

# Understanding the Role of Diversity in Interpersonal Communication and Professional Development

John Franklin MD, M.Sc  
Associate Professor of Psychiatry and Surgery  
Associate Dean of Minority and Cultural Affairs  
Feinberg School of Medicine, Northwestern University

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## Why care about diversity training?

- LCME
- ACGME
- National Standards for Culturally and Linguistically Appropriate Services in Health Care
- State Licensing Boards

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## Liaison on Committee on Medical Education

“The faculty and students must 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. Medical students must learn to recognize and appropriately address gender and cultural bias in themselves and others, and in the process of health care delivery.”

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## ACGME Core Competency

- Residents must demonstrate professionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient populations
  - Professional behavior
  - Ethical principles
  - Cultural competence

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## Interpersonal and Communication Skills

- Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their families, and professional associates
- Communicate effectively with patients and families
- Communicate effectively with team members

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## CLAS Standards (DHHS 2001) 13 in all, include

- Care compatible with cultural health beliefs, practices and preferred language
- Diverse staff, leadership representative of demographics of service area
- Staff receive training in culturally appropriate care
- Must provide language assistance services

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## Institute of Medicine: Unequal Treatment 2002

- Racial/ethnic disparities in health care exist and because they are associated with differences in health outcomes, are unacceptable
- Racial/ethnic disparities in health care occur in the context of broader historic and contemporary social and economic inequality and evidence of persistent racial/ethnic discrimination in many sectors of American life

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## IOM-Unequal Treatment

- Many sources-including health systems, health care providers, patients, and utilization managers-contribute to racial, ethnic disparities in health care
- Bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers contribute to racial/ethnic disparities in health care

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## Health Disparities

- AA men 10 years decrease life expectancy, AA woman 5 years
- AA: Cancer, CV, diabetes, Kidney Disease, HIV, HTN, obesity, TB, hepatitis, anemia
- Hispanics-diabetes, Immigrant Asians-hepatitis, TB
- Procedures: Heart Catheterization, breast cancer treatment, transplant, lung Ca surgery, pain treatment

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## Arthroplasty Disparity

- Skinner et al 2003 NEJM: Racial and Ethnic disparities in Rates of Knee Arthroplasty: medicare population
- White, Hispanic, black woman: 5.97, 5.37, 4.84 procedures per 1000 woman
- White, Hispanic, black men 4.82, 3.46, 1.84 procedures per 1000 men

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## IOM Recommendations

- Increase awareness of racial/health disparities in health care providers, policy makers and the public
- Cross-cultural education should be integrated into the training of all current and future health care professionals
- Diversify healthcare work force

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## Physician Workforce

- Minority groups 30% general population
- Estimates: greater than 50% year 2050
- U.S. Physicians: 3.5% Hispanic, 2.6% AA, 0.5% Native American, Alaska Natives
- Minorities 4.2% medical school faculty: 20% in four historically black universities,

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## Rheumatology Workforce Study 2006

- 4,946 adult rheumatologists U.S.
- 79% white, 30.2% woman, 35% fellows IMG's (implications for cultural training)
- 20 AA rheumatologists?

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## Academic Medicine

- Price et al 2004: minority faculty perceive poor retention efforts, lack of mentorship, isolation
- Palepu et al JAMA 1998: Minority faculty less likely than white faculty to hold senior rank: not explained by years as faculty member or measures of academic productivity
- Nunez-Smith JAMA 2007: Qualitative study: Issues of race remain a pervasive influence in the work lives of physicians of AA descent :“racial fatigue”

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## Achieving Diversity in Fellowships Wesson et al 2006

- Division Chiefs, program directors prominently commit to diversity, tie in diversity to annual evaluation
- Examine annually results in achieving diversity
- Publicize funding opportunities available to URM fellows
- Decrease isolation/ facilitate social and network opportunities for URM fellows
- Visiting Professorships with prominent URM physician scientists

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## Why Diversify Physician Workforce?

- Minority Physicians more likely to treat minority communities, lower SES
- Komaromy et al NEJM 1996: AA five fold more likely to practice AA community, Hispanics two fold more likely Hispanic community
- Saha 2000 Health AFF: 25% AA treated by AA physicians, 23% Hispanics, Hispanic physicians

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## Public Surveys

- Commonwealth Fund 2006: 7,000 people – 19% problems with communication with doctors; 16% whites, 23% AA, 27% Asians, 33% Hispanics
- Kaiser Family Fund 2006: 3,884 people; 15% whites, 35% AA, 36% Hispanics felt they were treated unfairly based on race or ethnicity

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## Surveys

- Boulware et al 2003: AA 37% less trust in health care systems compared to whites, but trust health insurance plans 28% more
- Collins et al 1999: 22% Hispanics, 16% AA, 8 % whites report “major “ problem accessing specialty care

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## Studies in Physician/Pt Race Concordance

- Quality Communication: pt better recall, adherence, pt satisfaction, clinical outcomes- blood sugar control, B.P, pain, continuity of care
- Cooper et al 1999; Survey 784 W, 814 AA: race concordance/greater participatory decision making (feeling of choice, control and self responsibility in patient)
- Cooper et al 2003 Annals Intern Med: Race concordance better pt centered care (longer, slower speech, less physician dominance/biomedical statements, more psychosocial/emotional statements/positive tone)

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## Definition

Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross cultural situations. "Culture" refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. "Competence" implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities.

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## Multiculturalism/Cultural Competency

- What is it?
- Why is it important?
- Content of Curriculum
- How do you teach it?
- How effective is it?
- Call to Action

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## Aspects of Culture

- Multidimensional
- Dynamic/fluid
- About meaning, survival: serious business

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## Characteristics of Cultural Competent Caregivers

- Cultural humility
- Stages/levels of competence
- Knowledge of cultural context
- Cultural competence=good care
- Patient centered

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## Why is it important?

- Health Disparities/Multicultural society
- Bias / stereotyping / poor medical decision making
- Stereotyping : Cultural incompetence / poor patient satisfaction / poor compliance / poor outcome

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## State of the Art

- 1970 - first medical school course in cultural medicine
- most schools have something
- quality/comprehensiveness varies
- formal/informal/hidden curriculums
- More questions than answers

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## Domains - Attitudes

- Confront personal bias/understand own culture
- Understand role of power and privilege – not just deficiency model
- Appreciate cultural complexity
- “Culture of medicine”

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## Domains-Knowledge

- Evidence based demographics/health status of population esp. local community
- Understand social/political issues of “isms” i.e. racism, classism, sexism, etc.
- Race does not equal genes/social construct
- Differentiate theories of others v. stereotyping  
Implicit Association Test:  
<https://implicit.harvard.edu/implicit/>

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## Understand Social Context

- Betancourt et al 2002 Academic Medicine:
- Social Stressors and Support Networks
- Change in Environment
- Life Control
- Literacy/ Health literacy

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## Domain - Skills

- Ability to obtain patient's explanatory models of illness i.e. ESFT, BELIEF, Kleinman etc.
- Use of Interpreters
- Knowledge of alternative and complimentary medicine
- Cultural negotiation with patients

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## ACGME Outcome Project

- Aid resident to understand diverse patients
- Helps resident to interact with diverse patients
- Help resident provide effective care with diverse patients
- Help resident understand own value/beliefs
- Help develop skills for difficult medical encounters

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## Modes of Instruction/Integration

- Lectures, small groups, cases, simulated patients, real time patient encounters, videos, role play, journal clubs, community immersion, modeling (hidden curriculum), extended workshops
- Integrated curriculum v. stand alone courses
- What do you do with one or two fellows?
- When is the optimal time to teach what?

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## ACGME Surveys

- 2001 35.7% of residency programs reported cultural competence training, 2004: 50% of programs
- Park et al 2006: Residency survey- most residents perceive little formal cultural competency training - challenges: language barriers, working with families, negotiating with non-biomedical health beliefs
- Lee et al 2006: Residents perceive little training in use of interpreters

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## Efficacy

- Does it really improve care/diminish health care disparities? (no undue burden of proof)
- How do we measure/evaluate attitudinal change?
- How can competence be sustained: life long learning

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## Review of Outcome Data

- Beach et al 2005 Medical Care: Reviewed 34 studies of cultural competence training
- 17 of 19 studies demonstrate increased knowledge
- 21 of 25 studies demonstrated improved attitudes and 14 of 14 improved skills, 3 of 3 studies increased patient satisfaction
- No studies directly link training with health status outcome

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## Evaluation Tools

- The Tool for Assessing Cultural Competency Training (TACCT) – curriculum
- Multicultural Assessment Questionnaire (MAQ) – perceived competence
- Objective Structured Clinical Exam (OSCE) – clinical skills
- Culturally and Linguistically Appropriate Services (CLAS) standards- health care institutions
- Residency/ community feedback

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## Call to Action

- Institutional senior leadership support
- Johnny one note – OK
- Curriculum development / research / best practices / dissemination
- Increase diversity in healthcare workforce

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