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THE CORE COMPETENCIES

Diversity in Emergency Medicine Education: Expanding the Horizon

Steven H. Bowman, MD, Lisa Moreno-Walton, MD, MS, Ugo A. Ezenkwele, MD, MPH, and Sheryl L. Heron, MD, MPH

Abstract

An emergency medicine (EM)-based curriculum on diversity, inclusion, and cultural competency can also serve as a mechanism to introduce topics on health care disparities. Although the objectives of such curricula and the potential benefits to EM trainees are apparent, there are relatively few resources available for EM program directors to use to develop these specialized curricula. The object of this article is to 1) broadly discuss the current state of curricula of diversity, inclusion, and cultural competency in EM training programs; 2) identify tools and disseminate strategies to embed issues of disparities in health care in the creation of the curriculum; and 3) provide resources for program directors to develop their own curricula. A group of EM program directors with an interest in cultural competency distributed a preworkshop survey through the Council of Emergency Medicine Residency Directors (CORD) e-mail list to EM program directors to assess the current state of diversity and cultural competency training in EM programs. Approximately 50 members attended a workshop during the 2011 CORD Academic Assembly as part of the Best Practices track, where the results of the survey were disseminated and discussed. In addition to the objectives listed above, the presenters reviewed the literature regarding the rationale for a cultural competency curriculum and its relationship to addressing health care disparities, the relationship to unconscious physician bias, and the Tool for Assessing Cultural Competence Training (TACCT) model for curriculum development.

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THE CASE FOR A CULTURAL COMPETENCY CURRICULUM

The Outcome Project is a long-term Accreditation Council on Graduate Medical Education (ACGME) initiative that emphasizes educational outcomes assessment in the residency accreditation process.[1,2] With the implementation of the Outcomes Project in 2001, the ACGME identified six core competencies: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. For the first time, residency programs were required to prepare residents to address issues related to the cultural diversity of patients. Two of the competencies, interpersonal and communication skills and professionalism, specifically address the need for programs to prepare residents to deliver culturally competent medical care. Cultural competence is essential to emergency medicine's (EM) unique practice setting in which all patients must be rapidly evaluated, diagnosed accurately, and treated appropriately regardless of potential cultural barriers.

In its 2002 report "Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare," the Institute of Medicine (IOM) concluded that "Racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors such as patients' insurance status and income are controlled."[3] It confirmed that health care disparities exist, are related to worse outcomes, and are unacceptable. This realization provided an essential goal of Healthy People 2010: the elimination of racial and ethnic health care disparities.[4]

The editorial board of *Academic Emergency Medicine* developed the 2003 consensus conference "Disparities

From Emergency Medicine, Rush Medical College, Department of Emergency Medicine, Stroger–Cook County Hospital (SHB), Chicago, IL; the Department of Emergency Medicine, Louisiana State University Health Sciences Center School of Medicine (LMW), New Orleans, New Orleans, LA; the Department of Emergency Medicine, New York University Langone Medical Center/Bellevue Hospital Center (UAE), New York, NY; and the Department of Emergency Medicine/Clinical Education, Emory University School of Medicine (SLH), Atlanta, GA.

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Supervising Editor: Nicole M. DeIorio, MD.

Address for correspondence and reprints: Steven H. Bowman, MD; e-mail: sbowman@ccbh.org.

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in Emergency Health Care'' with the goals of identification of disparities in emergency medical care, critical evaluation of EM education, development of an EM research agenda for health care disparities, and provision of a mechanism for translation of research into clinical practice.[5,6] Since then, several authors have addressed cultural competency and disparities as they relate to graduate medical education and the delivery of health care.[7,8] The Diversity Interest Group (DIG) of the Society for Academic Emergency Medicine (SAEM) continues to explore a variety of issues related to health care disparities and to promote its cultural competency monograph.[9] The American College of Emergency Physicians (ACEP), the American Academy of Emergency Medicine (AAEM), and SAEM have all developed position statements on matters of diversity.[10–12] Yet, even with directives from the ACGME, the IOM, and our professional societies, questions remain: have residency programs implemented their own cultural competency curricula? Are our educational programs moving forward? Are there enough resources for programs to design a curriculum? Are there specific challenges that prevent the integration of these topics into an EM program's curriculum? Do program directors and EM faculty want to integrate these topics? And if no, why not?

TOOLS AVAILABLE FOR TEACHING CULTURAL COMPETENCY

Although specifically addressed in the Outcome Project, it is interesting to note that the 2009 Model of the Clinical Practice of Emergency Medicine does not specifically mention cultural competency or health care disparities.[13] Few EM textbooks specifically address cultural competency and health disparities as they relate to the care of patients in the emergency department. Where does a program begin?

The process for development of a medical education curriculum has been extensively described by Kern et al.[14] The six steps of curriculum development are: 1) problem identification and general needs assessment, 2) targeted needs assessment, 3) goals and objectives, 4) educational strategies, 5) implementation, and 6) evaluation and feedback. These same steps should be applied in a stepwise fashion to develop a cultural competency and health disparity curriculum.

A recent article by Hobgood et al.[8] provides an extensive review of various educational models and methods to teach culturally appropriate care. The review provides several educational methods that may be used to teach cultural competency such as portfolios, cultural immersion, simulation, and didactics. The review also provides examples of how these methods are used in a variety of medical school settings. Hamilton and Marco[7] also provided a discussion on the importance of providing EM residents with education on disparities in health care. The article details the rationale for the educational emphasis in cultural diversity in EM, barriers to education in disparities in health care, and a variety of educational strategies that emphasize a multilevel approach to teaching cultural competency.

The Tool for Assessing Cultural Competency Training (TACCT) was developed by the American Association of Medical Colleges (AAMC) as part of the ''Medical Education and Cultural Competence: A Strategy to Eliminate Racial and Ethnic Disparities in Health Care'' project.[15,16] Although originally developed to assess cultural competence training in medical schools, this tool may also be used by EM faculty to aid in the development of a cultural competency curriculum. TACCT identifies several important content areas: health disparities, bias and stereotyping, communication skills specific to cross-cultural communication, use of interpreters, and the culture of medicine. Thus, the TACCT model may be used by EM programs to map existing curriculum elements, identify topics that are not currently addressed in the program's curriculum, implement educational methods to address these topics, and evaluate their effectiveness.

THE CORD ACADEMIC ASSEMBLY WORKSHOP: SURVEY RESULTS, REFLECTIONS, AND PARTICIPANT EXPERIENCES

To explore these topics further in a forum with EM faculty and program directors and to identify tools and resources for curriculum development, the authors accepted an invitation to facilitate a workshop at the annual Council of Emergency Medicine Residency Directors (CORD) meeting of EM educators. The workshop was held during the Best Practices Track at the 2011 CORD Academic Assembly in San Diego, California.

Approximately 50 participants registered for the workshop. The group was composed of program directors, EM teaching faculty, residents, and program coordinators. Although we did not capture each participant's specific role at his or her programs, we approximate that 80% of the group consisted of program directors, associate and assistant program directors, and EM faculty. EM residents and program coordinators constituted the remainder.

The workshop consisted of six main elements: 1) a preworkshop cultural competency curriculum survey, 2) a preworkshop invitation to take the Race Implicit Association Test, 3) a discussion of survey results, 4) a discussion of the relevance of bias in a cultural competency curriculum, 5) a review of the TAACT model for curriculum development, and 6) suggested first steps to curriculum design and implementation.

Preworkshop Curriculum Survey

Prior to the workshop, the authors conducted an informal survey of EM programs on the current state of cultural competency education. The authors e-mailed a link to a Web-based survey to 154 EM program directors using the CORD e-mail list. The survey instrument was designed to ascertain the baseline knowledge and attitudes of EM programs on a curriculum on diversity and cultural competency. Reponses were collected over a 4-month period from October 2010 to February 2011. Repeat invitations were sent to program directors and designees who did not respond at 1, 2, and 3 months after the initial e-mail, with a final reminder in February

at the end of the enrollment period. Fourteen survey questions targeted three primary areas: 1) interest and value of training and teaching on diversity, disparities, and cultural competency; 2) teaching modalities currently used by the program to provide training and teaching on diversity, disparities, and cultural competency; and 3) barriers to implementing training and teaching on diversity, disparities, and cultural competency. Responses were collected, tabulated, presented, and discussed at the workshop. We did not confirm how many program directors in attendance completed the survey.

Preworkshop Curriculum Survey Results

Of the 154 eligible programs, 96 completed the survey, yielding a 62% response rate. Most respondents answered all of the questions, although a range of one to six individuals per item did not provide answers.

With respect to training formats, of the 95 programs that responded, 68 (71.6%) were PGY 1–3, 25 (26.3%) were PGY 1–4, and 2 (2.1%) were PGY 2–4. When questioned about the importance of training in patient diversity issues in the practice of EM, teaching about the effect of disparities on health, and teaching about cultural competency, respondents overwhelmingly felt that these topics were important in EM training. The importance of each of the three topics was 84, 89, and 89%, respectively (Table 1).

When asked to identify teaching modalities used when providing educational sessions on diversity and disparities, respondent programs employed a variety of formats, suggesting that many programs use multiple formats and that topics were covered on more than one occasion. Of the responses provided for each modality, the most commonly used were lectures (94%), grand rounds (79%), and journal club (71%; Table 2).

When asked to identify the barriers to establishing a curriculum on diversity, disparities, and cultural competency in health care, the majority of respondents identified lack of time (56.3%) and lack of content experts (56.3%) as significant barriers (Table 3). When asked to indicate their level of individual or departmental interest in developing a curriculum that addresses diversity, disparities, and cultural competence, respondents also indicated a high level of interest. (Table 4).

Although informal, and intended to facilitate discussion, to our knowledge this is the first survey that attempted to identify the current status of cultural competency, diversity, and disparity education in U.S. EM residency programs. Our sampling of residency training programs identified important factors that program directors felt affect the creation of a curriculum on diversity, disparities, and cultural competence.

Preworkshop Implicit Association Test

Psychologists, social scientists, educators, and diversity experts have pushed a relatively new concept, ''unconscious bias,'' to the forefront of cultural competency education because it drastically changes our traditional understanding of bias. The traditional paradigm assumes that patterns of discriminatory behavior in organizations are conscious; good people do the right thing, and bad people do the wrong thing. As a result, there has been a ''good person/bad person'' paradigm of diversity: a belief that good people are not biased, but inclusive, and that bad people discriminate based on their biases. A prime area of focus in the work of diversity and inclusion professionals, almost since the inception of the first corporate diversity efforts, has been to find the ''bad people'' and fix them in order to eradicate bias. It has become apparent that this paradigm may be wrong. A significant body of literature demonstrates that well-intentioned individuals can introduce bias unconsciously, without the intent of discrimination.[17,18] Unconscious bias is pervasive within our society, and social stereotypes about certain groups are formed outside of conscious deliberation. The effect of such bias may alter how we, as emergency physicians, interact with and treat patients. A recent study demonstrated that physicians are more likely to recommend thrombolysis for white patients than for black patients.[19] Thus, well-intentioned physicians (good people) may be biased in their practice. In addition to clinical practice, unconscious bias may represent another challenge for EM educators, residents, and students with respect to the implementation of a cultural competency curriculum.

Prior to attending the workshop, registrants were also provided a link via e-mail and asked to complete the Implicit Association Test (IAT), which was first introduced in 1998, and was developed by Project Implicit, a research and educational consortium based at Harvard University (https://implicit.harvard.edu/implicit). This Web-based test is widely used to measure bias that may not be consciously recognized.[20] With over 4.5 million tests since its inception, the IAT has been validated. The IAT measures the time it takes subjects to match representatives of social groups (e.g.,

Table 1
Importance of Training and Teaching in Diversity, Disparities, and Cultural Competency/Awareness

Answer Options	Extremely Important, *n* (%)	Important, *n* (%)	Slightly Important, *n* (%)	Neutral, *n* (%)	No Opinion, *n* (%)	Total Response Count	Sum Important, %
Patient diversity issues	28 (29.47)	52 (54.74)	13 (13.68)	1 (1.05)	1 (1.05)	95	84.21
The effects of disparities on health	31 (32.63)	54 (56.84)	9 (9.47)	0 (0.00)	1 (1.05)	95	89.47
Cultural competency awareness	32 (33.68)	53 (55.79)	8 (8.42)	1 (1.05)	1 (1.05)	95	89.47

Table 2
Educational Modalities and Frequency of Modality Used in Diversity, Disparities, and Cultural Competence Education

Annual Frequency	None	1	2	3	4	5	6 or More	Response Count	% Who Use Modality
Modality									
Lecture	5	24	22	14	7	0	12	84	94.44
Grand rounds	19	33	10	6	3	1	3	75	78.89
Small group study	33	14	9	3	5	2	4	70	63.33
Case study	32	17	12	5	2	1	5	74	64.44
Journal club	26	22	10	7	4	1	2	72	71.11
OSCE	46	7	7	3	0	0	0	63	48.89
Other								16	
Answered question								90	
Skipped question								6	

OSCE = Objective Structured Clinical Exam.

Table 3
Educational Barriers: What Are the Barriers to Creating a Curriculum on Diversity, Disparities, and Cultural Competence?

Answer Options	*n*	%
Total answered	87	
Not enough time	49	56.3
Low priority	29	33.3
Lack of content experts	49	56.3
Other	6	6.9
Other (please specify)	8	9
Skipped question	9	

Table 4
Which Best Describes Your Individual or Department Interest in Creating a Curriculum That Addresses Diversity, Disparities, and Cultural Competence?

Answer Options	*n*	%
Answered question	94	
Very interested	24	25.5
Somewhat interested	36	38.3
Interested	21	22.3
Not interested	13	13.8
Other (please specify)	3	
Skipped question	2	

age, sex, race) to particular attributes (e.g., good, bad, cooperative, stubborn). The IAT quantifies unconscious bias based on the hypothesis that a subject will more rapidly associate an attribute to a group member if the subject has previously made that association. This occurs regardless of the subject's awareness of the association. To discuss bias and its potential relationship to health care disparities, and on the initiation and implementation of a curriculum on diversity, the authors instructed conference participants to specifically take the Race IAT prior to attending the workshop using a link provided via e-mail.

Implicit Association Test Workshop Discussion

The moderators and approximately 10 attendees discussed their experiences with the Race IAT. Several attendees were surprised to learn that they were biased. Analysis of pooled data from Project Implicit demonstrates that most people unconsciously favor whites over blacks, and even among medical practitioners, this association remains true.[21] In addition to the bias toward whites among whites, many black attendees were surprised to learn that they shared the same bias. The explanation for this particular phenomenon is beyond the scope of this article; however, it does illustrate the complexities involved when addressing cultural competency, diversity issues, and race matters from an educational perspective. Whether health professionals' biases contribute to such disparities in care is a subject of speculation and an area for study. Additionally, it also unknown how individual biases may affect the planning and implementation of a cultural competency curriculum. Workshop attendees agreed that, as health care providers and educators, recognizing and addressing one's own biases is an important first step for anyone committed to improving diversity and cultural competency education.

Workshop attendees offered other barriers to implementation of a cultural competency curriculum at their respective institutions. Several attendees commented that initiating discussions on cultural competency is more difficult in institutions where patient populations, faculty, and residents are relatively less diverse. Minority faculty at the workshop noted that in some instances, they do not want the additional burden of being the primary resource for cultural competency and disparity education. The consensus was that this is a common good, with value to all, and that minority faculty should not be responsible or the lone voice in implementing curricular change.[22] Many non–program director faculty participants were encouraged that there was such overwhelming interest on the part of program directors to develop diversity curricula, and some expressed the intent of initiating dialogues on the matter with program leadership. Others felt uncomfortable recommending changes to cultural competency practice in institutions that had little or no programming in place. Attendees also noted that in some institutions, certain behaviors and negative attitudes toward patients of different groups are tolerated.

There are several areas related to the current state of cultural competency education that need additional exploration. These results of the preworkshop survey and the workshop discussions represent a preliminary report rather than a true consensus of opinion. The moderators plan to initiate a more detailed study in the near future with the possibility of developing a formal consensus meeting.

STRATEGIES FOR IMPROVING CULTURAL COMPETENCY EDUCATION

The panel and several workshop participants offered suggestions that can be easily implemented by residency programs to introduce or augment diversity and disparities content into their existing curricula. This list is:

1. Take the Race IAT.
2. During orientation, and periodically, review the SAEM, AAEM, and ACEP policies on diversity.
3. Access the Health Care Disparities Bibliography located on the CORD Sharepoint website (http://cord.sharepointsite.net/default.aspx). This bibliography, compiled by the Louisiana State University Health Sciences Center–New Orleans and the Emory University School of Medicine EM residency programs, identifies numerous current and landmark articles that address health care disparities and cultural competency by specialty area.
4. Ask invited guests or program faculty to include/discuss diversity issues relevant to their topics during didactic sessions.
5. Invite a content expert to deliver a presentation on diversity and health care disparities at resident conferences or departmental grand rounds.
6. Assign, review, and discuss articles that address health care disparities and cultural competency at journal club.
7. Enlist the help of residents in improving your program's cultural competency curriculum.
8. Use case-based examples during didactic sessions, bedside teaching, and sign-out rounds to explore how health care disparities and implicit bias affect treatment recommendations and medical decision-making.
9. Encourage residents to consider the principle of justice in research and to evaluate whether or not diseases most prevalent among minority populations are as well studied as are diseases prevalent in the majority population.
10. Involve residents and faculty in the hospital's community: tour neighborhoods, visit clinics or other referral centers, volunteer at local schools, or participate in mentorship programs.

CONCLUSIONS

There appears to be a high level of interest in creating a curriculum on diversity, disparities, and cultural competency in EM. Unconscious bias may be one of several obstacles in implementing a curriculum; however, further research is needed to determine the extent. EM programs can use the Tool for Assessing Cultural Competency Training and other tools to start to assess their current offerings.

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