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## RECOMMENDATIONS FOR TEACHING ABOUT RACIAL AND ETHNIC DISPARITIES IN HEALTH AND HEALTH CARE

Wally R. Smith, MD  
Professor of Medicine and Chairman,  
Division of Quality Health Care  
Medical Director, Center on Health Disparities  
Virginia Commonwealth University  
Box 980306  
Richmond, Virginia, 23298-0306  
(804) 828-6938  
fax (804) 828-4862  
Email: [wrsmith@vcu.edu](mailto:wrsmith@vcu.edu)

Joseph R. Betancourt, MD, MPH  
Senior Scientist, Institute for Health Policy  
Program Director for Multicultural Education, Massachusetts General Hospital  
Assistant Professor of Medicine, Harvard Medical School  
Massachusetts General Hospital  
55 Fruit St - S50, 9th Flr.  
Institute for Health Policy  
Boston, MA 02114  
617/724-9713  
Email: [jbetancourt@partners.org](mailto:jbetancourt@partners.org)

Matthew K. Wynia, MD, MPH  
Director, The Institute for Ethics  
American Medical Association  
515 N. State St.  
Chicago, IL 60610  
(312) 464-4980  
(312) 464-4613 (fax)  
Clinical Assistant Professor of Medicine  
University of Chicago  
5841 S. Maryland Ave.  
Chicago, IL 60637  
Email: [matthew\\_wynia@ama-assn.org](mailto:matthew_wynia@ama-assn.org)

Jada Bussey-Jones, MD  
Assistant Professor of Medicine  
Emory University School of Medicine  
69 Jesse Hill Dr., SE  
Atlanta, GA 30303  
(404)616-7490  
Fax (404)880-9464  
Email: [jbusse@emory.edu](mailto:jbusse@emory.edu)

Valerie E. Stone, MD, MPH  
Director, Primary Care Residency Program  
Associate Chief, General Medicine Unit  
Massachusetts General Hospital

Bulfinch 130  
55 Fruit Street  
Boston, MA 02114  
(617) 726-7708  
fax: (617)726-3838  
e-mail: [vstone@partners.org](mailto:vstone@partners.org)

Christopher O. Phillips, MD, MPH  
Director, Health Services Research  
Section of Hospital Medicine, E13  
Department of General Internal Medicine  
The Cleveland Clinic Foundation  
9500 Euclid Avenue  
Cleveland, OH 44195  
Phone: (216) 444-0933  
Fax: 216-455-5362  
E-mail: [chr\\_phi@yahoo.com](mailto:chr_phi@yahoo.com)

Alicia Fernandez, MD  
Assistant Clinical Professor of Medicine  
Division of General Internal Medicine  
University of California San Francisco  
San Francisco General Hospital  
Primary Care Research Center, Ward 95  
995 Potrero Ave  
San Francisco, CA 94110  
Phone : (415)206-5394  
Fax: (415)206-5586  
Email: [aliciaf@itsa.ucsf.edu](mailto:aliciaf@itsa.ucsf.edu)

Elizabeth Jacobs, MD MPP  
Assistant Professor of Medicine  
Collaborative Research Unit  
Cook County Hospital & Rush Medical College  
1900 W Polk Street, 16th Floor  
Chicago, IL 60612  
Phone: 312-864-7311  
Fax: 312-633-6783  
Pager: 312-333-4209  
[Elizabeth\\_Jacobs@rush.edu](mailto:Elizabeth_Jacobs@rush.edu)

Jacqueline Bowles, MD, MSCE  
Associate Clinical Professor of Medicine  
Sepulveda Ambulatory Care Center  
16111 Plummer Street (00PG)  
North Hills, CA 91343  
Beeper/voicemail 818-819-4112  
Fax 818-895-9571  
Email [Jacqueline.bowles@med.va.gov](mailto:Jacqueline.bowles@med.va.gov)

**Submitted on behalf of the SOCIETY OF GENERAL INTERNAL  
MEDICINE HEALTH DISPARITIES TASK FORCE**

**Corresponding Author:**

Wally R. Smith, MD  
Professor of Medicine and Chairman,  
Division of Quality Health Care  
Medical Director, Center on Health Disparities  
Virginia Commonwealth University  
Box 980306  
Richmond, Virginia, 23298-0306  
(804) 828-6938  
Fax (804) 828-4862  
Email: [wrsmith@vcu.edu](mailto:wrsmith@vcu.edu)

**Word count: 3659**

## **ABSTRACT**

Improvements in health outcomes observed for Americans as a whole have often been dramatically smaller among racial and ethnic minority populations, due in part to now well-documented, pervasive inequities in the quality of health care that minorities receive. Recent calls in the literature for medical students and physicians to learn about disparities and how to eliminate them present challenges to teachers. Few curricula address understanding and eliminating health disparities, and there are no well-accepted guidelines on what and how to teach in this complex area.

The Society of General Internal Medicine Health Disparities Task Force therefore used a review and consensus process to develop specific recommendations and guidelines for curricula targeting health disparities. We provide in this, our report, learning objectives, suggested content and methods for teaching, and a set of current resources. Though developed primarily for teaching residents, our recommendations should also apply for medical students, other health care trainees, faculty, and practicing physicians.

The Task Force recommends that teaching address 3 broad areas, with several specific learning objectives in each area: 1) examine and understand attitudes, such as mistrust, subconscious bias and stereotyping, that practitioners and/or patients may bring to the clinical encounter; 2) gain knowledge of the existence and magnitude of health disparities, including the multi-factorial etiologies of health disparities and the multiple solutions required to eliminate them; and 3) acquire the skills to effectively communicate and negotiate across cultures, including trust-building and the use of key tools to improve communication, such as culturally appropriate language services. Ultimately, learners should develop a professional commitment to eliminating inequities in health care

quality, and should understand and assume their role in eliminating racial and ethnic health care disparities.

## Background

Health and life expectancy have dramatically improved over several decades for Americans as a whole. However, racial and ethnic minority populations continue to fare far worse than does the majority. Until recently, these disparities were felt to be due solely to factors outside the health care system, and previous curricula on minority health issues often made that assumption.<sup>1</sup> But recent publications<sup>2</sup> culminating in 2002 with the Institute of Medicine (IOM) report “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,” have highlighted the fact that racial and ethnic minorities—even with equivalent access to the health care system—receive lower quality care than white patients for many medical conditions.<sup>3</sup> As a result, increased attention is now focused towards 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).<sup>4 5</sup> Emerging consensus among national experts suggests that, without new and more effective interventions, health care disparities will be difficult to eliminate,<sup>6</sup> and may become an even larger problem as racial and ethnic minorities will compose 50% of the population by the year 2050 (United States Census, 2000)<sup>7</sup>.

Even so, many physicians believe that health care disparities are not prevalent. A national physician survey in 2002, prior to the release of the IOM report, found that most respondents believed that the health care system “rarely” (55%) or “never” (14%) treated people unfairly based on their race or ethnicity.<sup>8</sup> While a more recent survey showed that 55% of physicians now agree with the statement, “Across the United States, minority patients generally receive lower quality care than white patients,”<sup>9</sup> it also showed a

large number of physicians remain unaware of health care disparities. Another recent survey found that only 33% of cardiologists believed that disparities in cardiac care occurred nationally and even fewer (5%) believed they might exist in their own practices.<sup>10</sup>

Thus, a main recommendation of the IOM report was that physicians and other key healthcare stakeholders should receive training to better understand and address health care disparities. This has been supported by medical school faculty and directors of residency training programs.

However, would-be teachers about health disparities have encountered significant challenges, including sparse, ill-formed teaching guidelines, and little time in the curriculum. In preparation for this report, the Society of General Internal Medicine Health Disparities Task Force (Task Force) conducted a brief survey of directors of internal medicine training programs in 2004 (N=22) and found that 86% of respondents reported some form of curricular intervention to address health disparities, though none reported offering “a lot” of training. Moreover, 77% agreed that learning about health disparities was associated with improved quality of care and 73% reported that residents’ level of interest was not a barrier to teaching health disparities (footnote<sup>1</sup>). On the other hand, shortages of qualified faculty and lack of standardized curricula were often noted as barriers. A more recent formal survey found that “Resident physicians' self-reported preparedness to deliver cross-cultural care lags well behind preparedness in other clinical and technical areas. Although cross-cultural care was perceived to be important, there

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<sup>1</sup> The needs assessment survey was conducted by the SGIM Task Force on Disparities, 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, of who 22 responded within the one month time frame (37% response rate).

was little clinical time allotted during residency to address cultural issues, and there was little training, formal evaluation, or role modeling.”<sup>11</sup> A national series of focus groups found that residents were receiving the message that health care disparities are important and that residents must play a role in eliminating them. But residents felt they received little help with assuming their role, and developed “coping behaviors rather than skills based on formally taught best practices.”<sup>12</sup>

This report therefore presents the work of the Task Force to develop guidelines for medical education on health disparities. We provide learning objectives, suggested content and methods for teaching, and a set of current resources. Though developed primarily for teaching residents, our recommendations should also apply for medical students, other health care trainees, faculty, and practicing physicians.

## **Methods**

The Task Force consists of volunteer SGIM members, many of whom have faculty roles that include teaching about ethics, health disparities, and/or cross-cultural care. The guidelines presented herein have been developed by consensus, though there remain variations in interpretations among members of the Task Force in the application of specific principles.

To prepare these guidelines, the Task Force convened a series of meetings over the course of 2002-2005, which included multiple conference calls, e-mail exchanges and four face-to-face meetings to review the literature, elicit novel ideas, share personal experiences, and arrive at consensus regarding the recommendations. Discrepancies were resolved by consensus of all Task Force Members.

## Literature Review

In addition to the needs assessment outlined above, Task Force members initially searched for model curricula on which to build and studies of curricular attempts to teach about health disparities and cross-cultural medical care that might help guide our efforts. We identified very few such resources. Several studies have summarized existing curricula and evaluations of their effectiveness. A 1978 survey of curricula for medical students concluded that there were substantial deficits in courses on cross cultural care then taking place in US medical schools.<sup>13</sup> A subsequent comprehensive literature and program review of US and British medical school teaching curricula in 1999 showed little apparent improvement.<sup>14</sup> At that time, only 17 published curricular studies met search criteria, 13 of which were conducted in North America. Of these, 11 were for first or second year medical students, seven were part of core (required) curricula, and only one reported any post-teaching evaluation of learners. Another comprehensive survey of all US and Canadian medical schools in 2000 concluded that most U.S. and Canadian medical schools provided inadequate instruction about cultural issues, especially the specific cultural beliefs and practices of large minority groups.<sup>15</sup> In this study, separate courses addressing cultural issues were identified in only 8% of U.S. schools and in no Canadian schools. Usually, one to three lectures were integrated into larger, mostly preclinical courses. With regard to effectiveness, a recent review of studies evaluating cultural competence training interventions found that targeted learners were nurses (n=32) more often than physicians (n=19), and noted a general lack of methodological rigor, limiting evaluation of any effects of training on health care quality.<sup>16</sup> Nevertheless,

the review found good evidence that training improved professionals' knowledge, attitudes, and skills, little documented evidence of an effect on patient adherence, and no evaluations of effects on patient health status.<sup>17</sup>

In 2004, the Liaison Committee on Medical Education (LCME) required 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.”<sup>18</sup> Also in 2004, the Accreditation Council on Graduate Medical Education (ACGME) included cultural sensitivity as a prerequisite skill set within its core competencies for residency training. Under the core “Professionalism” requirement, programs must teach and monitor residents’ ability to “demonstrate sensitivity and responsiveness to patients’ culture, age, gender, and disabilities.”<sup>19</sup> The American Board of Medical Specialties and ACGME have created a “Toolbox” of resources for monitoring professionalism that includes useful materials for assessing residents’ in these domains.<sup>20</sup>

Since these accreditation requirements have been implemented, new curricula<sup>21 22</sup> and suggested standards for training programs<sup>23 24 25</sup> have begun to emerge, though as yet none are widely accepted.

### **Recommended Goals of a Curriculum**

The ultimate aim of a curriculum to address health disparities should be for learners to develop a professional commitment to eliminating inequities in health care quality and, more specifically, to understand their role in eliminating racial and ethnic health care disparities. To accomplish this, the Task Force recommends that the content,

goals and organization of a curriculum in health disparities reflect the general goals of all education: to affect learners' attitudes, impart or enhance knowledge, and impart or enhance skills. More specifically, the Task Force recommends that curricula set three learning goals.

- 1) Attitudes: examine and understand attitudes, such as mistrust, subconscious bias and stereotyping, that practitioners and/or patients may bring to the clinical encounter;
- 2) Knowledge: gain knowledge of the existence and magnitude of health disparities, including the multi-factorial etiology of health disparities and the multiple solutions required to eliminate them;
- 3) Skills: acquire the skills to effectively communicate and negotiate across cultures, including trust-building and the use of important tools to improve communication, such as culturally appropriate language services

Each of these learning goals is explored in more detail below and in Tables 1-3. For each goal, we provide a set of learning objectives and some brief comments on teaching methods. Several general comments about teaching methods follow, as well as a list of available resources (Table 4).

### **Attitudes**

Acquisition of knowledge and skills are the usual goals of teaching, whereas self-reflection and systematic examination of personal attitudes and beliefs are given little priority. But conscious and unconscious attitudes influence health care practice and patient behavior, and may therefore lead to health care disparities. Moreover, in this

domain of learning, attitudes sometimes pose a barrier to acquiring new knowledge and skills. Therefore, the Task Force recommends exploration of attitudes as a foundation to facilitate didactic teaching about health disparities.

Table 1 provides suggested learning objectives and topics regarding attitudes that can affect health disparities, as well as suggestions for how to help learners explore their own attitudes and patients' attitudes. In particular, the table lists important probing questions to use in structuring and conducting learning sessions. These learning objectives are often best met in explicit, moderated small-group teaching sessions. Ideally, small-group sessions provide a structured, confidential and non-threatening environment in which learners examine their personal beliefs and practices, and compare them with beliefs and practices of other cultures. Learners then reflect in depth about their reactions to discordant cultural practices and beliefs between care-givers 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.

Small group sessions of this nature can be sensitive and challenging. The success of small group discussion hinges on the training and skill of faculty facilitators. Hence appropriate investment of time in faculty development is a prerequisite to convening, moderating, and concluding small group discussions. Perhaps the most common pitfall for faculty to recognize and address promptly is cynicism expressed by some learners as they ponder conclusions drawn from recent evidence about health disparities. In particular, learners may question the validity of conclusions based on studies of

differences in physicians' treatment patterns by gender, socioeconomic status, and race. Some may view discrimination as only historical or anecdotal. Others may readily recognize potentially discriminatory behaviors in colleagues, but experience difficulty recognizing similar patterns in themselves.

Other pitfalls include: 1) feelings of isolation and/or vulnerability by learners from racial and ethnic minority backgrounds, who may feel they are expected to "represent the views" of their ethnic group; 2) inappropriate assumptions that personal experiences with discrimination or racism somehow make one immune to holding stereotypes, or to having biased views of minority or non-minority groups; 3) thinking about clinicians as either "saints" or "sinners" rather than as human beings.

Finally, ongoing controversies may arise during small group discussions, such as whether to incorporate information about race in medical presentations or treatment decisions. Some may urge it, citing the genetic basis of some diseases. Some may discourage it, citing race as a sociological rather than biological construct, and pointing out the possibility of racial stereotyping in medical decision making.<sup>26</sup> Because of their emotional as well as political and scientific content, such discussions can become heated, necessitating thoughtful and skilled facilitation on the part of the teacher.

Throughout this curriculum, teachers should encourage an attitude of curiosity about their patients' backgrounds. Continuous learning about the health values, beliefs, and experiences of patients is required for cultural sensitivity, a cornerstone of professionalism in care. Like addressing errors in medicine, addressing health care disparities necessitates a systematic, multidisciplinary approach and a move beyond the individual "blame game," yet students must also recognize that individual engagement in

vital to ending health care disparities, and must be given an opportunity to address attitudes that may underlie disparate care.

### **Knowledge**

A knowledge base about health disparities is presented in Table 2. Several key reports can be used to teach about health disparities and health care disparities, respectively. To teach about the former, both the Agency for Healthcare Research and Quality's National Healthcare Disparities Report,<sup>27</sup> and "Data 2010", a quarterly-updated, web-searchable database sponsored by Healthy People 2010, the Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services,<sup>28</sup> provide the latest data on prevalent health disparities. Many of the key findings of these reports are integrated into Table 2. For health care disparities, the IOM's "Unequal Treatment" report<sup>29</sup> is best suited, given its rigorous, evidence-based approach.

To help learners integrate existing and new knowledge about health disparities from published research, the teacher should offer a framework for categorizing this knowledge. One approach is to group articles in terms of the evolution of research towards solutions. For instance, one review categorized published articles into studies documenting disparities, explaining disparities, or of strategies to reduce disparities, although there was some overlap.<sup>30</sup> A related framework is to consider the proximity of each article's findings to proof 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,"<sup>31</sup> and can help target interventions.

Learners should also recognize that racial and ethnic minorities are dramatically underrepresented within the profession, and that minority physicians practice in skewed locations.

To teach this knowledge base, the Task Force recommends didactic sessions and readings at minimum, but strongly encourages case-based discussions and especially incorporation of these issues in discussion around the daily care of patients to expand and reinforce the didactic teaching. Most residency training programs the Task Force surveyed reported that using didactic formats to teach about disparities is only “somewhat effective.” Formats more often rated “very effective” were case discussions, electives in social issues, and teaching during specific conferences or retreats.

## **Skills**

Effective cross-cultural communication skills should be examined and assured for all physicians. Learning objectives and some suggested ideas for skill building are proposed in Table 3. Supplementary skills in cross-cultural or cross-language communication, such as foreign language training, will be useful for many physicians, such as those training or practicing in certain geographic areas or with specific populations, but all physicians can make use of basic skills for effective patient-centered communication. The United States Department of Health and Human Services’ National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS) recommends teaching a minimum skill set for all clinicians, to “improve access to care, quality of care, and ultimately, health outcomes.”<sup>32</sup>

Two CLAS 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 a patient's health beliefs, accommodate these beliefs when possible, and treat all patients respectfully. In addition learners should be taught how to identify when there are language barriers that interfere with communication and how to address these barriers using appropriate interpreter assistance.

As for respectful, patient-centered communication, the Task Force does not endorse a single method for teaching these skills, but notes that several methods have been studied and probably are effective. Early frameworks include Berlin and Fowkes' L-E-A-R-N model (listen to the patient's perspective, explain and share one's own perspective, acknowledge differences and similarities, recommend a treatment plan, negotiate a mutually agreed-on treatment plan),<sup>33</sup> Kleinman's "elicitation techniques",<sup>34</sup> and Stuart and Lieberman's BATHE model: background; affect; trouble; handling; and empathy<sup>35</sup>. One recent framework<sup>36</sup> suggest that providers begin a journey towards 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/conceptual framework of the patient); to cultural skill (the skill set to access an individual's background and formulate a treatment plan that is culturally relevant); to cultural encounters (processes which allow the health care provider to directly engage in cultural interaction with clients from diverse backgrounds).<sup>37</sup> <sup>38</sup> One especially useful guidebook (see Table 4), intended for cancer

care providers, is generalizable to all physicians and was written using this “cultural journey” framework.<sup>39</sup>

CLAS Standard 6 addresses language barriers, reinforcing the need for competent language assistance by describing appropriate versus inappropriate interpreters. Learners should be taught to distinguish appropriate (e.g. trained interpreters), from usually inappropriate interpreters (e.g., family and friends), and 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.<sup>40</sup>

To teach these skills, the Task Force recommends methods similar to those used to teach other clinical 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.

## **Resources and Methods**

Table 4 provides a current compendium of teaching resources, including general curriculum standards, textbooks, other books, pamphlets, videos, and web resources. Included are resources for promoting attitudinal self-examination, as well as didactic, skill-building, and experiential resources.

The Task Force recommends using several methods and a variety of timing, venues, and formats for delivery of a curriculum to address health disparities. Teaching about health disparities should be reinforced repeatedly throughout the curriculum in the

same way that teaching about other clinically relevant matters is reinforced. There is no expectation that students will effectively care for patients with acid-base disorders after a single lecture – we should not make this assumption about the knowledge and skills needed to effectively care for patients from diverse cultural backgrounds. Therefore, 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 in the care of patients.

Regarding timing, options for delivery include developing a dedicated course, integrating curricular elements into existing programs, or both. The advantage to a dedicated approach is that teaching about disparities separately communicates its importance to teachers and learners and highlights that it has been underemphasized and deserves special attention. The advantage to an integrated approach is that teaching about disparities, like teaching about topics such as ethics, professionalism, and communication, may have a better reception when integrated into existing training and frequently reinforced.

Regarding venues and formats for teaching, the Task Force recommends small group sessions in multiple formats to enhance training, including role-plays, case based learning, objective structured clinical exams (OSCEs), and audio/visual documentation of encounters with timely and appropriate feedback.

## **Evaluation**

The Task Force recommends that health disparities training be evaluated with regard to its ability to achieve the three goals listed earlier: affecting the attitudes,

knowledge and skills of learners. Ultimately the Task Force envisions training programs that document their impact on improving quality of care and eliminating health care disparities. Task Force members identified funding, methodological and logistical barriers that may limit the ability of training programs to show such an impact on clinical outcomes. But this is not dissimilar to many other aspects of medical education, including both basic science and ethics and professionalism courses, which nonetheless are valued parts of training.

The ACGME and ABMS have ranked the desirability of methods of resident evaluation for each of the skills within their recommended competencies. To evaluate the skills of being sensitive to cultural, age, gender, and disability issues, the ACGME/ABMS's "Tool Table" lists 360° global ratings (combinations of surveys of superiors, peers, subordinates, and patients and families), and OSCEs as the most desirable methods.<sup>41</sup> Since up to 20 separate standardized patient encounter stations are required for most OSCEs, these skills would have to be examined in concert with many others, and for many residents at one time, to make assessment using OSCEs feasible. Ideally, the Task Force suggests that evaluation take on multiple forms, including surveys of observers of care and/or videotaped encounters (especially suited to evaluate both attitudes and skills), standardized written tests (especially suited to evaluate knowledge), and OSCEs (especially suited to evaluate skills).

## **Conclusion**

Health care teachers must help learners identify, model and cultivate attitudes that can help to eliminate, rather than potentially exacerbate, health disparities. Teachers must impart knowledge of disparities and their possible causes, so that learners may effectively

intervene to eliminate them. And teachers must model, and learners must adopt, communication skills considerate of patients' disparate 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, because it is difficult to change individuals and organizations. This response must be countered with reminders that our population is becoming increasingly diverse, and that an estimated 800,000 lives were already lost due to health inequities in the past ten years alone. It is therefore critical that educational institutions broadly adopt guidelines for teaching about health disparities, adapt their curricula to include this teaching, and evaluate this teaching in order to improve teaching guidelines. Because these institutions seminally influence the attitudes, knowledge and skills of learners, redirecting their resources towards training about health disparities can deliver a payoff of generations of better trained clinicians and scientists-- a health care workforce that portends a future of health equity.

## Tables

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

Learning Objective		Example Topics/Questions to Address
1.	Understand your own cultural background, including your health-related values, beliefs, and experiences	<ul style="list-style-type: none"> <li>• What are "mainstream American" health beliefs and values?</li> <li>• What are your own/family experiences with doctors and the health care system?</li> <li>• What do you expect when you visit a doctor or hospital for care?</li> <li>• How important is health care to you, in relation to other issues?</li> </ul>
2.	Explore your feelings about caring for racial, ethnic, or cultural groups unlike yourself	<ul style="list-style-type: none"> <li>• How easy/hard is it for you to talk about race or to interact with people from other races/cultures?</li> <li>• Who is to blame for prejudice and racism in medicine and society?</li> <li>• Explore possible feelings of incompetence/nervousness with regard to clinical encounters.</li> </ul>
3.	Understand common patient attitudes and beliefs related to race, ethnicity and culture that can affect quality of care and clinical outcomes	<ul style="list-style-type: none"> <li>• What historical and current factors might drive patient mistrust in you as a doctor?</li> <li>• How often will your patients share the same health-related values, beliefs and experiences as you?</li> <li>• How can mistrust or misunderstanding lead to poor health outcomes?</li> <li>• Discuss examples: patient provides inaccurate history or feigns compliance; patient refuses medically indicated therapy; patient chooses not to disclose alternative therapies</li> </ul>
4.	Recognize that physician attitudes and behaviors (both past and present) related to race, ethnicity and culture can affect quality of care and clinical outcomes	<ul style="list-style-type: none"> <li>• How often does the health care system treat people unfairly due to their race or ethnicity?</li> <li>• How important are stereotyping or bias in determining medical care? Why?</li> <li>• Is there racism in medicine?</li> <li>• Discuss examples: physician fails to offer more effective but more expensive medication because of assumed poverty; physician oversimplifies a complex medical condition because of assumed ignorance; physician assumes similar religious background to patient.</li> </ul>
5.	Develop healthy attitudes and curiosity regarding the health values, beliefs and experiences of diverse cultural groups and each individual patient	<ul style="list-style-type: none"> <li>• Be curious to continuously learn about people from different backgrounds</li> <li>• Acknowledge and accept differences between and within cultures</li> <li>• Acknowledge that health disparities exist and are often avoidable</li> <li>• Forgive (oneself or others) for racism or intolerance</li> <li>• Be patient with one's own, patients,' and physicians' progress</li> <li>• As required, confront others' unhealthy attitudes and actions</li> <li>• Mediate, make peace</li> </ul>

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

	<b>Learning objective</b>	<b>Example Topics/Questions to Address</b>
1.	Understand US population demographics, especially demographic trends that are likely to affect health care	<ul style="list-style-type: none"> <li>•The United States is projected to be nearly half populated by minorities by 2050</li> </ul>
2.	Know the prevalence and severity of key health disparities in the most common disease categories	<ul style="list-style-type: none"> <li>•Examine each of the top five causes of death in the US in each age group by race/ethnicity. What trends are present?</li> <li>•Note that along with racial and ethnic minorities, other groups such as women, children, the poor, elderly, and individuals with special health care needs experience health disparities.</li> </ul>
3.	Be able to differentiate disparities in health care outcomes from disparities in health care treatments	<ul style="list-style-type: none"> <li>•Outcomes include, for example, that infant mortality rates are twice as high among African-American infants as whites<sup>42 43</sup> and that several minority groups suffer and die disproportionately from conditions such as cardiovascular disease, diabetes, asthma, cancer, and HIV/AIDS.<sup>44</sup></li> <li>•Treatment differences include that African-Americans are referred less than whites for cardiac catheterization and bypass grafting;<sup>45 46 47 48 49</sup> African-Americans and Latinos receive less pain medication than whites for long bone fractures and cancer;<sup>50 51 52</sup> African-Americans receive less curative surgery than whites for non-small cell lung cancer;<sup>53</sup> less referral to renal transplantation,<sup>54</sup> treatment of pneumonia, congestive heart failure,<sup>55</sup> and HIV/AIDS<sup>56 57</sup>, utilization of general services covered by Medicare ( e.g., immunizations and mammograms),<sup>58</sup> and various procedures and levels of ambulatory care.<sup>59</sup></li> </ul>
4.	Understand the disparities in racial backgrounds of US physicians vs. the US population as a whole, and disparities in who cares for disadvantaged populations	<ul style="list-style-type: none"> <li>•Compared to the US population, US physicians are disproportionately white.</li> <li>•Black physicians and Hispanic physicians often practice in areas where the percentage of black or Hispanic residents is higher, caring for significantly more minority, Medicaid, and uninsured patients.<sup>60</sup></li> <li>•Black patients and white patients may to a large extent be treated by different physicians. Physicians treating primarily black patients often have less access to important clinical resources, and may be less well-trained clinically than physicians treating primarily white patients.<sup>61</sup></li> <li>•Comprehensive data and recommendations on minority healthcare workforce issues can be found in a recent report of the IOM, "In the Nation's Compelling Interest"<sup>62</sup> and in the Sullivan Commission Report, "Missing Persons: Minorities In The Health Professions."<sup>63</sup></li> </ul>
5.	Explore the relationships between race, class, and ethnicity, including the impact of social determinants of health on disparities	<ul style="list-style-type: none"> <li>•There are complicated interrelationships between race, ethnicity, and socioeconomic status</li> <li>•Knowledge of the etiologies of health disparities is limited</li> <li>•Social determinants, particularly socioeconomic status, account for much of the observed racial disparities in health outcomes,<sup>64</sup></li> <li>•Racial differences in health often persist even at equivalent levels of socioeconomic status.<sup>65</sup></li> <li>•Minorities disproportionately lack education, literacy, and/or employment, which are powerful</li> </ul>

		determinants of health. <sup>66 67</sup> <ul style="list-style-type: none"> <li>•How might work and environmental hazards, such as pollution or lead paint exposures, or safety and violence risks, affect health outcomes among minorities?<sup>68</sup></li> </ul>
6.	Understand the history of segregation in health care in the US	<ul style="list-style-type: none"> <li>•The US Public Health Service Study at Tuskegee is often seen as a touchstone for minority mistrust in medicine.<sup>69</sup></li> <li>•Separate health care facilities for racial and ethnic minorities were common until the mid to late 20th century.</li> </ul>
7.	Explore the relationship between patient preferences and disparities	<ul style="list-style-type: none"> <li>•Patient preferences influence care seeking and adherence to recommended therapy.</li> <li>•There may be differences in minority patients' preferences.</li> <li>•How might mistrust in medicine affect care preferences?</li> </ul>
8.	Understand how differential access can lead to disparities in quality of care	<ul style="list-style-type: none"> <li>•Uninsured individuals are less likely to have a regular source of care, are more likely to report delaying seeking care, and are more likely to report that they have not received needed care—all resulting in increased avoidable hospitalizations, emergency hospital care, and adverse health outcomes.<sup>70</sup></li> <li>•Minorities more often lack health insurance or a usual source of care,</li> </ul>
9.	Understand that disparities come at a personal and societal price	<ul style="list-style-type: none"> <li>•The number of excess deaths attributable to health disparities in African-Americans vs. whites from 1991 to 2000 was 886,202, contrasted with 176,633 additional minority lives saved by medical advances in that time.<sup>71</sup></li> </ul>
10	Understand that improvement is possible	<ul style="list-style-type: none"> <li>•Opportunities to provide preventive care are frequently missed</li> <li>•Data limitations hinder targeted improvement efforts</li> </ul>

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

Learning Objective		Example Topics/Questions to Address
1.	Understand the community in which you practice	<ul style="list-style-type: none"> <li>•Identify and catalog key cultures and racial minorities within the local community.</li> <li>•Learn about the role of family, social, geographic, financial, health literacy, sexual/gender issues, and other variables in clinical encounters and health outcomes for the minority communities you serve</li> </ul>
2.	Know how to conduct cross-cultural and cross-language clinical encounters	<ul style="list-style-type: none"> <li>•Discuss which of the CLAS standards relate to individual physicians.</li> <li>•What makes for a good interpreter-mediated encounter? What is the proper role for a language interpreter? What can the clinician do to help?</li> </ul>
3.	Utilize a patient-centered approach to clinical encounters	<ul style="list-style-type: none"> <li>•Multiple methods are available. See text for examples.</li> </ul>
4.	Negotiate conflict resulting from differences between patient explanatory models of illness and treatment and physician models	<ul style="list-style-type: none"> <li>•Elicit patients' explanatory model (the patients' experience and perceptions of their illness, their preferences, priorities and agenda)</li> <li>•Hear patients concerns and explore patient beliefs with genuine curiosity and respect.</li> <li>•View each patient as an individual teacher, an expert on their own life and experiences, and a starting point for discovering when the patient's explanatory model, health beliefs, health behaviors, expectations, or goals differ from the learner's.</li> <li>•When differences appear to be based on race, culture, language, or health beliefs, initiate patient-physician negotiation to facilitate patient involvement in decision-making and care.</li> <li>•Explore alternative practice styles and approaches that may be useful depending on the requirements and concerns of individual patients</li> </ul>
5.	Learn and apply skills to combat difficult issues such as racial mistrust, previous negative experiences, and your own biases	Try questions such as, "What do you fear most about your illness" and "What have your other experiences with medical care been like for you?" and be prepared for opportunities to address experiences in the health care system that may foster mistrust.

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

(Resources are listed alphabetically within categories. The Task Force does not endorse any of these resource over others listed or that may be available but not listed.)

Source Information	Resource Type	Description, Suggested Use
Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda. <a href="http://www.omhrc.gov/clas/ds.htm">http://www.omhrc.gov/clas/ds.htm</a> , and <a href="http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf">http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf</a> .	Standard/ Guideline	Reference. National standards for culturally and linguistically appropriate services (CLAS) in health care. Based on an analytical review of key laws, regulations, contracts, and standards. Accompanied by commentary
ACGME General Competencies Version 1.3 (9.28.99). <a href="http://www.acgme.org/outcome/comp/compFull.asp">http://www.acgme.org/outcome/comp/compFull.asp</a>	Standard/ Guideline	Reference. Guiding principles for constructing a residency curriculum.
Liaison Committee on Medical Education Accreditation Standards (updated June 8, 2004). <a href="http://www.lcme.org/functionslist.htm">http://www.lcme.org/functionslist.htm</a>	Standard/ Guideline	Reference. Guiding principles for constructing a medical school curriculum.
Joint Commission on Accreditation of Health Care Organizations. 2005 Standards Related to the Provision of Culturally and Linguistically Appropriate Health Care <a href="http://www.jcaho.org/about+us/hlc/hlc_jc_stds.pdf">http://www.jcaho.org/about+us/hlc/hlc_jc_stds.pdf</a>	Standard/ Guideline	Reference. Hospital standards that support the provision of culturally and linguistically appropriate services
Jenkins S. African American Health Disparities. McGraw-Hill. 2003. ISBN: 0072918233	Book	Intended primarily for African-Americans, to increase awareness of obesity (diet & nutrition, physical activity) and stress. Focuses on the 10 leading causes of health-related deaths among African Americans, health disparities and the relationship between obesity, stress and health.
LaVeist T (Editor). Race, Ethnicity, and Health: A Public Health Reader. October 2002, Jossey-Bass ISBN: 0-7879-6451-4	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 health care providers in health disparities and discusses the issue of matching patients and doctors by race.
LaVeist T. Minority Populations and Health: An Introduction to Health Disparities in the U.S. April 2005, Jossey-Bass ISBN: 0-7879-6413-1	Book	Textbook addressing U.S. health and social policy; the role of race and ethnicity in health research; social factors contributing to mortality, longevity and life expectancy; quantitative and demographic analysis; and access and utilization of health services.
Satcher D, Pamies RJ, (eds). Multicultural Medicine and Health Disparities. 2006. McGraw-Hill Professional ISBN: 0071436804	Book	Textbook with 34 chapters addressing specific skills, answers and guidance to clinical issues relevant to management of patients of 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.
Sanchez-Huclez J. First Sessions with African American Clients: A Step by Step Guide, Jossey Bass, November 1999.	Book	Guidebook intended primarily for use by mental health professionals, but with interviewing principles generalizable to medical care.
Cultural Competence in Cancer Care: A Health Care Professional's Passport Baylor College of Medicine Intercultural Cancer Council 713-798-4617 <a href="http://iccnetwork.org">http://iccnetwork.org</a> Email: <a href="mailto:info@iccnetwork.org">info@iccnetwork.org</a>	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/Latino, Asian, Native, Pacific Islander cultures. Offers steps to put cultural sensitivity into practice, extensive bibliography on cross-cultural care, and extensive list of web sites on cultural sensitivity, cross-cultural and cross-language care.
<a href="http://www.mfdp.med.harvard.edu/fellows_faculty/cfhuf/about/index.htm">Fellowship in Minority Health Policy</a> The Commonwealth Fund/Harvard University <a href="http://www.mfdp.med.harvard.edu/fellows_faculty/cfhuf/about/index.htm">http://www.mfdp.med.harvard.edu/fellows_faculty/cfhuf/about/index.htm</a>	Experiential training	Especially for minority physician leaders. Imparts knowledge of policy, government and management, as well as clinical medicine and public health. Intended to produce policy leaders in minority health.
<a href="http://www.ache.org/carsvcs/internship.cfm">Minority Internship and Postgraduate Fellowship</a> (Undergraduate and Graduate Students) American College of Healthcare Executives  <a href="http://www.ache.org/carsvcs/internship.cfm">http://www.ache.org/carsvcs/internship.cfm</a>	Experiential training	Available to health care professionals.
<a href="http://www.cdc.gov/omh/training.htm">Training Opportunity Links</a> Centers for Disease Control and Prevention - Office of Minority Health <a href="http://www.cdc.gov/omh/training.htm">http://www.cdc.gov/omh/training.htm</a>	Experiential training	Training opportunities for qualified students at all levels of their education in order to increase the capacity of the organizations in which these students will work in the future.
M. Jean Gilbert PhD (for the California Endowment). Resources in Cultural Competence Education for Health Professionals. <a href="http://www.calendow.org/reference/publications/pdf/cultural/resources_book.pdf">http://www.calendow.org/reference/publications/pdf/cultural/resources_book.pdf</a>	Web-based Toolkit	Chapters contain comprehensive lists of: 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.
Harvard Office for Diversity and Community Partnership, Office of Community Outreach Programs. <a href="http://www.hms.harvard.edu/dcp/text_version/contact.htm">http://www.hms.harvard.edu/dcp/text_version/contact.htm</a>	Resources and tools	University minority outreach program with significant track record, model for institutional training and minority outreach.
CHERP Health Disparities Primer. Veterans Administration Center for Health Equity Research and Promotion (CHERP) HSR&D Center of Excellence in Health Services Research. From	Primer (Web-based)	For the beginning learner. Distinguishes between health disparities and health care disparities; a glossary of terms included.

<p><a href="http://www.cherp.org/primer.php">http://www.cherp.org/primer.php</a>  <a href="#">Strategies to Reduce Health Disparities</a>          (Workshop Brief). Agency for Healthcare Research and Quality: Workshop Brief for State, Local, and Tribal Policymakers (pdf file)  <a href="http://www.ahcpr.gov/news/ulp/dispar/dispar.htm">http://www.ahcpr.gov/news/ulp/dispar/dispar.htm</a></p>	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 promising strategies to increase them. Describes methods of using purchasing power to improve care delivery. Shows data can be used to target reduction efforts.
<p>The Health Disparities Collaboratives Providers Guide to Quality and Culture.  <a href="http://erc.msh.gov">http://erc.msh.gov</a>  <a href="http://www.healthdisparities.net/">http://www.healthdisparities.net/</a></p>	Course (Web-based)	Discusses getting to know cultures; strengths and protective factors; challenges to health and well-being; and principles for culturally competent health services. Quiz.
<p>One America in the 21st Century: The President's Initiative on Race.  <a href="http://www.ncjrs.org/pdffiles/173431.pdf">http://www.ncjrs.org/pdffiles/173431.pdf</a></p>	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. Model of dialogue is: 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?
<p><i>Worlds Apart: A Four-Part Series on Cross-Cultural Health Care</i> <a href="#">Fanlight Productions</a>, Maren Grainger-Monsen, M.D., and Julia Haslett. 1-800-937-4113, <a href="mailto:info@fanlight.com">info@fanlight.com</a>.</p>	Video	Films documenting the experiences of minority Americans and patients from other countries in the U.S. health care system. Dramatizes communication between patients and their doctors, tensions between modern medicine and cultural beliefs, and the ongoing burdens of discrimination. Film clips and study guide
<p>The American Medical Association's Health Disparities web sites (various sites/pages)  <a href="http://www.ama-assn.org">http://www.ama-assn.org</a></p>	Resources and tools	Health Disparities Introductory Kit; Roadmaps for Clinical Practice series; Commission to End Health Care Disparities Survey Brief; AMA's Cultural Competence Compendium and The Critical Measures web-based program.; Virtual Mentor, the online ethics journal of the American Medical Association on caring for a culturally diverse patient population
<p>Eric J. Hardt, M.D. "The Bilingual Medical Interview." Faculty and Staff of the Primary Care Training Programs in Internal Medicine and Pediatrics at Boston City Hospital. Length: 31:15. Video Post Production: CF Video/Watertown © 1987.</p>	Video	Discusses cross-cultural medicine, translation, triadic interviewing. Suggests role-playing in learners' areas of ethnic interest. Provides Kleinman's "Tool to Elicit Health Beliefs." Illustrative vignettes/case studies with do's and don'ts.
<p>"Communicating Effectively Through An Interpreter: Barriers to Communication." CCHCP – The Cross Cultural Health Care Program. Length: 28:14. Contact: PacMed Clinics, 1200 12th Avenue S, Seattle, WA 98144. 206-621-4161 or (206) 326-4161 1998. <a href="http://www.xculture.org">www.xculture.org</a>.</p>	Video	Offers vignettes/case studies. Key points: 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.

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<p>Kaiser Permanente CARE Actors cultural issues videos. Total Length (all vignettes):70:0. Contact: Gus Gaona (323-259-4776) at Kaiser Permanente Multimedia Communication, 825 Colorado Boulevard, Suite 301, Los Angeles, California 90041. 2001</p>	<p>Video</p>	<p>Brief vignettes, support materials for facilitators and participants. Questions and discussion points. Topics in Series A: Diabetic Compliance, Latino; Sickle Cell in E.R.; Pediatric Asthma, Middle-Eastern doctor and aggressive mother; Somatic Complaint, painful memories; A Gay Adolescent. Series B also available.</p>
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