Culturally Appropriate & Socially Responsive Care [CASRC] Thread

Price, M., Sotto-Santiago, S., Lazarus K., & Christy, L. (2018)

Medical Education **Objectives** for the Social Science Thread (Now:Culturally Appropriate & Socially Responsive Care [CASRC] Thread)

- The primary goal of the CASRC Thread is not to develop specific sessions for presentation of thread material but to work on identifying gaps and working with course and clerkship management teams to integrate thread content to cover those gaps.

- There is a need to add emotional behavioral health to the medical student curriculum to help students develop communication skills, rapport with patients, develop ways to interact with patients and how to understand, treat, and build a relationship with patients and those with chronic diseases.

- Incorporate thread objectives into courses and clerkships from first year through fourth year.

Rationale: The integration of social science and medical humanities content into medical education is not an end unto itself but part of a larger effort to improve the ability of physicians in their roles as patient and community-centered clinicians and health care advocates. Physician preparedness is predicated upon exposure to, immersion in and critical reflection on the appropriate foundational knowledge, skills, dispositions and experiences to approach clinical practice, medical science, and healing in ways that affirm the worth and preserve the dignity of individuals, families, and communities. In particular, integration of the social sciences and humanities into medical education should be designed to equip future physicians to enter their careers as lifelong learners with the agency, awareness and capacity to act as agents of change with patients, families, other health professionals and policymakers to:

- improve equity, access and quality of care to patients and families from increasingly diverse and unequally resourced communities,
- contribute to and enhance team-based clinical and community-based care, and
- engage in advocacy and practice that improves policy and strengthens health and health care systems.

"Knowledge, skills, and attitudes taught through behavioral and social sciences weave together intellectual, interactional, emotional, and values-related lessons, some of them in very personal ways" (AAMC, 2011, p. 22).

Domain 1 – Disparities and Factors Influencing Health
Definition: Health disparities negatively affect groups of people that have systematically experienced greater social or economic obstacles to health. These obstacles stem from characteristics historically linked to discrimination or exclusion such as race or ethnicity, religion, socioeconomic status, gender, mental health, sexual orientation, or geographic location.

K1. Identify and apply knowledge of historically underrepresented populations in terms of health care

K2. Describe the social determinants of health and their influences on patient and population outcomes

K3. Compare and contrast differences in health disparities across populations and contexts

K4. Discuss barriers to eliminating health disparities

S1. Effectively use data to discern and analyze differences in health outcomes among populations

S2. Critically appraise literature on health disparities to inform treatment plans* (EBM)

A1. Articulate the significance of eliminating health disparities on patient and population health care outcomes

Domain 2 – Community Engagement
Definition: Community engagement is both the application of institutional resources to address and solve challenges facing communities, through collaboration with these communities, and the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices.

K1. Explain barriers different communities face in negotiating health care systems including identifying community assets to overcome these barriers

K2. Understand factors influencing population health variability in communities

K3. Recognize how local public health problems and policies impact the medical practice within that community

K4. Demonstrate understanding of the concepts of community engagement, community-engaged scholarship and their relevance to the science and practice of medicine

S1. Describe the process by which community-based medical interventions are developed and implemented

A1. Describe the unique contributions that patients, families and community partners provide health care team

A2. Demonstrate clinical decisions that are based on a shared decision-making model with patients, families and community partners

Domain 3 – Bias Stigma and Stereotyping in Professional Practice
Definition: (1) Unconscious or implicit bias is defined as "mental associations that take place without intention, awareness, or control. (2) Stigma "is an attribute that links a person to an undesirable stereotype, leading other people to reduce the bearer from a whole and usual person to a tainted, discounted one. (3) Prejudice is "an aversive or hostile attitude toward a person who belongs to a group, simply because he belongs to that group, and is therefore presumed to have the objectionable qualities ascribed to the group.

K1. Describe how conscious and unconscious physician and patient bias impact clinical practice

K2. Recognize structural inequality that contribute to issues of power and oppression

S1. Apply appropriate strategies to navigate patient and physician bias

A1. Explain the legacy of "othering" and its impact on current population health as well as subsequent health care delivery

A2. Describe how bias informs our images of ourselves and others

Domain 4 – Intercultural Communication
Definition: Intercultural Communication is the verbal and nonverbal exchange of information between and among people, places, and objects/artifacts from different cultural backgrounds. (2) A body of scholarship focused on people's interface with different cultures and the influence of cultural backgrounds/identities on one's worldview.

K1. Recognize patients' healing traditions and beliefs

K2. Describe cross-cultural communication models and their relevance to clinical and professional practice

K3. Recognize the influence of environment on preventive health measures (e.g. food deserts and nutrition, 'unsafe' neighborhood and exercise, etc.)

S1. Use appropriate negotiating and problem-solving skills in navigating social differences

S2. Assess and enhance adherence utilizing techniques that take into account the patient’s and families’ and communities’ social environment

S3. Adjust and adapt oral communication [speaking and listening] skills to account for differences in patient, families, and colleagues that fosters respect, trust, and safety

S4. Adjust elements of nonverbal communication effectively and appropriately for patients’ and professionals’ cultural backgrounds

A1. Respect patient’s cultural beliefs

A2. Demonstrate understanding of various cultural perceptions of health care and health care providers

A3. Identify strategies for conflict resolution

Domain 5 - Use of Interpreters

Definition: Working with interpreters is an essential professional competency for physicians in order to provide equitable care for any patient with a barrier to communication in English (speaking, reading, writing, and/or understanding) in a health care setting.

K1. Describe cross-cultural communication challenges and models that are used to overcome those challenges

K2. Describe factors in the physician's use of interpreters that may impact health

K3. Describe the role of interpreters on a healthcare team

S1. Recognize institutional responsibility to cross-cultural communication

S2. Work collaboratively with interpreter to elicit a comprehensive medical history that includes various patient identities

S3. Utilize interpreters to assess and enhance patient adherence

A1. Value the role of interpreters on a healthcare team

Domain 6 - Self-Awareness, Cultural Humility and Reflexivity

Definition: (1) Cultural humility is an alternative concept to cultural competence, posits that one can never be fully competent in another person's culture. Instead, one must undertake a lifelong commitment involving self-evaluation, self-critiquing, and redressing power imbalances. (2) Reflexivity is beyond reflection; the ability to understand how one's own social locations and experiences of advantage or disadvantage have shaped the way one understands the world and produces knowledge.

K1. Describe the physician-patient power dynamic and possible imbalances

K2. Describe trust-building strategies relevant to the practice of health care

K3. Describes the role one's own social positionality [within an organization and society] has on one's professional identity and decision-making

S1. Recognize institutional structural and cultural barriers that contribute to issues of power and oppression

S2. Using reflection on one's own biases and beliefs to influence professional practice and patient care

S3. Employs reflexive practices effectively to enhance patient care and one's own professional well-being

S4. Apply strategies to enhance trust among patient and members of the healthcare team

A1. Recognize how others view you and how you view others

A2. Value the importance of medical and cultural humility in the practice of medicine

A3. Appreciate the limits of one's own knowledge and expertise

A4. Recognize that application of knowledge [medical and cultural] is contextual and connected to personal, social, and political interests that impact patient and population health outcomes

Domain 7 - Patient and Family Engagement

Definition: Patient and family engagement is a method to the planning, delivery and evaluation of health care grounded in principles of mutually beneficial partnerships among patients, families and health care professionals. This approach implements the core concepts of trust, respect, dignity, communication and collaboration within these relationships.

K1. Identify the relationship between family-oriented healing traditions and beliefs and patient health practices

K2. Describe individual, familial, and relational dynamics that impact health outcomes

K3. Recognize and utilize patient's capacity for self-care and ability to participate in shared decision making

S1. Examine the role of intersectionality in one's own familial identity and how it impacts one's approach to health care and patient engagement

A1. Recognize the influence of one's own cultural background and biases and their influence on interpreting the health beliefs of patients

A2. Demonstrate respect for patient's health beliefs and cultural practices and incorporate these into clinical relationships and decision making

Domain 8 - Negotiating Intersectionality in Professional Practice

Definition: Intersectionality is the interplay of multiple identities, which impact how individuals perceive and navigate the world.

K1. Define intersectionality

K2. Describe the primary, secondary and tertiary characteristics of one's own individual social identity

K3. Compare and contrast sources of structural inequality and their influence on patient, family and population health and capacity

K4. Recognize the implications of intersectionality of all healthcare stakeholders on health equity and health policy

K5. Describe how elements of social identity [race, class, gender, culture, sexuality, faith, etc.]* impact clinical practice

A1. Recognize how different combinations of identities and life experiences impact the healthcare team's attitudes toward health and health care

A2. Compare and contrast how one's seen and unseen identities inform worldview and its relationship to healthcare

Domain 9 - Physician Orientation to and Role in Health Care Advocacy
Definition: A physician's role in health care advocacy is action by a physician to promote those social, economic, educational and political changes that ameliorate the suffering and threats to human health and well-being that he or she identifies through his or her professional work and expertise.

K1. Define methods of physician advocacy

K2. Recognize that physician advocacy occurs at many levels -individual, organizational, community, health systems, and policy/legislative

K3. Reflect on how one's own personal identities and lived experiences impacts physician advocacy

S1. Work collaboratively with the healthcare team to utilize advocacy organizations and community resources to help patients receive needed services

S2. Demonstrates the ability to effectively represent patient/family values and concerns in clinical encounters

A1. Seek opportunities to engage in initiatives that enhance the well-being of others, including but not limited to participation in student professional organizations, free clinics, health care screenings or other community programs

A2. Advocate for excellence in care of patients regardless of individual identities.

Selected References

Allport, G. W. (1958). The nature of prejudice (abridged). Garden City, NY: Doubleday.

Bhate, T., & Loh, L.C.(2015). Building a generation of physician advocates: the case for including mandatory training in advocacy in Canadian medical school curricula. *Academic Medicine*, 90:1602-1606.

Bowleg, L. (2012). The problem with the phrase women and minorities: intersectionality-an important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267-1273.

Center for Disease Control (2011). Principles of Community Engagement Report, 2nd ed. NIH Publication No. 11-7782. https://www.atsdr.cdc.gov/communityengagement/index.html

Community-Engaged Scholarship in the Health Professions, 2005

Cook-Ross, Inc. (2017). Retrieved from http://cookross.com/services/thought-leadership/publications/.

Danielewicz, J. (2001). *Teaching selves: Identity, pedagogy, and teacher education*. New York: State University of New York Press.

Earnest, M.A., Wong, SL, Federico, SG. (2010). Physician advocacy: What is it and how do we do it? *Academic Medicine*, 85:63-67.

Dobson, S., Voyer, S., Regehr, G. Agency and activisim: Rethinking health advocacy in the medical profession. *Academic Medicine*, 87(9): 1161-1164.

Freeman, J. (2014). Advocacy by physicians for patients and for social change. *AMA Journal of Ethics* 16(9): 722-725.

Freire, P. (1968). *Pedagogy of the oppressed*. New York: Seabury Press.

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. New York: Simon and Schuster.

Halman, M., Baker, L., & Ng, S. (2017). Usining critical consciousness to inform health professions education: A literature review. *Perspectives on Medication Education*, 6:12-20.

Hankivsky, O., Grace, D., Hunting, G. & Ferlatte, O. (2012). Introduction: Why intersectionality matters for health equity and policy analysis. *An Intersectionality-Based Policy Analysis Framwork*. Retrieved from http://www.sfu.ca/iirp/ibpa.html.

Hankivsky, O., Grace, D., Hunting, G., Giesbrecht, M., Fridken, A., Rudrum, S., Ferlatte, O., & Clark, N. (2014). An intersectionality-based policy analysis framework: critical reflections on a methodology for adbancing equity.

Jernigan, V., Hearod, J.B., Tran, K., Norris, K.b., Buchwald, D. (2016). An examination of cultural competence training in US medical education guided by the Tool for

Assessing Cultural Competence Training(TACCT). *Journal of Health Disparities Research & Practice*, 9(3): 150-167.

Johnson, J.L., Bottorff, A.J., Browne, G.B., Hilton, A. & Clark. H. (2004). Othering and Being Othered in the Context of Health Care Services. *Health Communication*, 16(2): 255-271.

Martin, J. N. and Nakayama, T. K. (2010). *Intercultural communication in contexts*. New York: McGraw-Hill Higher Education.

Metzl, J. M. & Hansen, H. (2014). Structural competency: Theorizing a new medical engagement with stigma and inequality. *Social Science & Medicine, 103*, 126-133.

Mostow, C., Crosson, J., Gordon, S., Chapman, S., Gonzalez, P., Hardt, E., Delgado, L., James, T., & David, M. (2010). Treating and precepting with RESPECT: A relational model addressing race, ethnicity, and culture in medical training. *Society of General Internal Medicine, 25*(2), 146-154.

Muntinga, M. E., Krajenbrink, V. Q. E., Peerdeman, S. M., Croiset, G. & Verdonk, P. (2015). Toward diversity-responsive medical education: Taking an intersectionality-based approach to a curriculum evaluation. *Advances in Health Sciences Education, 21*(3), 541-559.

Ocloo, J. & Matthews, R. (2013). From tokenism to empowerment: progressing patient and public involvement in healthcare improvement. *BMJ Qual Saf* 2016: 1-7.

Rajaham, S. S. & Bockrath, S. (2014). Cultural competence: New conceptual insights into its limits and potential for addressing health disparities. *Journal of Health Disparities Research and Practice, 7*(5), 82-89.

Sears, K. P. (2012). Improving cultural competence education: the utility of an intersectional framework. *Medical Education, 46*, 545-551.

Tervalon, M. & Murray-GarcÍa, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125.

University of Massachusetts Medical School. (n.d.) Physician as patient and community advocate competency. Retrieved from http://www.umassmed.edu/som/curriculum/physician-as-advocate/ .

U.S. Department of Health and Human Services (2009). Healthy People 2020 Draft. 2009, U.S. Government Printing Office. Retrieved from https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html

Thread team

Initial thread participation 2018: KariLynn Besing, Christopher Burns, Lisa Christy [co-director], Kathleen Eggleson, Antwione Haywood, Liam Howley, Ken Lazarus, Mary Austrom, Paul Porter, Mary Price [co-director], Kristin Richey, Sylk Sotto, Paige Thomas, Toni Hardwick [support]; inactive: Sarah Kirk, Melanie Wiseman.

Final thread development by: Mary Price [co-director], Sylk Sotto, Ken Lazarus & Lisa Christy.