
■ CULTURE IN MEDICINE

Cultural Immersion in a Cultural Competency Curriculum

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Objective: Cultural competency is becoming increasingly important nationally. During recent seminars held throughout Hawai'i on Native Hawaiian health, several questions were raised related to cultural competency. First, can providers' cultural competency improve the poor health status of Native Hawaiians? Second, how can Native Hawaiian physicians, who are trained in Western medicine and Western ways of thinking, bridge the gap that exists between them and traditional Native Hawaiian approaches to health and healing? The purpose of this curriculum was to teach community physicians how to become more culturally competent and to see whether adding an intense cultural immersion experience would increase the success of the curriculum.

Description: The Native Hawaiian Center of Excellence of the John A. Burns School of Medicine at the University of Hawai'i, the 'Ahahui o na Kauka (the Native Hawaiian Physicians Association), and the CME sponsor, the Straub Foundation, designed a CME curriculum entitled, "Increasing Cultural Competency in Native Hawaiian Physicians." The five-day program was offered in August 2000 on the islands of Maui and Kaho'olawe. Kaho'olawe, a former Navy bombing target, is currently uninhabited but access to the island is granted monthly to Native Hawaiian groups for cultural purposes. Since there are no facilities on the island, all the participants' food, water, camp gear, and personal items were brought over by boat. The participants were 23 physicians, two traditional healers, guests, and family members. The curriculum addressed the following topics: historical and cultural aspects of Native Hawaiian health; traditional healing methods, including herbal medicine (*La'au lapa'au*), massage (*Lomi lomi*), and conflict resolution (*Ho'oponopono*); traditional diet; cultural competency from a global perspective; cultural competency in the medical school; and how culture affects the MD-patient relationship. Intense cultural immersion experiences were included. Activities such as tours and hikes to archeological and culturally significant sites, sessions for family and spiritual sharing, prayers, chanting, music, hula, and ecologic restoration work projects enabled the participants to experience traditional Native Hawaiian values of *aloha* (to care for), *malama* (to take care of), *'imi 'ike* (to seek knowledge), *loko maika'i* (to share), and *olakino maika'i* (to be healthy). Everyone also participated in cooking, cleaning, and transporting gear.

Discussion: This novel approach to a cultural competency curriculum was very well received. The ability of speakers to meet objectives was rated on average 4.6 on a scale of 1 (poor) to 5 (excellent). The written evaluations were extremely positive. The following comments summarize what participants liked about the experience: "incredible program, site, environment," "cultural immersion," and "learning occurred on many levels." One physician commented that it was "the best CME program ever!" The few negative comments concerned the breadth and limited time for discussion of many of the topics addressed. There are plans to repeat the program next year. Modifications will include decreasing the numbers of speakers to allow for more discussion time and increasing the attendance of non-Native Hawaiian physicians.

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A Course about Culture and Gender in the Clinical Setting for Third-year Students

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Objective: In the clinical setting psychological issues often modify presenting physical symptoms. Clinicians need to assess any emotional overlay in medical problems in order to diagnose and appropriately treat them. Cultural differences between clinicians and patients add to potential miscommunication.

The department of psychiatry at San Francisco General Hospital (SFGH) teaches a four-session course to third-year medical students during the clinical clerkship in obstetrics and gynecology in order to enhance students' ability to apply these skills in non-psychiatric settings. The course covers psychiatric problems commonly encountered in ob-gyn, and it includes ways of assessing the roles of race, ethnicity, socioeconomic difference, gender, and sexual preference in clinical presentations.

Description: In this required course, the instructor uses stimulus videos for three of the four sessions, as well as case material from the students' own experiences in wards and

clinics. The four topics are postpartum disorders, substance abuse in childbearing years, domestic violence, and communication with challenging patients. For the last session the students are instructed to jot down vignettes of witnessed interactions between their residents or attendings and patients that went “extraordinarily well, or very badly.” The group deconstructs the interactions in order to understand the elements of good communication with patients and among the members of the treatment team.

The course is interactive, and the instructor encourages the students to apply the principles they have learned to the patients they care for. The issues covered in each session are common clinical dilemmas, e.g., treatment of pain in opiate-addicted patients, cultural issues that may inhibit disclosure of domestic violence, and how the prior psychiatric history or psychosocial stressors affects the prevalence of mental disorders in the postpartum period. The session on witnessed interactions allows students to reflect on which physician behaviors increase rapport and enhance clinical care, as well as to process negative behaviors in a way that allows them to think about how they might handle the situation differently. An example of a positive interaction was that with a patient with a history of drug use, who was being treated for a pelvic infection and was in a great deal of pain. The patient was labeled by some of the team as “drug seeking and manipulative.” An attentive senior resident’s questioning elicited a history of sexual assault that had contributed to the patient’s behavior. This led to appropriate pain control and more empathy from the team.

Discussion: The students’ evaluations have ranged from good to excellent. They have commented on how helpful it is to have strategies for addressing mental disorders in ob-gyn setting, a clearer idea of what psychiatric consultation has to offer, and an opportunity to talk about the dynamics within the treatment team and the impact on patient care. This model could be replicated in other departments in collaboration with psychiatric consultation–liaison services.

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A Pathway on Serving Multicultural and Underserved Populations

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Objective: The Pathway on Serving Multicultural and Underserved Populations has two major goals: to develop the linguistic and cultural competence of medical students, and to develop their interest in serving newcomer groups in Mas-

sachusetts. The program is in response to changing local and national demographics. Massachusetts is the seventh leading state in terms of newcomer immigrant and refugee populations, many of whom are uninsured and underserved. Nationally, by 2050 it is estimated that ethnic minority populations will become a majority. As a consequence, cultural competency training has become a focus of curricular innovations nationally, as well as a requirement for medical school accreditation. A review of relevant curricula, however, indicates that they are nearly always minor components of larger courses and that they are poorly evaluated. The Pathway program is a coordinated, longitudinal curriculum.

Description: The Pathway is an elective, four-year module now in its third year, that, has accepted 20 matriculating students annually, for a total of 60 in the program as of 2000–01. The program involves linguistic, cultural, and clinical immersion experiences with newcomer groups both in their countries of origin and in the United States. Afterward, these experiences are processed using reflective exercises. Specifically, the students participate in the following curriculum: (1) a longitudinal preceptorship program in which the Pathway students shadow a physician in a community health center and learn how culture, language, and poverty influence health care delivery, (first-year and second-year students [MS1, MS2]); (2) an assignment to a local newcomer family during which the students learn about the family’s culture, health beliefs and practices, and barriers to health care (MS1); (3) a summer immersion experience, which can either be language/cultural immersion abroad in a country that reflects populations in Massachusetts, or a community service project in Massachusetts with a newcomer group; 90% of the students go abroad for six weeks and attend a language school and observe health care delivery, or, if relatively fluent in the language, they participate in a health-related project; (4) a community service project in Massachusetts with the same language and/or cultural group as in the summer (MS2); (5) a family medicine clinical clerkship in a community health center (MS3); and (6) international and/or U.S. electives in countries that reflect newcomer groups.

Evaluation methods are self-assessment instruments that measure linguistic and cultural competence and attitudes toward serving underserved populations, given annually to all students.

Discussion: The program has only begun its third year, and therefore our experience is still with its preclinical components. The students’ evaluations reveal that the summer immersion experiences, especially those abroad, have worked very well. Narrative reports indicate that the experience of hardships living in another country is powerful in developing cultural humility and empathy. The family assignment has been the least effective component; some students have

found the experience artificial and lacking clear boundaries on expectations. Preliminary data analyses indicate that the students participating in the preclinical modules of the program develop important linguistic and cultural competencies at a higher level than the non-Pathway students do.

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A Culture OSCE: Teaching Residents to Bridge Different Worlds

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Objective: Residency training programs have attempted to instill cultural competency skills by exposures to varied patient populations, lectures on cultural issues, or small-group discussions that explore the trainees' own cultural values. However, culturally appropriate care has a large skills component, and organized practice and feedback are necessary to instill these skills. Multiple-station exercises—such as teaching OSCEs that expose trainees to strategically planned clinical scenarios and provide systematic practice and feedback by faculty observers and standardized patients—are uniquely suited to impart such complex competencies. The objective of the Culture OSCE was to provide such an opportunity to develop cultural competency skills.

Description: In the fall of 1999, a six-station formative cultural OSCE was developed and administered to all second-year pediatrics residents (23 residents). The residents had to explore the patient's and family's beliefs and behaviors regarding illness and treatment, recognize differences in communication styles within families and with health care providers, and address differences in perspective in order to negotiate a mutually acceptable plan of action. The OSCE stations were as follows. (1) Informed Consent—requesting consent for a child's emergency surgery and blood transfusions from a parent who is a Jehovah's Witness. (2) Life-threatening Illness—discussing the possibility of openly addressing a teenager's cancer with his Nigerian parents who are opposed to such practices. (3) Pelvic Exam—explaining the need for pelvic exam to rule out pelvic inflammatory disease to a girl from a traditional Muslim background who fears her sexual activity will be severely punished. (4) Down's Syndrome—exploring the expectations of a couple about their Orthodox Jewish community's reactions to the birth of a child with Down's Syndrome. (5) Suspected Child

Abuse—discussing suspicions of child abuse with an Orthodox Jewish family. (6) Alternative Medicine (paper-and-pencil task)—match questions about alternative treatments and photo identification of skin marks that result from traditional healing practices but can be mistaken for child abuse (e.g., cupping, coining).

The residents received verbal and written feedback on their performances, based on rating scales developed for each scenario. Input from the residents, faculty observers, and standardized patients was gathered to assess the educational value of this experience and to continue to develop the exercise.

Discussion: The results of this initial cultural OSCE were quite promising. The residents and faculty found it a useful learning experience, and it generated much discussion about how to deal with challenging situations. We are now in position to build on these experiences by expanding and improving the station pool and undertaking a rigorous evaluation study to delineate the learning gains from such a program. Over the next year, we plan to repeat this training exercise with a new class of second-year residents and to assess their cultural skills before and after the OSCE exercise. It is hypothesized that residents who have an opportunity to deal with standardized patients and to receive specific feedback about their performances and the issues related to the case will be better able to recognize culturally related issues and deal openly and respectfully with differences in perspective.

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A One-month Cultural Competency Rotation for Pediatrics Residents

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Objective: As the U.S. population becomes increasingly diverse and racial/ethnic disparities in health care delivery and outcomes persist, the need for effective cultural competency training in medical education has reached critical proportions. We developed a program for pediatrics residents with three components: diversity training, cultural issues in health care, and field work in community settings.

Description: Among the 84 total residents in the Department of Pediatrics at the University of California; San Fran-

cisco (UCSF), 30 are in the primary care program (ten per year). All primary care residents participate in a required one-month community rotation during their second year. This is offered twice per year so that half participate in the fall and the other half in the spring.

The cultural competency component of the rotation, initially developed in 1997–98, currently consists of a three-hour diversity training workshop, a three-hour literature-based seminar on cultural issues, and three four-hour field-work sessions in community settings. Diversity trainers from the UCSF Department of Affirmative Action, Equal Opportunity and Diversity facilitate the workshop, in which each resident shares his or her cultural heritage and describes its impact on his or her perceptions of individuals from other cultures.

The subsequent seminar is a discussion of cultural issues based on Anne Fadiman's "The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures." The residents respond to passages depicting variations in meaning and problems in health communication based on cultural differences. They recall similar incidences from their own clinical experiences and, through group process, identify ways in which these experiences affect perceptions and behaviors. The group then moves to building skills in recognizing bias and practicing more effective communication with people of other cultures.

Finally, each resident provides direct health care services under a preceptor's supervision at community health clinics serving distinct racial/ethnic populations in San Francisco and in Alameda and Marin Counties. Although the individual community experiences have varied, most clinics now offer a comprehensive orientation to the populations they serve, with overviews on providing culturally sensitive care and opportunities to interact with experienced members of the health care team (e.g., nutritionist, social worker, health educator).

Discussion: Thirty-five residents participated in the initial rotation, and they gave it consistently positive reviews. As a result, diversity training was extended to all first-year residents during their orientation week starting in 1999. Currently, 79% of pediatrics residents (66/84) have undergone such training during either orientation week or the community rotation. Successive case-based evaluations before and after the training have demonstrated that the residents, after completing the rotation, have been more comfortable with cross-cultural communication and have identified potentials for disparate health care more accurately. We plan to expand the current literature-based discussions to include other cultures, and we will begin to incorporate into the residents' regular continuity clinics the effective systems of culturally sensitive care practiced at the community sites in the new program.

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Teaching Pediatrics Residents to Communicate with Patients across Differences

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Objective: Although recommendations and standards for providing culturally effective health care have been published on the federal level and by the American Academy of Pediatrics, pediatrics residency programs are lagging behind in integrating cultural competency into their curricula. A curriculum was designed to integrate the principles of culturally effective health care throughout the residency program in order to develop pediatrics residents who communicate effectively and efficiently with patients and families of diverse sociocultural backgrounds.

Description: A four-unit curriculum was designed to develop the attitudes, knowledge, and skills necessary for better communication between physicians and patients who have differences not only in ethnicity but also in economics, religion, gender, and education. The four units are: Acknowledging Differences, Recognizing Core Cultural Concepts, Utilizing Resources, and Negotiating a Plan. These units occur during the intern retreat, during noon conferences, and on the resident's ambulatory block month. The Acknowledging Differences unit covers the biomedical model versus the patient explanatory model, principles of effective communication, and skills in eliciting the patient's perspective. Recognizing Core Cultural Concepts addresses concepts found in all cultures (such as authority, family, gender, communication style, and time) and their roles in health care. Utilizing Resources covers how to use interpreter services and to access information and community resources. Negotiating a Plan incorporates the previous units and includes negotiating differences between the physician's and patient's perspectives in order to develop a feasible and acceptable management plan. The instructional strategies are short didactic sessions, demonstrations, small-group discussions, and role-plays.

The curriculum was developed in fulfillment of the Michigan State Primary Care Faculty Development Fellowship and was reviewed by three experts: Dr. Kent Sheets, a curriculum development specialist; and Dr. Kathleen Culhane-

Pera and Dr. Robert Like, who are both family practitioners and experts in culturally effective health care. A pilot test of the Acknowledging Differences unit was conducted in March of the residents' first year and evaluated by the residents and facilitators.

Discussion: The input from the residents after the pilot of one unit was extremely helpful. While their overall response was very positive regarding the content and time frame, they offered many constructive suggestions for improving the role-play of case scenarios. The unit has been revised and will incorporate their suggestions. While many of the residents had been trained in effective communication skills as medical students, they found this review at the end of their first year of residency very helpful and revealing.

Throughout the course of designing, developing, and implementing the curriculum, I observed some strong emotional reactions among both residents and faculty to the topic of culturally effective health care. These encounters often reflect what is occurring internally rather than the particular case scenario or topic at hand. In view of this and the recommendations of the expert reviewers, faculty development has taken priority over the implementation of all four units. Faculty development will aid in the implementation of the full curriculum and contribute to the integration of the material throughout the residency.

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An International Health/Tropical Medicine Elective

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Objective: A unique approach to the development of cultural competency has been provided at Drew University of Medicine and Science through an elective in international health/tropical medicine for medical students. Through a

six-week combined classroom and clinical experience, medical students learn about the clinical symptoms, diagnoses, treatment, prevention, and control of six major tropical diseases and explore prevalent public health complications in tropical countries.

Description: Topics addressed in the initial two-week classroom sessions include traditional medicine in tropical countries, the impact of tropical disease on economic and agricultural development, nutrition need and habits, current health projects, and initiatives in tropical countries, and the management of patients who travel to and return from the tropics.

The introduction is followed by a four-week clinical clerkship assigned in tropical countries, where the participants observe, study, and work with patients under the supervision of the local attending physicians in the area. The preferred areas for the clerkship are Kenya, Zimbabwe, Costa Rica, Colombia, Mexico, Puerto Rico, India, and Peru.

Discussion: Between 1987 and 1998, 52 alumni who had completed the course as medical students completed and returned a survey. It indicated that two thirds of the participants had joined national or international relief organizations such as Doctors Without Borders, Global 2000, or the World Health Organization after completing the elective. Eighty percent had traveled several times to the areas in which they had completed the elective. They reported that the elective had improved their clinical diagnostic skills and reduced their dependence on laboratory testing and other procedures.

The diverse population of Los Angeles County includes thousands of first- and second-generation immigrants from tropical and semitropical regions. Physicians working in an urban underserved setting often encounter patients who have come from or recently traveled to these regions. Having learned about and experienced tropical diseases and cultures first-hand, our graduates are prepared to recognize and respond to the health care needs and beliefs of this special segment of the urban community, who make up a large portion of the urban population seen in underserved areas of Los Angeles.

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