



How Training in Cultural Competence Can Improve American Medical Education

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Bias, prejudice, and stereotyping among healthcare providers contribute to unequal treatment of patients in medical institutions. Renewed attention to longstanding disparities between demographic groups in public life has placed new emphasis on improving the delivery of care for all – and in a crucial step toward such improvement, cultural competence training has proliferated in U.S. medical schools. Cultural competence – the combination of knowledge, attitudes, and skills necessary for healthcare providers to work with culturally and ethnically diverse patient populations effectively – is a cornerstone of quality healthcare delivery, and must be fully integrated into medical education. When the needs of diverse patients are not met, the consequences can be severe – leading to even greater health problems and inequities. To make medical care effective as well as fair, medical education must help providers competently work with patients from many social backgrounds and walks of life.

The History of Medical Education Reform

American medical education reform began with the birth of experimental medicine in Europe and the migration of American medical graduates to France and Germany to acquire the latest scientific techniques. The scientific method was widely adopted as a guiding principle, emphasizing inquiries using measurable evidence and logical reasoning. In 1893, Johns Hopkins University School of Medicine opened with an innovative scientific curriculum, requiring a college degree for admission to four years of study with nine-month terms. By 1906, the American Medical Association had created an educational board to review 160 schools; and in 1910 the Flexner Report crystallized efforts to reform medical education based on the scientific method. This first wave of transformation in U.S. medical education grew from a revolution in ideas emphasizing hard sciences and measurable evidence.

In our era, the beginnings of reforms stressing health equity grew from legislative milestones such as the 1964 Civil Rights Act banning discriminatory practices in private and public institutions and the 1986 establishment of the U.S. Office of Minority Health, tasked with tracking and addressing health disparities for racial and ethnic minorities. In 2000, this agency published the *National Standards for Culturally and Linguistically Appropriate Services* as a “blueprint” to help healthcare workers and organizations to better serve patients of all cultural backgrounds. Additionally in 2000, the Liaison Committee on Medical Education – which awards accreditation to medical schools – introduced a requirement that faculty and students demonstrate “an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness, and respond to various symptoms, diseases and treatments.” Unfortunately, such efforts around cultural competence have not been fully realized. Major reports in 2003, 2006, and 2010 by the Institute of Medicine continue to document persistent inequities and errors in health care delivery. Challenges remain in both the healthcare system and medical education arena.

Modern-Day Reforms and the Social-Cultural Model

While the Flexner Era was about scientific rigor, the current reform emphasis is inspired by social scientific findings about bias, health disparities, cultural competence, and professionalism. This second wave of medical education is an outgrowth of a conference held at the University of Illinois College of Medicine in June 1986 to commemorate the 75th anniversary of the publication of the Flexner Report. The vision that emerged from this gathering called for a future healthcare workforce made up of physicians and other health professionals all capable of assessing their own performance and making the changes needed to provide the best care for diverse patients. Learning should be competency based, embedded in the workplace, linked to patient needs, and undertaken by individual providers, care teams, and healthcare institutions. The central theme in today's reform push is to make the *social* mission of medicine much more of a priority than it has previously been, in order to better address health problems in our society. Leading professional institutions including the American Medical Association strongly support these reforms.

Growing recognition of the importance of cultural competency has led 21st-century medical schools to focus on broadening their students' understanding of the social aspects of medicine. The nonpartisan Commonwealth Fund introduced a Tool for Assessing Cultural Competency Training at the 2004 annual meeting of the Association of American Medical Colleges as a way to help medical implement such training. Cultural competency training in medical education continues to gained traction as a strategy to redress disparities and improve health care.

Evaluating Medical Instruction in Cultural Competence

How can sensitivity to cultural diversity be taught? Today's medical schools are tackling this challenge in a variety of ways. Reformed curricula include topics such as patient-provider communication with diverse populations, the impact of stereotyping and bias in medical decision-making, the social determinants of health, and diverse cultural understandings of health and illness. However, very few studies have been done to assess the effectiveness of such teaching, beyond data gathered and reported by teachers and institutions on their own. Although these topics are important, it is not easy to incorporate them into already crowded medical school curricula or get lessons across to students who already face grueling workloads.

Given today's increasingly diverse population and growing health disparities, more research is needed to identify the most effective ways to teach socio-cultural skills. Policies that promote systematic documentation of this aspect of medical school curricula would go a long way toward laying the basis for further reforms. In addition, undergraduates headed to medical school could be encouraged to learn more about the ways in which diverse cultural and social backgrounds shape patient perceptions of illness and disease. Finally, we need increased funding for assessing the impact of cultural competence training in medical schools – above all for rigorous evaluations that go beyond self-rated results. And new efforts beyond medical schooling will be needed to ensure that health care institutions marry scientific and technological advances to socio-culturally sensitive engagement with patients of all backgrounds.