Recommendations for Teaching about Racial and Ethnic Disparities in Health and Health Care

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Racial and ethnic minorities often receive lower-quality health care than white patients, even when socioeconomic status, education, access, and other factors are used as controls. To address these pervasive disparities, health care professionals should learn more about them and the roles they can play in eliminating them, but few curricula are focused on understanding and addressing racial and ethnic health disparities, and well-accepted guidelines on what and how to teach in this complex area are lacking.

The Society of General Internal Medicine Health Disparities Task Force used a review and consensus process to develop specific recommendations and guidelines for curricula focusing on health disparities. Learning objectives, content, methods for teaching, and useful resources are provided. Although the guidelines were developed primarily for teaching medical students, residents, and practitioners in primary care, the Task Force's general recommendations can apply to learners in any specialty.

The Task Force recommends that a curricula address 3 areas of racial and ethnic health disparities and focus on the following specific learning objectives: 1) examining and understanding attitudes, such as mistrust, subconscious bias, and stereotyping, which practitioners and patients may bring to clinical encounters; 2) gaining knowledge of the existence and magnitude of health disparities, including the multifactorial causes of health disparities and the many solutions required to diminish or eliminate them; and 3) acquiring the skills to effectively communicate and negotiate across cultures, languages, and literacy levels, including the use of key tools to improve communication. The broad goal of a curriculum on disparities should be for learners to develop a commitment to eliminating inequities in health care quality by understanding and assuming their professional role in addressing this pressing health care crisis.

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The health and life expectancy of Americans has dramatically improved during the past several decades, but racial and ethnic minorities have not benefited equally from this progress. Differences in health outcomes between majority and minority populations, commonly referred to as *racial* or *ethnic disparities in health*, are the result of several factors operating in complex sociologic, cultural, political, economic, and health care contexts. Until recently, curricula addressing racial and ethnic health disparities focused on factors outside the health care system, including socioeconomic disadvantage and lack of health insurance (1), but some publications (2–5), culminating in 2002 with the Institute of Medicine report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, have highlighted the fact that racial and ethnic minorities—even those with equivalent access to the health care system—receive lower-quality care than white patients for many medical conditions (6). As a result, increased attention is now focused on addressing racial and ethnic disparities in health care (hereafter referred to as *health care disparities*) as a component of addressing racial and ethnic disparities in health (hereafter referred to as *health disparities*) (7, 8).

Emerging consensus among national experts suggests that without new and more effective interventions, health disparities will be difficult to eliminate (9), and they may become an even larger problem as racial and ethnic minorities become a larger proportion of the U.S. population (10). Key stakeholders need to engage at many levels to eliminate disparities, including at the community and societal levels. However, considering the significance of the physician–patient relationship in health care delivery, interventions by individual physicians will be an important component of an overall strategy to reduce health care disparities.

Several surveys show that many physicians remain unaware of health care disparities nationally and in their own practices (11–13). The Institute of Medicine's report recommends that health professionals receive training to better understand and address disparities (6). However, few curricula on health disparities exist, and there are no well-accepted guidelines on what and how to teach about this complex topic.

This report presents the work of the Society of General Internal Medicine Health Disparities Task Force to develop guidelines for medical education on disparities in health and health care. We provide learning objectives, suggested content, methods for teaching, and a set of current resources. Although they were developed primarily for teaching medical students, residents, and practitioners in primary care, our general recommendations should apply to learners in any specialty. The Task Force has also developed recommendations for system-level and environment-of-care interventions to eliminate health care disparities, which are as important as recommendations for training

See also:

Web-Only
Conversion of graphics into slides

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individual practitioners but are beyond the scope of this report.

Methods

The Society of General Internal Medicine is an international organization that comprises internal medicine physicians and others who combine patient care with education and research in primary care internal medicine. The Task Force includes volunteers from the Society of General Internal Medicine membership, many of whom teach about ethics, health disparities, and cross-cultural care at their institutions. The Task Force convened a series of meetings from 2002 to 2005, which included several conference calls, e-mail exchanges, and 4 face-to-face meetings. After the first meeting, Task Force teams completed a needs assessment and literature review. The entire Task Force then contributed to several versions of the recommendations. Subsequent meetings served to refine and tailor iterative versions of both the literature review and recommendations, which informed each other. Final recommendations were developed by a consensus, although various interpretations remain among members of the Task Force in the application of specific principles.

Needs Assessment

Few studies have formally assessed the need for health disparities training. Recent surveys on cross-cultural care demonstrate that "resident physicians' self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas" (14, 15). A national study on resident physicians reported that residents were receiving the message that health care disparities are important and that physicians should play a role in eliminating them, but they had not received guidance on how to do so. As a result, they developed "coping behaviors rather than skills . . . " (16). To supplement these studies, the Task Force conducted its own brief needs assessment survey with the assistance of the Institute for Ethics at the American Medical Association. The survey was sent to 60 randomly selected internal medicine program directors nationwide, 22 of whom responded within the 1-month time frame (37% response rate). Most of the 22 respondents (86%) reported teaching some information about health disparities, and none reported offering "a lot" of training. However, 77% agreed that learning about health disparities was associated with better quality of care, and 73% reported that a resident's level of interest was not a barrier to teaching: health disparities. Rather, shortages of qualified faculty and lack of standardized curricula were often noted as barriers.

Adding to the need for concrete guidance in this domain, the Liaison Committee on Medical Education, which sets standards for undergraduate medical education, required in 2004 that medical schools "document objectives relating to the development of skills in cultural competence, indicate where in the curriculum students are exposed to such material, and demonstrate the extent to which the objectives are being achieved" (17). The Accreditation Council on Graduate Medical Education, which accredits residency training programs, has also included cultural sensitivity as a skill set in its core competencies for residency training: Programs must teach and monitor residents' ability to "demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities" (18). The American Board of Medical Specialties and the Accreditation Council on Graduate Medical Education have created a toolbox of resources for monitoring professionalism that includes useful materials for assessing residents in these domains (19). Because these accreditation requirements have been implemented, new curricula (20–22) and suggested standards for training programs (23–25) have begun to emerge, although none are widely accepted yet.

Literature Review

Task Force members searched for published curricula focused on health disparities but found very little documentation. We searched MEDLINE (1966 to 2005), EMBASE (1980 to 2005), and the Cochrane Library of Systematic Reviews (all years) and article bibliographies for curricula on health disparities or cross-cultural medical care by using various search terms. For example, by using the Medical Subject Headings and text terms "health disparities" and "curriculum," our search yielded 39 articles. However, none of these reports on curricula explicitly focused on disparities by discussing the multifactorial causes of health disparities; describing health care disparities as a component of health disparities; targeting the elimination of health disparities as a professional goal for medicine; or teaching learners how to help eliminate disparities.

In contrast, several cross-cultural care curricula often prominently mentions the existence of health disparities and some root causes of disparities (26). Various studies have summarized these curricula and evaluations of their effectiveness. A 1978 survey of medical school curricula concluded that courses on cross-cultural care in U.S. medical schools had substantial deficits (27). A comprehensive review of U.S. and British medical school curricula in 1999 showed little apparent improvement (28). At that time, only 13 criteria; 11 were for first- or second-year medical students, 7 were part of core (required) curricula, and we only found 1 curriculum that reported any postteaching evaluation of learners. A survey of all U.S. and Canadian medical schools in 2000 concluded that most schools provided inadequate instruction about cultural issues; separate courses addressing cultural issues were identified in only 8% of U.S. schools and in no Canadian schools (29). Good evidence indicated that cross-cultural care training can improve a professional's knowledge, attitude, and skill, but there is little documented evidence of an effect on patient adherence and no evaluations of effects on patient health status (30–32).

Table 1. **Learning Objectives for Addressing Attitudes about Health Disparities**

Learning Objective and Topic	Example Questions to Address
Understand your own racial and cultural background	
Your health-related values, beliefs, and experiences	What are "mainstream American" health beliefs and values? What are your own or family experiences with doctors and the health care system? How do your experiences compare with those of your peers? What do you expect when you visit a doctor or hospital for care? How important is health care to you, in relation to other issues?
Your feelings about caring for racial, ethnic, or cultural groups unlike yourself	What is "race," and what is the evidence around race as a social or biological construct? How easy or difficult is it for you to talk about race or to interact with people from other races and cultural backgrounds? Who is to blame for prejudice and racism in medicine and society? Do you sometimes feel incompetent or nervous about clinical encounters with persons of a different race, ethnicity, or cultural background?
Understand cultural diversity and the relationship between racial and cultural attitudes and quality of care	
Stereotypes, biases, and mistrust of patients	How often will your patients share the same health-related values, beliefs, and experiences as you? How might historical factors, racial mistrust, previous negative experiences, and your own biases influence your patient's reaction to you or trust in you? How can a patient's racial, ethnic, or cultural mistrust or misunderstanding lead to poor quality and poor health outcomes?
Stereotypes, biases, and mistrust of physicians	Why do racial and ethnic health disparities exist? How often does the health care system treat people unfairly due to their race or ethnicity? How often is a physician's medical decision influenced by a stereotype or bias? Why? Is there racism in medicine?
Role of a physician's cultural attitude, cross-cultural knowledge, and exposure	How can a physician's attitude about and knowledge of cultural differences affect clinical care? How important are individual physicians to eliminating health care disparities? What about the medical profession as a whole? Should physicians address the racial and cultural values and attitudes of their colleagues when they believe they negatively affect care? How?

RECOMMENDATIONS

Recommended Goals of a Curriculum

The ultimate aim of a curriculum on disparities is that learners develop a professional commitment to eliminating inequities in health care quality and understand and accept their role in eliminating racial and ethnic health care disparities. The curriculum should accomplish this by meeting 3 core teaching goals: 1) to help learners examine and understand attitudes, such as mistrust, subconscious bias, and stereotyping, that practitioners and patients may bring to the clinical encounter; 2) to impart knowledge of the existence and magnitude of health disparities, including the multifactorial causes of health disparities and the many solutions required to eliminate them; and 3) to provide the learner with the skills required to effectively communicate and negotiate across cultures, languages, and literacy levels, including the use of key tools to improve communication.

Attitudes

Helping learners acquire knowledge and skills is commonly the primary goal of teaching; however, teachers may give little explicit attention to the goal of self-reflection and systematic examination of personal attitudes, beliefs, and conscious or unconscious attitudes. Nonetheless, attitudes can influence health care practice and patient behavior, leading to health care disparities. Moreover, attitudes sometimes pose a barrier to acquiring new knowledge and skills about disparities. The exploration of attitudes should therefore form a foundation to facilitate further learning about health disparities.

Table 1 lists probing questions to use in learning sessions on patient and physician attitudes that can affect disparities, including mistrust, subconscious bias, and stereotyping. The learning objectives about attitudes are often best met in moderated, small-group teaching sessions. Ideally, small-group sessions provide a structured, confidential, and nonthreatening environment in which learners can examine their personal beliefs and practices and compare them with beliefs and practices of other cultures. Learners may reflect on their reactions to discordant cultural practices and beliefs between caregivers and patients, self-examine for conscious and unconscious personal biases, and contemplate the interplay between these attitudes and health disparities. Learners may wish to disclose to others what they have learned from self-evaluation or to discuss difficult issues, such as racial mistrust, previous negative experiences, or their own biases.

Sessions of this nature can be sensitive and challenging. Their success often hinges on the skill of the faculty facilitators. Therefore, appropriate investment of time in faculty development is a prerequisite to successful discussions. As with any small-group session, some learners will be reluctant to talk, but discussing attitudes about racial disparities poses unique challenges. One important pitfall that faculty might encounter is learner cynicism about dis-

Table 2. **Learning Objectives for Addressing Knowledge about Health Disparities**

Learning Objective and Topic	Example Questions to Address	Suggested References
Understand U.S. racial and ethnic population trends and the prevalence and severity of racial and ethnic health disparities		
U.S. racial and ethnic demographic factors that may affect health care	What are the current U.S. population demographics for whites, African Americans, and Latin Americans? How are these population demographics projected to change over time? What are the relationships among race, class, and ethnicity, as they relate to medical care?	35–38
Prevalence and severity of key health disparities in common disease categories	What are the top 5 causes of death in the United States in each age group by race or ethnicity? What are some racial or ethnic disparities in prevalence and outcomes of common U.S. diseases? How much do women, children, elderly, individuals with special health care needs, and the poor experience health disparities? What are the projected costs in loss of life attributed to health disparities?	39, 40, 77
Identify several types and causes of racial or ethnic health disparities		
Differences in social determinants of health	How do racial or ethnic differences in social determinants of health affect health disparities? How much have disparities in income, education, housing, and poverty affected health in minorities over time? Are racial and ethnic minorities at higher risk for work and environmental health hazards?	41–44
History of segregation in U.S. health care	What were differences in the places of delivery of health care for racial and ethnic minorities versus white patients in the early to mid-20th century? What was the U.S. Public Health Service Study at Tuskegee? How is this study often seen as a touchstone for minority mistrust in medicine?	45–47
Differential access to care	What is the relationship between access to care (for example, insurance rates, geographic access to physicians, and waiting times) and outcomes of care? How large is the disparity in access to care for racial and ethnic minorities versus white patients? How have disparities in access to care affected health in minorities over time?	48–50
Disparities in treatment	How much do treatment differences for a disease influence outcome differences for that disease? Are there treatment differences as well as outcome differences for racial and ethnic minorities for common service and disease areas? Have treatments for cardiovascular care, pain management, cancer care, organ transplantation, and ambulatory and preventive care been the same for racial and ethnic minorities as for white patients?	51–65
Workforce disparities	How do the racial or ethnic and economic backgrounds of the average U.S. physician differ from those of the U.S. population? How large is the racial and ethnic minority workforce? Are there disparities in who cares for disadvantaged populations and racial or ethnic minorities versus who cares for more advantaged populations? Do physicians treating primarily racial or ethnic minority patients have the same access to clinical resources as physicians treating primarily white patients? Are these physicians as well trained clinically?	66–69
Differences in patient preferences	What is the evidence that minority patient preferences for health care services differ from majority preferences? How might minority versus majority patient preferences influence care seeking and adherence to recommended therapy? How might mistrust in medicine affect care preferences?	70–76

parities. Learners might question the validity of the concept of race or studies of differences in physicians' treatment patterns by race (33). Some may view racial discrimination as only historical or anecdotal. Others may recognize potentially discriminatory behaviors in colleagues but experience difficulty recognizing similar patterns in themselves. Some may have no interest in disparities for various reasons, including nonclinical career goals, anticipation of practicing among a homogeneous patient population, a belief in nonmedical bases for disparities, or a belief that disparities are a social problem best addressed outside the medical encounter.

Several other unique pitfalls include 1) feelings of isolation and vulnerability from those in a racial or ethnic minority group who might feel expected to represent the views of their group, 2) inappropriate assumptions that personal experiences with discrimination or racism somehow make one immune to holding stereotypes or to having biased views, and 3) viewing clinicians as either "saints" or "sinners" rather than as human beings. Such issues have

strong emotional content, and discussions can become heated, necessitating thoughtful and skilled facilitation on the part of the teacher.

Throughout this curriculum, teachers should promote humility and the attitude that practicing medicine is a lifelong learning journey that demands continuous curiosity about patients' backgrounds, not merely getting by with a minimal skill set that deems the learner culturally competent (34). In addition, like addressing errors in medicine, addressing health care disparities requires a systematic, multidisciplinary approach and a move beyond the individual blame game, yet students should also come to recognize that their individual engagement is vital to ending health care disparities.

Knowledge

Several key sources of information can be used to teach about health disparities and health care disparities (**Table 2**). The Agency for Healthcare Research and Quality's *National Healthcare Disparities Report* (78) and the U.S. Department of Health and Human Services' *Data 2010,* a quarterly-updated, Web-searchable database (79), provide the latest data on prevalent health disparities. The Institute of Medicine's report (6) is a rigorous, evidence-based resource for teaching about health care disparities.

To help learners integrate existing and new knowledge about disparities from published research, the teacher should offer useful frameworks for categorizing this knowledge. One approach is to group articles in terms of the evolution of research toward solutions. For instance, 1 review categorized published articles into studies documenting disparities, explaining disparities, or strategizing ways to reduce disparities, although there was some overlap (80). A related framework is to consider the proximity of each article's findings to prove that disparities exist in health care and not just in health. This approach "differentiates between initial reports of racial differences and subsequent classifications of their findings as racial disparities or racial bias in health care use" (81), and it helps to target interventions.

Didactic sessions on these frameworks should be expanded and reinforced by building case-based analyses and discussions around the daily care of patients. Most residency training programs that the Task Force surveyed reported that using didactic formats to teach about disparities is only somewhat effective. Formats that were more often rated very effective were case discussions, electives in social issues, and teaching during focused conferences or retreats.

Skills

Skills for effective patient-centered communication with and care for diverse patients should be taught and evaluated by all physicians (**Table 3**). The U.S. Department of Health and Human Services' National Standards for Culturally and Linguistically Appropriate Services in Health Care standards recommend teaching a minimum skill set for all clinicians, to "improve access to care, quality of care, and ultimately, health outcomes" (103).

Two Culturally and Linguistically Appropriate Services standards (standard 1 and standard 6) are particularly applicable to individual learners. Standard 1 requires that clinicians provide effective, understandable, and respectful care in a manner compatible with patients' cultural health beliefs and practices and preferred language. Thus, learners should be taught how to elicit patients' health beliefs, accommodate these beliefs when possible, and treat all patients respectfully.

The Task Force does not endorse a single method for teaching respectful, patient-centered communication but notes that several methods have been studied and are probably effective (104–106). One framework (107) suggested that practitioners begin a journey toward increasing capacity at cross-cultural care, progressing from cultural awareness (having cultural sensitivity and avoiding cultural biases) to cultural knowledge (understanding the cultural world view and theoretical and conceptual framework of the patient) to cultural skill (the skill set to access the patient's background and formulate a treatment plan that is culturally relevant) to cultural encounters (processes that allow the physician to directly engage in cultural interaction with patients from diverse backgrounds) (108, 109). A useful guidebook intended for cancer care clinicians is generalizable to all physicians and was written using this cultural journey framework (110).

Standard 6 of the Culturally and Linguistically Appropriate Services addresses language barriers, which reinforces the need for competent language assistance by describing appropriate versus inappropriate interpreters (for example, trained interpreters vs. family and friends). Learners should be taught how to identify a language barrier that may interfere with communication and how to address this barrier. Learners should be taught to distinguish appropriate from inappropriate interpreters. In some instances, special cross-language communication, such as foreign language training, is useful, especially for those training or practicing in certain geographic areas or with specific populations. At the same time, physicians need to recognize their own limitations as effective communicators if they have limited skills in a patient's language. Learners should receive specific instruction on how to work effectively with interpreters, including optimal seating arrangements, how to brief an interpreter before the visit, and common pitfalls in interpretation (111). Other necessary skills include clear communication techniques for addressing patients with low literacy, which is more frequent among minorities and a common contributor to health disparities (6, 112).

To teach these skills, the Task Force recommends methods that are similar to those used to teach other complex skills essential to interviewing and physical assessment. When didactic lectures are used, they should be followed by hands-on practice with feedback and formative evaluation.

Table 3. **Learning Objectives for Addressing Clinical Skills about Health Disparities***

Learning Objective and Topic	Example Questions to Address	Suggested References
Understand the community in which you practice		
Racial, ethnic, and cultural identity, and demography	What are the key racial and ethnic minorities within your local community? What are the key cultures within your local community?	82, 83
Cultural norms and effects on care	What is the role of family in the communities you serve? How might social, geographic, financial, and health literacy differences between clinicians and patients affect clinical encounters in your community? How might sexual or gender issues and other variables affect clinical encounters and health outcomes in your community?	
Know how to conduct cross-cultural and cross-language clinical encounters		
Requirements for cross-cultural care	Which of the federal Culturally Linguistically Appropriate Service standards relate to individual physicians? Where can one find additional information about the cultural background of diverse patient groups? How might a medical interpreter help to bridge cross-cultural misunderstandings?	84–92
Working effectively with medical interpreters	Is it appropriate to use a patient's family member as an interpreter? What if the family member is a child? What training do professional medical interpreters receive, and what is the code of ethics for medical interpretation? What can the clinician do to help an interpreter best provide mediation during an encounter? What level of language skill is required for a clinician to provide care directly in another language? How might this vary depending on the service or treatment under discussion?	93–96
Use a patient-centered approach to clinical encounters		
Models and guides to patient-centered care	What is Berlin and Fowkes' LEARN model, and how can it be used to improve patient-centered care? What is Stuart and Lieberman's BATHE model, and how can it be used to improve patient-centered care?	40, 97
Negotiate conflict resulting from differences between patient explanatory models of illness and treatment and physician models		
Racial, ethnic, and cultural differences in models of illness and treatment	How can patients' explanatory models of their illness (experience and perceptions of their illness, preferences, priorities, and agenda for the encounter) differ from your own? What unexpressed concerns and beliefs might patients bring to the clinical encounter? How should you negotiate to facilitate patient involvement in decision-making and care? How should you negotiate differences between your clinical agenda and expectation and your patient's, when it is based on race, culture, language, or health beliefs?	40, 93, 98, 99
Learn and apply skills to combat racial, ethnic, and cultural barriers to effective care		
Negotiating negative stereotypes, biases, and mistrust	How should you prepare for opportunities during the clinical encounter to address experiences in the health care system that may foster mistrust?	100–102

* BATHE = background situation, patient's affect, problem that is most troubling for the patient, manner in which the patient is handling the problem, and response that conveys empathy; LEARN = listen with sympathy and understanding to the patient's perception of the problem, explain your perceptions of the problem, acknowledge and discuss the differences and similarities, recommend treatment, and negotiate agreement.

Faculty Development, Competence, and Evaluation

There is no standard certification program for teaching about health care disparities, nor is there certification for teaching about many other complex but core facets of medical training. The Task Force suggests that institutions strive to develop local experts. Teachers should be comfortable with the knowledge base and have a personal commitment to reducing health care disparities. The main measure of that commitment is that the faculty members serve as a role model, as well as a teacher, of desired attitudes and

skills. Often, they are already doing so when they teach about disparities. Modeling humility, faculty should acknowledge their own shortcomings in skills, knowledge, and attitudes when appropriate. Having this ability, and the ability to negotiate and manage conflict and strong emotion among learners, makes a thoughtful and skilled teacher about health disparities. Faculty should be evaluated by their students and other experienced teachers.

Being a member of a racial minority group is neither required nor a guarantee of effectiveness in teaching about disparities, although it may enhance empathy for disparity populations. In addition, it would be a mistake to relegate all teaching about health disparities to minority faculty, because this could give the wrong impression—that is, that health disparities are a "minority problem." In fact, health disparities are a problem for the entire medical profession and must be recognized as such (113).

Faculty development on teaching about health disparities has been offered at meetings of the Society of General Internal Medicine and other professional societies. We recommend that institutions train enough of their faculty to deliver a broad disparities curriculum across undergraduate and postgraduate training, using professional societies, available local experts, and other resources (**Table 4**). Methods for faculty development sessions should include techniques similar to those used to train teachers in other complex areas, such as medical interviewing, medical ethics, and physical diagnosis; case-based teaching, videos, small-group sessions, analysis of videotaped interviews, and role-play can be especially useful.

RESOURCES AND METHODS

Table 4 provides a compendium of teaching resources for promoting attitudinal self-examination as well as didactic, skill-building, and experiential resources. Teachers should use various teaching methods, timings, and venues for delivery of a curriculum to address health disparities. Teaching should be reinforced repeatedly throughout the curriculum in the same way that teaching about other clinically relevant and complex matters is reinforced. There is no expectation that students will effectively care for patients with complex medical disorders after a single lecture, and we should make no assumption about the knowledge and skills needed to effectively care for patients from diverse racial and ethnic backgrounds. Initial didactic and interactive teaching should be followed by case-based discussions, observed clinical interactions with formative feedback, and ongoing discussions about these issues when they arise during patient care.

A key decision is often whether teaching should occur in a dedicated course, by integration of curricular elements into existing programs, or by both methods. The advantage to a dedicated approach is that it communicates the importance of disparities and underscores that the issue deserves special attention. However, it risks segregating teaching about disparities from the rest of the curriculum. The advantage to an integrated approach is that teaching about disparities, similar to teaching about such topics as ethics, professionalism, and communication, may be better received when it is integrated into existing training and frequently reinforced. It also reinforces the complexity and pervasiveness of disparities when a physician considers clinical care, yet it risks dissipation of core curricular content. As a result, a combined approach is likely to be most effective.

Teaching venues can include group sessions in several formats: role-playing, case-based learning, Objective Structured Clinical Examinations, and audio and visual documentation of encounters with timely and appropriate feedback. In addition, relationships with role models and mentors or exposure to literature through individual reading or in small discussion groups may be even more important than a structured curriculum (135).

EVALUATION

The success of health disparities training should be evaluated in the context of the 3 main educational goals: affecting the attitudes, knowledge, and skills of learners. The ultimate evaluation of these training programs would be an investigation of their effect on improving quality of care and eliminating disparities, but funding, methodological, and logistical barriers frequently limit the ability of training programs to show such an effect on clinical outcomes. This is similar to many other aspects of medical education, including both basic science and ethics and professionalism courses, which nonetheless are valued parts of training.

One promising evaluation tool is the Association of American Medical College's Tool for the Assessment of Cultural Competence Training (136). Although this survey tool for medical schools is geared toward improving cultural sensitivity, its main component focuses on disparities education. The Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties have also ranked the desirability of methods for evaluating residents' skill. The Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties' tool table lists 360-degree global ratings; a combination of surveys by superiors, peers, subordinates, and patients and families; and Objective Structured Clinical Examinations as the most desirable methods for evaluating sensitivity to culture, age, gender, and disability issues (19). Because at least 20 separate standardized patient encounter stations are required for most Objective Structured Clinical Examinations, these skills should be examined in concert with many others and for many residents at 1 time. Ideally, evaluation should take several forms, including surveys of observers of care, videotaped encounters (especially suited to evaluation of both attitudes and skills), standardized written tests (especially suited to

Table 4. **An Annotated List of Curricular Resources in Health Disparities and Cross-Cultural Care***

Resource Type	Description, Suggested Use	Reference
Book	Intended primarily for African Americans. Aimed to increase awareness of obesity (diet and nutrition and physical activity) and stress. Focuses on the 10 leading causes of health-related deaths among African Americans, health disparities, and the relationship among obesity, stress, and health.	114
Book	Compendium of peer-reviewed research literature. Provides a historical and political context for the study of health, race, and ethnicity, with key findings on disparities in access, use, and quality. Examines the role of clinicians in health disparities and discusses the issue of matching patients and doctors by race.	115
Book	Textbook addressing U.S. health and social policy; the role of race and ethnicity in health research; social factors contributing to death, longevity, and life expectancy; quantitative and demographic analysis; and access and utilization of health services.	116
Book	Guidebook intended primarily for use by mental health professionals but has interviewing principles generalizable to medical care.	117
Book	Textbook with 34 chapters addressing specific skills, answers, and guidance to clinical issues relevant to management of patients with varied cultural and economic backgrounds. Covers general principles of cross-cultural medicine as well as specific diseases, disorders, and clinical entities associated with genetic and cultural issues. Includes case studies and evidence-based recommendations and guidelines.	118
Booklet, primer, resources, and tools	Pocket guide for clinicians. ". . . a reference along a cultural journey, which health care professionals can explore when providing . . . care." Covers African American, Hispanic and Latino, Asian, and Native and Pacific Islander cultures. Offers steps to put cultural sensitivity into practice, has a comprehensive bibliography on cross-cultural care, and an extensive list of Web sites on cultural sensitivity and cross-cultural and cross-language care.	110
Course (Web-based)	Discusses strengths of getting to know cultures, strengths and protective factors found in various cultures, challenges to health and well-being, and principles for culturally competent health services. Quiz.	119
Experiential training	Especially for minority physician leaders. Imparts knowledge of policy, government, and management, as well as clinical medicine and public health. Intended to train policy leaders in minority health.	120
Experiential training	University minority outreach program with significant track record. Serves as a model for institutional training and minority outreach.	121
Experiential training	Training opportunities for qualified students at all levels of education to increase the capacity of the organizations in which these students will work in the future.	122
Primer (Web-based)	For the beginning learner. Distinguishes between health disparities and health care disparities. A glossary of terms is included.	123
Primer (Web-based)	Explores the roots of health disparities and identifies points of policy action to reduce them. Describes barriers to access, identifies reasons for the lack of minority clinicians, and offers promising strategies to increase them. Describes methods of using purchasing power to improve health care delivery. Shows data can be used to target reduction efforts.	124
Resources and tools	Instructions, script, and support for conducting cross-racial dialogues in communities. Can be adapted for small-group dialogues on race in medical settings. Provides examples of dialogue and chapters: Who Are We? (sharing of personal stories). Where Are We? (deeper exploration of personal and shared racial history). Where Do We Want to Be? and What Will We Do to Make a Difference?	125
Resources and tools	Includes links to the Health Disparities Introductory Kit; Roadmaps for Clinical Practice series; Commission to End Health Care Disparities; health literacy resources; the American Medical Association's Cultural Competence Compendium; a speaker's kit, and other resources on race, trust, and disparities; *Virtual Mentor* (an online ethics journal) and special issue for medical students on caring for a culturally diverse patient population produced by the American Medical Association.	126
Standard guideline	Reference. Guiding principles for constructing a residency curriculum.	18
Standard guideline	Reference. National Standards for Culturally and Linguistically Appropriate Services in health care. Based on an analytical review of key laws, regulations, contracts, and standards. Accompanied by commentary.	127
Standard guideline	Reference. Hospital standards that support the provision of culturally and linguistically appropriate services.	128
Standard guideline	Reference. Guiding principles for constructing a medical school curriculum.	129
Video	Offers vignettes and case studies. Key points include the following: unscreened, untrained, and unqualified interpreters make many mistakes, which can lead to multiple adverse outcomes; interpreters transmit the word they hear in one language into another language; translators transmit a written message from one language into another.	130
Video	Discusses cross-cultural medicine, translation, and triadic interviewing. Suggests role-playing in learners' areas of ethnic interest. Provides Kleinman's "Tool to Elicit Health Beliefs." Illustrative vignettes and case studies with do's and don'ts.	131
Video	Brief vignettes, support materials for facilitators and participants, and questions and discussion points. Topics in Series A: diabetic compliance, Latino; sickle cell in emergency department; pediatric asthma, Middle Eastern doctor, and aggressive mother; somatic complaint, painful memories; a gay adolescent. Series B also available.	132
Video	Films documenting the experiences of minority Americans and patients from other countries in the U.S. health care system. Dramatically illustrates miscommunication between patients and doctors, tensions between modern medicine and cultural beliefs, and the ongoing burdens of discrimination. Includes film clips and a study guide.	133
Web-based toolkit	Chapters contain comprehensive lists. Includes policy statements and standards, cultural competence guidelines and curricula designed for health care professionals, models for culturally competent health care, guidebooks and manuals, tools for assessing the cultural competence of organizations and health care personnel, personal assessments, culturally appropriate patient assessments, resource articles, books and reports, videos and CD-ROMs, journals, Web sites.	134

* The Society of General Internal Medicine Health Disparities Task Force does not endorse any of these resources over others listed or any that may be available but not listed.

evaluation of knowledge), and Objective Structured Clinical Examinations (especially suited to evaluation of skills).

CONCLUSION

Medical educators must help learners identify, model, and cultivate attitudes that can help to eliminate, rather than potentially exacerbate, health and health care disparities. They must also adopt and model communication skills considerate of diverse patient cultures and languages and use those skills to ensure reliable, high-quality care for every patient.

A common initial response to attempts at implementing curricula as far-reaching as the ones the Task Force herein proposes may be that implementation seems overwhelming, given the difficulty in changing individuals and organizations. Young adults, whose basic emotional and moral development is largely established, may not easily learn the attitudes, empathy, and social commitments needed for the goal of reducing health disparities. Although knowledge and skills can be enhanced more easily, attitudinal training may engage only those already predisposed to self-reflection.

Reticence to engage these issues in training should be countered with reminders that our population is becoming increasingly diverse and that an estimated 800 000 lives have been lost due to racial or ethnic health disparities in the past 10 years (78). There is an urgent need for educational institutions to adopt guidelines for teaching about health disparities, adapt their curricula to include this teaching, and evaluate this teaching to ensure its effectiveness. Waiting for broader cultural change is not a morally acceptable option, because it is not consistent with our professional responsibilities. By gaining new competencies that stimulate behavior change, learners can modulate the influence of preexisting attitudes on subsequent behavior. Institutions also need to bring more reflective and socially conscious persons into the profession, and because training programs seminally influence the attitudes, knowledge, and skills of learners, redirecting institutional resources toward training about health disparities can lead to generations of better trained clinicians and scientists and a health care workforce that portends a future of health equity.

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