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:
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<th>Topic</th>
<th>Students will be able to</th>
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<tr>
<td>1. Culture and History</td>
<td>Define cultural determinants; Recount historical events that shape how diverse populations interact with the health care system.</td>
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<td>2. Individual World View</td>
<td>Recognize how personal worldview shapes relationships and encounters. Describe and use Bennett’s Model of Intercultural Sensitivity.</td>
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<td>3. Demographic Changes in the United States</td>
<td>Recount changes in family structure, racial/ethnic distribution, socioeconomic status, immigrant/refugee movements in the last 20 years.</td>
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<td>4. Factors related to Culture and Health; Health Status Indicators</td>
<td>List the behavioral and social factors that influence population health; List differing health status for diverse groups.</td>
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<td>5. Immigrant and Refugee Health</td>
<td>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.</td>
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<td>6. Socioeconomics of Health Care Delivery</td>
<td>Recognize how SES and insurance influences access to care.</td>
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<td>7. Discrimination</td>
<td>Understand the many faces of discrimination and how they influence health – e.g. racial/ethnic, age, gender, religious, national origin, sexual orientation, disability.</td>
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<td>8. Diversity in Medical Education</td>
<td>Outline the representation of diverse groups at the faculty and students levels and describe the influence of public and legislative initiatives.</td>
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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
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:**
- Video – *In the Eye of the Storm.* 60 Minutes clip from 1968.
- 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.

**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 it’s 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:

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:
- 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)

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:

- Thompson, JW, Quality of Care for Children in Commercial and Medicaid Managed Care, Journal of the American Medical Association, 9/17/2003.
- Srikameswaran, A. Should Health Care For Minorities Be Based on Race or Ethnicity? Post-Gazette.com, September 24, 2002.
- Sireci SG, Allalouf A. Appraising item equivalence across multiple languages and cultures. Language Testing 2003(2) 148-166.
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 lge-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, Katsufrakis, 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.
- 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.
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:

- 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.
- Glied S and Little SE, The Uninsured and the Benefits of Medical Programs, Health Affairs, July/August 2003.
Session 7 Discrimination

Instructors: J. South-Paul and A. Soudi

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.]
- Bell Derek. *Faces From the Bottom of the Well*
- 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.
- Szaro, J. *Hospital Conforms to Racial Demands*. January 22, 2004. [www.thecowl.com](http://www.thecowl.com) (Published by Providence College in Rhode Island).
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:
- COGME Minorities in Medicine Report

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:

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<th>Evaluation</th>
<th>Essay</th>
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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.