such models are described in the literature focusing on communities in U.S.-Mexican border towns, communities with a new influx of a specific immigrant group, and Native-American reservations (Kristal et al., 1983; Nora et al., 1994).

The second instance of an effective knowledge-based approach is knowledge that has a specific, evidence-based impact on healthcare delivery. Examples include ethnopharmacology; disease incidence, prevalence, and outcomes among distinct populations; the impact of the Tuskegee Syphilis Study and segregation as the cause of mistrust in African Americans; the effect of war and torture on certain refugee populations and how this shapes their interaction with the healthcare system; and the common cultural and spiritual practices that might interfere with prescribed therapies (such as Ramadhan—the sunup-to-sundown fast observed by Muslims—and how this might affect people with diabetes), to name a few.

When learning facts about "cultural groups," it's important for providers to ask themselves several questions to avoid falling prey to ecologic fallacy. How accurate and generalizable are these group assumptions? How current are they, given the fluidity of culture and diversity among groups? What are the limitations? How can I use this knowledge

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TABLE 6-3 Conceptual Approaches to Cross-Cultural Education

Multicultural/Categorical Approach

- Primary focus on increasing provider **knowledge** of cross-cultural issues
  - o Previous focus on teaching unifying cultural characteristics of cultural groups (patients of culture x believe. . . and behave . . .)
- New focus on teaching methods of community assessment and evidence-based factors
  - o These include disease incidence/prevalence among groups, ethnopharmacology, and historical factors that might shape health behaviors
- Taught in undergraduate, graduate, and continuing medical education

to deliver better care? (Shapiro and Lenahan, 1996). In summary, if a knowledge-based approach (see Table 6-3) is taught, it should focus on community oriented or specific, evidence-based factors. Absent this, learning as much as possible about the patient's own sociocultural context and perspectives while minimizing the reliance on generalizations is ideal.

A Focus on Skills: The Cross-Cultural Approach

The cross-cultural approach teaches providers *skills* that meld those of medical interviewing with the ethnographic tools of medical anthropology (Shapiro and Lenahan, 1996; Carrillo et al., 1999). These framework-based approaches focus on communication skills, and train providers to be aware of certain cross-cutting cultural issues, social issues, and health beliefs, while providing methods to deal with information clinically once it is obtained (Nunez, 2000; Berlin and Fowkes, 1998; Clinton, 1996). Curricula have focused on providing methods for eliciting patients' explanatory models (what patients believe is causing their illness) and agendas, identifying and negotiating different styles of communication, assessing decision-making preferences, the role of family, determining the patient's perception of biomedicine and complementary and alternative medicine, recognizing sexual and gender issues, and being aware of issues of mistrust, prejudice, and racism, among others (see Table 6-4) (Carrillo et al., 1999; Hill et al., 1990; Zweifler and Gonzalez, 1998; Culhane-Pera et al., 1997). For example, providers are taught that while it is important to understand all patients' health beliefs, it may be particularly crucial to understand the health beliefs of those who come from a different culture or have a different healthcare experience. As such, frameworks including questions to obtain this and other information are taught. Instead of applying a deductive approach that applies broad rules and generalizations about cultures to the individual, this inductive approach

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TABLE 6-4 Conceptual Approaches to Cross-Cultural Education

Cross-Cultural Approach

• Primary focus on developing **tools and skills** for providers
• Process-oriented instruction that melds medical interviewing and communication skills with sociocultural and ethnographic tools of medical anthropology
  • Approaches to elicit patient's explanatory model (patient's conceptualization of illness)
  • Methods to assess patient's social context
  • Strategies for provider-patient negotiation and facilitation of participatory decision making
• Foundation to care for diverse populations through development of interviewing frameworks
• Practical approach for clinical years; taught in undergraduate, graduate, and continuing medical education

focuses on the patient, rather than theory, as the starting point for discovery (Shapiro and Lenahan, 1996). With the individual patient as teacher, providers are encouraged to adjust their practice style accordingly to meet their patients' specific needs. The cross-cultural approach has gained favor among educators who see its clinical applicability as a framework in caring for either diverse or targeted populations.

Teaching Methods and Opportunities

There have been a variety of teaching methodologies utilized for cross-cultural education at different levels of training (Table 6-6). In general, interactive, experiential, practical, case-based approaches that address cognitive, affective, and behavioral aspects of the learner are most effective (Welch, 1998). At the level of undergraduate and graduate medical education, strategies such as self-reflection (particularly for cultural sensitivity/awareness approach), focused didactics (especially for multicultural approach), and the use of vignettes, problem-based learning cases, medical encounter videos, and individual case-based discussion (usually for cross-cultural approach) are most common (Nunez, 2000; Carrillo et al., 1999; Louden et al., 1999; Culhane-Pera et al., 1997). Innovative educational strategies include learner community immersion (whereby students or residents rotate through community-based healthcare facilities), role-play (whereby students or residents practice interviewing techniques using scripted cases), patient narratives, video interviews of patients, and the use of patients or actors for faculty facilitated, simulated medical encounters (Gonzalez-Lee and Simon, 1987; Rubenstein et al., 1992). Continuing education for practicing providers has focused more on "cultur-

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ally competent" approaches to treating specific clinical conditions in targeted populations (i.e. "Hypertension in African Americans," or "Managing Diabetes in Latinos"). In these instances, a knowledge-based approach is most commonly employed, in which disease incidence and prevalence of a specific condition in a target population is presented, along with focused strategies for managing said condition. These strategies may include evidence for the use of specific medications in certain populations or methods for incorporating community based resources for clinical support. Although other "provider-patient communication" continuing education courses focus more specifically on the process of improving understanding in the medical encounter, few have "cross-cultural communication" as a central theme.

There are various opportunities to incorporate cross-cultural issues in health professions education. In undergraduate and graduate medical education, courses have been taught during orientation, as part of established courses or electives, during retreats, as part of weekly conferences, or less frequently, as an optional or required stand-alone (see Table 6-5). Since there is currently no clear focus on cross-cultural issues within undergraduate and graduate health professions curricula, stand-alone courses are favored for the time being, although integration into the standard curricula would be optimal (Kai et al., 1999).

For practicing providers, integration of cross-cultural curricula as part of continuing education, or as part of the grand rounds series, or as part of faculty development, has been attempted. Certain states are considering requiring a standard number of continuing education credits in cross-cultural communication as part of professional licensure. Similarly, the Na-

TABLE 6-5 Methods and Opportunities for Cross-Cultural Education

Methods	Opportunities
Undergrad/Graduate Medical Education	*Undergrad/Graduate Medical Education*
• Facilitated reflection	• Orientation
• Didactics	• Electives
• Vignettes	• Retreats
• Individual Cases	• Rounds
• Problem-Based Learning	• Conferences
• Videos	• Introduction to Clinical Sciences
• Simulated Patients	• Stand Alone Course
• Community Immersion	
Continuing Education	**Practicing Providers**
• Didactics	• Continuing Education
• Problem-Based Learning	• Faculty Development
• Case-Based Discussion	• Licensure/Exams

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tional Board of Medical Examiners is exploring methods of incorporating questions that address cross-cultural issues in medical care on licensing exams. Certain medical malpractice insurers are offering premium discounts to providers who complete provider-patient communication courses, and are now considering applying the same discounts to providers who complete cross-cultural communication courses. Regardless of the setting, it is felt that cross-cultural education should be linked to the level of the learner's training, with more theoretical approaches in the pre-clinical years and more practical approaches during the clinical years (Nunez, 2000).

Evaluation

To date, there has been limited evaluation published on the impact of cross-cultural education. Building on the three-legged stool model of attitudes, knowledge, and skills described above, we see some studies that have primarily shown improvements in cross-cultural knowledge (the type of knowledge has varied relative to the individual curricula taught). For example, Rubenstein et al. used pre- and post-test methodology to demonstrate that students who completed a "Culture, Communication, and Health" course displayed an increase in knowledge regarding:

1. The way in which a physician's ignorance of a patient's health beliefs and practices can adversely affect the clinical encounter;
2. The pervasiveness of non-conventional health beliefs and practices; and
3. The types of resources available for learning about patients' health beliefs and practices. (Rubenstein et al., 1992).

Similarly, Nora et al. used multiple-choice question methodology to show that an experimental group of students who completed a "Spanish Language and Cultural Competence Curriculum" had greater knowledge of Hispanic health and cultural issues, including disease prevalence, cultural perceptions of illness, and traditional health practices, compared with a control group (Nora, 1994). In addition, when compared with the control group, the experimental group was found to be less ethnocentric and more comfortable with others after the curricular intervention, based on the "Misanthropy Scale." In the area of graduate medical education, one published study found that family practice residents exposed to a three-year, multi-method cross-cultural curriculum displayed an increase in cultural knowledge and cross-cultural skills via self-report and faculty corroboration (Culhane-Pera et al., 1997). Research on continuing medical education courses for practicing providers targeted at improving commu-

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nication skills (without a focus on cross-cultural communication) have shown mixed results (Haynes et al., 1984; Davis et al., 1992; Davis et al., 1995). Joos et al. showed no significant improvement in patient satisfaction for providers who had completed such courses versus those who hadn't (Joos et al., 1996). Levinson et al. did show a moderate increase in patient satisfaction and a significant increase in provider satisfaction for those who completed a course on improving doctor-patient communication (Levinson et al., 1993). It is difficult to know whether one can extrapolate these results to continuing medical education focusing on cross-cultural communication as there is yet no evaluative data in this area.

Cross-cultural education poses significant challenges for evaluation. For example, it's difficult to evaluate change in provider attitudes given the potential for social desirability bias on surveying, and the difficulty in observing encounters in real time. Assessing knowledge is perhaps easier, and can be assessed with standard evaluation tools such as pretest-post-tests and essays (Louden et al., 1999; Nora et al., 1994; Rubenstein et al., 1992). Skills can be evaluated in undergraduate and graduate health professions education using techniques such as the objective structured clinical examination, or videotaping actual clinical encounters (Nunez, 2000; Robins et al., 1998a; Robins et al., 2001). For practicing providers, one might assess patient satisfaction improvements among those who have completed cross-cultural communication courses. All in all, we should be able to evaluate some dimensions of attitudes, knowledge, and skills.

Another approach to evaluation asks three questions about the impact of curricula, building towards the link to outcomes. First, do providers learn what is taught? Second, do they use what is taught? And third, does what is taught have an impact on care?

These questions can be assessed using mixed methodologies that include both quantitative and qualitative techniques (Table 6-6) (Nunez, 2000; Like et al., 1996). These include pre- and post-tests, unknown clinical cases, qualitative physician and patient interviews, medical chart review, audio or videotape of medical encounter, objective structured clinical exams, patient and provider satisfaction, and processes of care (i.e. completion of health promotion/disease prevention interventions). It's important that we not hold cross-cultural curricula to unfair evaluation standards, as detractors have asked for a direct link between curricula and the improvement of hard clinical outcomes Any assessment should match the educational objectives and be carried out in a careful, step-wise fashion, controlling for all possible confounders and focusing first on process measures (such as patient and provider satisfaction).

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TABLE 6-6 Evaluation of Cross-Cultural Curricula

Key Question	Evaluation Strategy
Do providers learn what is taught?	Pre-, Post -Test Unknown Clinical Cases Objective Structured Clinical Exam
Do they use what is taught?	Qualitative physician and patient interviews Medical Chart Review Audio or Videotape of medical encounter Patient, Provider Satisfaction
Does what is taught have an impact on care?	Processes of Care (i.e., completion of health promotion/ disease prevention interventions)

Challenges and Opportunities

There are several challenges ahead for cross-cultural education (Table 6-7). First, given the biomedical focus of health professions education, there is significant resistance to curricula that are viewed as "soft" or lacking an evidence base (Culhane-Pera et al., 1997). Second, given that providers are accustomed to factual, practical learning, they are often disappointed when specific group cultural knowledge ("Hispanic patients believe . . . or behave . . .") is not presented (Kai et al., 1999). Third, providers feel that they don't have the time needed to explore and negotiate complex sociocultural issues with patients, due to the short length of today's medical encounter. Fourth, there is lack of consensus on fundamental, conceptual approaches and teaching methodologies, and lack of institutional support (both formal and informal) (Shapiro and Lenahan, 1996; Kai et al., 1999). Fifth and finally, although there is circumstantial

TABLE 6-7 Challenges for Cross-Cultural Education

Challenges: Provider Perspectives	Challenges: Developing the Field
• Provider resistance to curricula in this area • Limited awareness of impact of cross-cultural factors on healthcare and presence of health disparities • Desire for categorical approach to cross-cultural education • Time constraints for implementation of skills	• Varying fundamental approaches without consensus • Multiple teaching methodologies • Limited time, resources, faculty, and institutional support • Hypothetical link between cross-cultural education and the elimination of disparities that must be strengthened

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evidence that would substantiate the claim that improving provider cross-cultural communication will help eliminate disparities in healthcare, there are yet to be published studies to support this hypothesis.

Despite these challenges, several opportunities exist for the field. First, since the government has realized the importance of educational initiatives in this area (U.S. DHHS, 1999), there are broadening funding streams for cross-cultural education and research. Given the evidence linking provider-patient communication to patient satisfaction, adherence, and outcomes, cross-cultural education holds promise as one effort of a multi-pronged approach towards eliminating racial/ethnic disparities in healthcare. Research that would help to solidify this link should be developed. Second, expanded cross-cultural curricula that include teaching specific data on racial/ethnic disparities in healthcare, in addition to exploration and discussion of potential causative factors, are being piloted. Given the limited awareness of disparities on the part of providers and the public (The Henry J. Kaiser Family Foundation, 1999), this seems to be a worthy strategy. Finally, with growing acknowledgement as to the impact of social cognitive factors (including stereotyping) on provider decision-making, cross-cultural curricula are now reviewing the normal processes by which clinical decisions are made, and what negative impact they might have on minority populations.

Ultimately, cross-cultural curricula should focus on securing provider buy-in by introducing evidence on how sociocultural barriers affect medical care and lead to racial/ethnic disparities in health, and how specific cross-cultural strategies can help ameliorate them. Curricula should balance their approaches between addressing attitudes, knowledge, and skills in a way that offers providers multiple approaches to address the problems they face.

SUMMARY

This chapter reviews evidence that sociocultural differences between patient and provider influence communication and clinical decision-making (Eisenberg, 1979). Evidence suggests that provider-patient communication is directly linked to patient satisfaction, adherence, and subsequently, health outcomes (Stewart et al., 1999). When sociocultural differences between patient and provider aren't appreciated, explored, understood, or communicated in the medical encounter, the result may be patient dissatisfaction, poor adherence, poorer health outcomes, and racial/ethnic disparities in care (Flores, 2000; Betancourt et al., 1999; Stewart et al., 1999; Morales et al., 1999; Cooper-Patrick et al., 1999; Langer, 1999).

There is a body of literature defining and supporting the importance

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of cross-cultural education in the training of health professionals. Despite this, curricula in this area have been implemented to a limited degree in health professions education. There are several theoretical approaches to cross-cultural education that vary in their relative emphasis on attitudes, knowledge, and skill building. Current published evaluations do not support conclusive statements about the effectiveness of particular approaches. However, the approaches that focus on skill building are likely more effective in providing clinicians with the clinical acumen to diagnose and treat diverse populations of patients.

There are various opportunities in which cross-cultural communication courses could be integrated into the health professional curricula, including during undergraduate, graduate, and continuing medical education. A set of core competencies for cross-cultural education should be developed. These should include achievement of certain attitudes, knowledge and skills from which learners will benefit and that they will utilize in the medical encounter. Improving quality of care and developing a strategy to eliminate racial/ethnic disparities in the medical encounter should be the goal. Research to date supports implementing a combination of each of the conceptual approaches presented here to develop efficient, solution-oriented ways of introducing cross-cultural principles to guide physician-patient interactions (Shapiro and Lenahan, 1996). Inductive frameworks should focus on individualized, patient-centered care (Donini-Lenhoff, 2000). While there is no one "right" way to teach cross-cultural medicine, and interventions should be tailored to the specific learning environment, there are some guiding principles that can be followed and disseminated—some of which exist in the literature today (Betancourt et al., 1999; Nunez 2000; Like et al., 1996; Carrillo et al., 1999; Kristal et al., 1983). There should be some determination as to how best to incorporate cross-cultural education into the health professional's curricula as part of a multipronged effort to eliminate racial/ethnic disparities in healthcare. Research suggests that required, full integration into the standard undergraduate and graduate medical curricula should be the gold standard. Yet in the absence of the capacity to do this, we should be including the teaching of cross-cultural medicine as a stand-alone (Flores, 2000; Nunez, 2000; Like et al., 1996; Bobo et al., 1991; Clinton, 1996). For practicing providers, continuing medical education—as part of licensure, as part of faculty development, and as part of obtaining medical malpractice insurance—all remain promising areas of integrating cross-cultural curricula and assessing cross-cultural communication skills.

Appropriate evaluation strategies and monitoring that directly assess the attitudes, knowledge and skills taught to providers should be devised. Careful attention should be given to the complexities of evaluation and

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measurement in these types of curricula, with a strategic, step-wise, mixed-method, process-driven approach as a starting point for future research.

Finding 6-1: Sociocultural differences between patient and provider influence communication and clinical decision making.
Evidence suggests that provider-patient communication is directly linked to patient satisfaction, adherence, and health outcomes. Ineffective communication in the medical encounter may lead to patient dissatisfaction, non-adherence, poorer health outcomes, and subsequently, racial and ethnic disparities in healthcare.

Finding 6-2: A significant body of literature defines and supports the importance of cross-cultural education in the training of health professionals.
Despite several approaches and various opportunities for integration, curricula in this area have been implemented to a limited degree in undergraduate, graduate, and continuing health professions education.

Finding 6-3: Cross-cultural education offers promise as a tool to improve healthcare professionals' ability to provide quality care to diverse patient populations and thereby reducing healthcare disparities.

Recommendation 6-1: Integrate cross-cultural education into the training of current and future health professionals.
Strategies should be developed to fully integrate cross-cultural curricula into undergraduate, graduate, and continuing education of health professionals. These curricula should be expanded to include modules documenting the existence of racial and ethnic disparities in healthcare, and the impact of social cognitive factors and stereotyping on clinical decision- making. Required, practical, case-based curricula based on a set of core competencies, amenable to evaluation, should be the desired standard of training.

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