

**U.S. Public Health Service  
Office of Minority Health  
and  
Office on Women's Health**

**PROCEEDINGS:**

**National Conference on  
Cultural Competence  
and  
Women's Health  
Curricula in  
Medical Education**

**October 26-28, 1995**

**Washington, DC**

**U.S. Department of Health and Human Services**

U.S. Public Health Service  
Office of Minority Health  
and  
Office on Women's Health

PROCEEDINGS:

National Conference on Cultural Competence  
and  
Women's Health Curricula in Medical Education

October 26-28, 1995

Washington, DC

U.S. Department of Health and Human Services

**Editors**

Elena Rios, M.D., M.S.P.H.  
Guadalupe Pacheco, M.S.W.  
Betty Lee Hawks, M.S.  
Saralyn Mark, M.D.

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## **Opening Letter**

Dear Colleagues:

On behalf of our partners and our respective offices, we are delighted that you joined us during the National Conference on Cultural Competence and Women's Health Curricula in Medical Education, held on October 26-28, 1995, at the Hotel Washington in Washington, D.C. More than 300 participants, representing medical schools and other academic institutions, physicians, professional and trade associations, and medical students attended the conference.

The U.S. Public Health Services' Office on Women's Health (OWH) and Office of Minority Health (OMH) are the lead Public Health Service offices that coordinate and promote health policies and programs for improving the health status of women and minorities.

The absence of cultural competence and women's health curricula in medical education has been a concern of both offices. As we approach the 21st century, the United States is increasingly multi-ethnic and multi-cultural. Changes being made throughout the health care delivery system will require that health professionals today and tomorrow are well trained at providing culturally competent health care to diverse patient populations.

Recognizing the importance of these critical issues, OWH and OMH convened the national conference to present innovative curricula models in the areas of cultural competence and women's health in undergraduate and graduate medical education, faculty development, and continuing medical education (CME).

We have begun taking the first steps towards forging Federal and private sector policies and programs that will promote development and replication of cultural competence and women's health curricula models in medical education settings. Several recommendations for changes in the medical education curricula were formulated at the conference. These proceedings attempt to capture the discussion and recommendations of the participants on these critical issues, and to provide information regarding progress to integrate the issues of cultural competence and women's health throughout medical education.

The enclosed is a synopsis of key sections of the meeting including a summary of the plenary sessions, workshops strategy sessions and responses, as well as a set of administrative documents. We hope that you will find this information useful in promoting policy and institutional changes for the inclusion of cultural competence and women's health curricula in medical education.

Sincerely,

Susan J. Blumenthal, M.D., M.P.A.  
Deputy Assistant Secretary for Health  
(Women's Health)  
Assistant Surgeon General

Clay E. Simpson, Jr., M.S.P.H., Ph.D.  
Deputy Assistant Secretary  
for Minority Health

Elena Rios, M.D.  
Medical Advisor  
Office on Women's Health

Guadalupe Pacheco, M.S.W.  
Special Assistant to the Deputy Director  
Office of Minority Health

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# **Program Agenda**

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**U.S. Public Health Service  
Office of Minority Health  
and  
Office on Women's Health**

**National Conference on Cultural Competence and Women's Health  
Curricula In Medical Education**

**Hotel Washington  
Washington, D.C.**

**October 26-28, 1995**

**Thursday, October 26, 1995**

2:00 p.m. - 4:00 p.m.

**Washington Ballroom**

**Exhibit/Poster Set-up**

2:00 p.m. - 6:00 p.m.

**Hotel Lobby**

**Registration**

5:00 p.m. - 6:00 p.m.

**Washington Ballroom**

**Exhibits/Poster Session Opens**

6:00 p.m. - 9:00 p.m.

**Washington Ballroom**

**Welcome and Opening Remarks/Reception**

Susan J. Blumenthal, M.D., M.P.A.  
Deputy Assistant Secretary for Health  
(Women's Health)  
Assistant Surgeon General  
U.S. Department of Health and Human Services

Clay E. Simpson, Jr., M.S.P.H., Ph.D.  
Deputy Assistant Secretary for Minority Health  
U.S. Department of Health and Human Services

**Friday, October 27, 1995**

7:00 a.m. - 8:15 a.m.

**Washington Room**

**Continental Breakfast**

7:00 a.m. - 6:00 p.m.

**Hotel Lobby**

**Registration**

**Friday, October 27, 1995**

8:30 a.m. - 9:00 a.m.  
**Washington Room**

**Welcome and Opening Remarks**

Susan J. Blumenthal, M.D., M.P.A.  
Deputy Assistant Secretary for Health  
(Women's Health)  
Assistant Surgeon General  
U.S. Department of Health and Human Services

Clay E. Simpson, Jr., Ph.D.  
Deputy Assistant Secretary for Minority Health  
U.S. Department of Health and Human Services

9:00 a.m. - 10:00 a.m.  
**Washington Room**

**Opening Plenary Session**  
***Changing Medical Education for the 21<sup>st</sup> Century***

Herbert Pardes, M.D.  
Dean, Columbia University College of  
Physicians and Surgeons  
Chairman, Council of Deans, Association of  
American Medical Colleges  
Chairman-Elect AAMC Executive Council

Henry Foster, M.D.  
Professor of Obstetrics and Gynecology  
Meharry Medical College  
School of Medicine

10:00 a.m. -12:30 p.m.  
**Washington Room**

**Demographic Trends and  
Their Impact on Health Delivery**

Harold Hodgkinson, Ph.D.  
Co-Director for Demographic Policy  
Institute for Educational Leadership

10:00a.m. - 12:30 p.m.  
**Washington Room**

**Principles of Cultural Competence**

Arthur Kleinman, M.D.  
Maude and Lillian Presley Professor of Medical  
Anthropology  
Professor of Psychiatry and Chairman  
Department of Social Medicine  
Harvard Medical School

**Women's Health Curricula in Medical Education -  
State of the Art**

Janet Henrich, M.D.  
Associate Professor of Medicine  
Yale University School of Medicine

Margo Krasnoff, M.D.  
Clinical Associate Professor of Medicine  
Hertel Elmwood Internal Medicine Center

**Incorporating Women's Health and Cultural  
Competence in Medical Education**

Ana Nuñez, M.D.  
Assistant Dean of Generalism and the Community  
Medical College of Pennsylvania and  
Hahnemann University School of Medicine

12:30 p.m. - 1:45 p.m.  
**Washington Ballroom**

**Lunch  
Cultural Competence and Women's Health Curricula in  
Osteopathic Medicine**

Barbara Ross-Lee, D.O.  
Dean, Ohio University College of  
Osteopathic Medicine

**Friday, October 27, 1995**

1:45 p.m. - 3:15 p.m.

**Workshops**

**Workshop 1A:  
Capital Room**

**Cultural Competence in Medical Student Curricula**

Moderator: Guadalupe Pacheco, M.S.W.

PHS Office of Minority Health

Ronald Garcia, Ph.D.  
Stanford University School of Medicine

Walt Hollow, M.D.  
University of Washington  
School of Medicine

Doric Little, Ed. D.  
University of Hawaii  
John A. Burns School of Medicine

**Workshop 2A:  
Council Room**

**Women's Health in Medical Student Curricula**

Moderator: Saralyn Mark, M.D.

PHS Office on Women's Health

Thomas Johnson, M.D.  
University of Massachusetts Medical School

Kathryn Peek, Ph.D.  
University of Texas  
Medical School at Houston

Sharon Phelan, M.D.  
University of Alabama at Birmingham  
School of Medicine

Jay Bachicha, M.D.  
Northwestern University Medical School

vii

**Friday, October 27, 1995**

1:45 p.m. - 3:15 p.m

**Workshop 3A:  
Washington Room**

**Workshops (continuation)**

**Faculty Development - Women's Health and Cultural  
Competence Models**

Moderator: Juanita Evans, M.S.W.

HRSA Maternal and Child Health Bureau

Robert Like, M.D., M.S.  
UMDNJ - Robert Wood Johnson Medical School

Lois Monteiro, Ph.D.  
Brown University Program in Medicine

Ana Nuñez M.D.  
Medical College of Pennsylvania and  
Hahnemann University School of Medicine

**Workshop 4A:  
Two Continents**

**Social Issues in Medical Education -- Violence and  
Two Continents Substance Abuse**

Moderator: Frances Page, R.N., M.P.H.  
PHS Office on Women's Health

Michael Wilkes, M.D.  
University of California, Los Angeles  
UCLA School of Medicine

Carol Hodgson, Ph.D.  
University of California, Los Angeles  
UCLA School of Medicine

Catherine Dube', Ed.D.  
Brown University Program in Medicine

viii

**Friday, October 27, 1995**

1:45 p.m. - 3:15 p.m.

**Workshop 5A:  
Washington Ballroom**

**Workshops (continuation)**

**Lessons for Integrating Women's Health in Medical  
Education**

Moderator: Debbie Jackson, M.A.  
HRSA Bureau of Health Professions

Lucia Beck Weiss  
Medical College of Pennsylvania and  
Hahnemann University School of Medicine

Kathleen McIntyre-Seltman, M.D.  
University of Pittsburgh  
School of Medicine

Linda Nieman, Ph.D.  
Medical College of Pennsylvania and  
Hahnemann University School of Medicine

**Workshop 6A:  
Washington Room**

**What is the Role of the Federal Government in  
Medical Education?**

Moderator: Elena Rios, M.D. M.S.P.H.  
PHS Office on Women's Health

Lynn Short, Ph.D., M.P.H.  
Centers for Disease Control and Prevention

Barbara Wynn, M. A.  
Health Care Financing Administration  
Bureau of Policy Development

Fitzhugh Mullan, M.D.  
Health Resources and Services Administration  
Bureau of Health Professions

Sharon F. Barrett, M.S.  
Health Resources and Services Administration  
Bureau of Primary Health Care

Johanna Clevenger, M.D.  
Indian Health Service

ix

**Friday, October 27, 1995**

1:45 p.m. - 3:15 p.m.

**Workshop 6A:  
Washington Room**

**Workshops (continuation)**

**What is the Role of the Federal Government in  
Medical Education? (con't)**

Moderator: Elena Rios, M.D., M.S.P.H.  
PHS Office on Women' Health

Edward T. Morgan  
Substance Abuse and Mental Health Services  
Administration  
Center for Substance Abuse Treatment

Gloria J. Holland, Ph.D.  
Department of Veterans Affairs

Office of Academic Affairs

3:15 p.m. - 3:30 p.m.

**Afternoon Break**

3:30 p.m. - 5:30 p.m

**Workshops**

**Workshop 1B:  
Capital Room**

**Cultural Competence and Medical Residency  
Education**

Moderator: Elsie Quiñones, M.A.  
HRSA Bureau of Health Professions

Kathleen Culhane-Pera, M.D.  
St. Paul Ramsey Medical Center

Roberta Goldman, Ph.D.  
Brown University Program in Medicine

Melanie Tervalon, M.D.  
Children's Hospital, Oakland

x

**Friday October 27, 1995**

3:30 p.m. - 5:30 p.m.

**Workshops (continuation)**

**Workshop 2B:  
Council Room**

**Women's Health and Clinical Medical Education**

Moderator: Dorynne Czechowicz, M.D.  
National Institute on Drug Abuse, NIH

Pamela Charney, M.D.  
Albert Einstein College of Medicine  
of Yeshiva University

Mitzi Krockover, M.D.  
University of California  
UCLA Los Angeles School of Medicine

Leah Dickstein, M.D.  
University of Louisville School of Medicine

**Workshop 3B:**

**Women's Health Curricula: Residency Track vs.**

**Federal Room**

**Fellowship**

Moderator: Saralyn Mark, M.D.  
PHS Office on Women's Health

Sandra Hoffmann, M.D.  
Michigan State University  
College of Human Medicine

Michelle Roberts, M.D.  
University of Pittsburgh  
School of Medicine

Kathleen Thomsen, M.D., M.P.H.  
UMDNJ - Robert Wood Johnson Medical School

Anne Moulton, M.D.  
Brown University School of Medicine

xi

**Friday October 27, 1995**

3:30 p.m. - 5:30 p.m.

**Workshops (continuation)**

**Workshop 48:  
Parkview Room**

**Model Curricula -- Gays and Lesbians, Midwives  
and Hispanics**

Moderator: Marcy Gross  
Agency for Health Care Policy & Research

Robert Cabaj, M.D.  
San Mateo County Mental Health Services

Desiree McCloskey, M.D.  
University of California, San Francisco  
School of Medicine

Denice Cora-Bramble, M.D.  
George Washington University  
School of Medicine and Health Sciences

**Workshop 5B:  
Washington Ballroom**

**Lessons From Integrating Cultural Competence Into  
Medical Education Curricula**

Moderator: Betty Lee Hawks, M.A.

PHS Office of Minority Health

Diane Appelbaum, M.D.  
University of Wisconsin  
Medical School

B U.K. Li, M.D.  
Ohio State University  
College of Medicine

A. Belinda Towns, M.D., M.P.H.  
UCLA - Charles R. Drew University of Medicine  
and Science

xii

**Friday, October 27, 1995**

**Workshop 6B:  
Federal Room**

**Managed Care, Cultural Competence, and Women's  
Health Curricula in Medical Education**

Moderator: Joan Jacobs, M.P.H.  
PHS Office of Minority Health

Lesley Levine, M.D.  
Kaiser Permanente Medical Care Program

Deborah Gould, M.D.  
Kaiser Permanente Medical Care Program

Kathryn Rexrode, M.D.  
Harvard Community Health Plan

5:30 p.m. - 7:00 p.m

**Dinner (On Your Own)**

7:00 p.m. - 7:15 p.m.

**Washington Ballroom**

**Plenary: Setting the Ground Rules**

Elena Rios, M.D., M.S.P.H.  
Medical Advisor  
Office on Women's Health  
PHS Office of Minority Health

Guadalupe Pacheco, M.S.W.  
Special Assistant to the Director

7:15 p.m. - 8:30 p.m.

**Strategy Development Sessions**

**Council Room**

**Federal Government**

Facilitator: Marcy Gross  
Agency for Health Care Policy and Research

**Capital Room**

**State Government**

Facilitator: Julia P. Fortier  
Resources for Cross Cultural Health Care

xiii

**Friday, October 27, 1995**

7:15 p.m. - 8:30 p.m.

**Strategy Development Sessions**

**Federal Room**

**Medical Schools**

Facilitator: Billy R. Ballard, D.D.S., M.D.  
The University of Texas Medical Branch

**Two Continents**

**Residency and Fellowship Programs**

Facilitator: Saralyn Mark, M.D.  
PHS Office on Women's Health

**Parkview Room**

**Health Professional Associations**

Facilitator: Wendy Rivers, M.D.  
George Washington University Medical Center

**Room 334**

**Foundations**

Facilitator: Debra Delgado  
The Annie E. Casey Foundation

**Washington Ballroom**

**Medical Board Exam Organizations**

Facilitator: Lila Wallis, M.D.  
Cornell University Medical Center

**Caucus Room**

**Licensing and Accreditation Bodies**

Facilitator: D. Daniel Hunt, M.D.  
University of Washington School of Medicine

**Saturday, October 28, 1995**

7:00 a.m. - 12:00 noon  
**Hotel Lobby**

**Registration**

7:30 a.m. - 8:30 a.m.  
**Washington Ballroom**

**Continental Breakfast**

xiv

**Saturday, October 28, 1995**

8:30 a.m. - 9:00 a.m.  
**Washington Room**

**Plenary Session/Opening Remarks**

Susan J. Blumenthal, M.D., M.P.A.  
Deputy Assistant Secretary for Health  
(Women's Health)  
Assistant Surgeon General  
U.S. Department of Health and Human Services

Clay E. Simpson, Jr., Ph.D.  
Deputy Assistant Secretary for Minority Health  
U.S. Department of Health and Human Services

9:00 a.m. - 9:45 a.m.  
**Washington Room**

**Cultural Competency From A Minority Perspective**

Dyanne Affonso, Ph.D., F.A.A.N.  
Professor and Dean  
Nell Hodgson Woodruff School of Nursing  
Emory University

Gerald L. Hill, Jr., M.D.  
Director  
Center of American Indian and Minority Health  
University of Minnesota Medical School -  
Minneapolis

9:45a.m. - 11:45 a.m.

**Strategy Development Sessions**

**Council Room**

**Federal Government**

Facilitator: Marcy Gross  
Agency for Health Care Policy and Research

**Capital Room**

**State Government**

Facilitator: Julia P. Fortier  
Resources for Cross Cultural Health Care

**Federal Room**

**Medical Schools**

Facilitator: Billy R .Ballard, D.D.S., M.D.  
The University of Texas Medical Branch

xv

**Saturday, October 28, 1995**

9:45a.m. - 11:45a.m.

**Strategy Development Sessions (con't)**

**Washington Room**

**Residency and Fellowship Programs**

Facilitator: Saralyn Mark, M.D.  
PHS Office on Women's Health

**Parkview Room**

**Health Professional Associations**

Facilitator: Wendy Rivers, M.D.  
George Washington University Medical Center

**Room 334**

**Foundations**

Facilitator: Debra Delgado  
The Annie E. Casey Foundation

**Room 331**

**Medical Board Exam Organizations**

Facilitator: Lila Wallis, M.D.  
Cornell University Medical Center

**Caucus Room**

**Licensing and Accreditation Bodies**

Facilitator: D. Daniel Hunt, M.D.  
University of Washington School of Medicine

12:00 p.m. - 1:30 p.m.

**Lunch**

**Washington Ballroom**

**Federal Perspective on Cultural Competence  
and Women's Health Curricula**

Jo Ivey Boufford, M.D.  
Principal Deputy Assistant Secretary for Health  
U.S. Department of Health and Human Services

1:30 p.m. - 2:30 p.m.

**Washington Room**

**Reports from Strategy Development Sessions**

2:30 p.m. - 2:45 p.m.

**Afternoon Break**

xvi

**Saturday, October 28, 1995**

2:45 p.m. - 4:00 p.m.  
**Washington Room**

**Response Panel**

**Federal Government**

Ciro V. Sumaya, M.D., M.P.H.T.M.  
Administrator  
Health Resources and Services Administration

**State Government**

David Werdegar, M.D., M.P.H.  
Director, State of California  
Office of Statewide Health Planning and  
Development

**Medical Schools**

Ana Nuñez, M.D.  
Assistant Dean of Generalism and the Community  
Medical College of Pennsylvania and  
Hahnemann University School of Medicine

**Residency & Fellowship  
Programs**

Jeannette South-Paul, M.D.  
Chair, Department of Family Practice  
Vice President for Minority Affairs  
Uniformed Services University of the Health  
Sciences

**Health Professional  
Associations and  
Accreditation Bodies**

Harry Jonas, M.D.  
Director, Undergraduate Medical  
Education Division  
Liaison Committee-Medical Education  
The American Medical Association

**Medical Board  
Exam Organizations**

Gerald S. Golden, M.D.  
Vice-President  
National Board of Medical Examiners

**Saturday, October 28, 1995**

**Licensing Boards**

Susan Spaulding  
Vice President  
Federation of State Medical Boards of the  
U.S., Inc.

3:45 p.m. - 4:15 p.m.  
**Washington Room**

**Audience Response to Recommendations**

4:15 p.m. - 4:30 p.m.  
**Washington Room**

**Closing Remarks**

Susan J. Blumenthal, M.D., M.P.A.  
Deputy Assistant Secretary for Health  
(Women's Health)  
Assistant Surgeon General  
U.S. Department of Health and Human Services

Clay E. Simpson, Jr., Ph.D.  
Deputy Assistant Secretary for Minority Health  
U.S. Department of Health and Human Services

4:30 p.m.

**Adjournment**

**CME ACCREDITATION INFORMATION**

The National Health Service Corps designates this continuing medical education activity for 7.75 credits hours in Category 1 of the Physician's Recognition Award of the American Medical Association.

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# **Chapter I. Opening Remarks**

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## **The Changing Face of American Medicine**

Susan Blumenthal, M.D., M.P.A.  
Deputy Assistant Secretary for Health (Women's Health)  
Director, The Office on Women's Health  
Assistant Surgeon General  
U.S. Department of Health and Human Services

### **Background**

Susan J. Blumenthal, M.D., M.P.A., is a national expert in women's health and mental illness and has been a leader in bringing these important public health issues to scientific and public attention. Dr. Blumenthal was recently appointed the country's first Deputy Assistant Secretary for Women's Health. In this position, she oversees and coordinates research, services and education programs and activities across the agencies of the U.S. Public Health Service, including the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), and the Food and Drug Administration (FDA). She also serves as Assistant Surgeon General and Rear Admiral in the United States Public Health Service and as a Clinical Professor of Psychiatry at Georgetown University School of Medicine. Dr. Blumenthal is responsible for the coordination and implementation of the National Plan for Breast Cancer, a public-private partnership that should make significant progress in the battle against this disease. Dr. Blumenthal served as a member of the Mental Health Workgroup of the President's Task Force on Health Care Reform. Formerly, she served as Chief of the Behavioral Medicine and Basic Prevention Research Branch and the Head of the Suicide Research Unit at the National Institute of Mental Health where she directed major national research programs on these public health issues.

### **Presentation**

We have come a long way since the graveyards of the 19th century were littered with women who died prematurely of infectious diseases, especially those developed from giving birth. Today, lifestyle or unhealthy patterns of behavior cause over fifty percent of chronic illnesses. More than any other intervention, changing behavior has had a tremendous impact on preventing premature death, extending the quality of life of both men and women and decreasing our health care costs.

But we have a long way to go to create a medical education system that can meet the needs of our increasingly diverse populations. We need to integrate women's health into the curricula of all of our medical institutions. Cultural competencies need to be infused into our mainstream medical education to help us reflect and better address the needs of our diverse population. We must increase the numbers of women and minorities in our health care profession and in the positions of leadership in our nation's academic and medical centers.

We hope the recommendations crafted at this conference, will help to change medical education in this country well through the 21st century. To paraphrase the eminent author Ralph Ellison, "America is woven of many strands. From these strands, we must weave

one cloth." The very fabric of our society has changed into an expanded variety of colors, backgrounds and cultures. This diversity greatly impacts every profession, but especially our medical and health care professions. They are, perhaps, more closely linked to human lives than any other. Sadly, we have a long way to go.

Today, only nine percent of women who graduate from medical school are African American, six percent are Hispanic and less than one percent Native American. These small numbers exist in an already under represented population of female medical school graduates. This cannot continue if we are to reflect and meet the needs of all Americans. Yet too much of what is taught in medical school today is based upon the physiology of white males. There are well-documented differences in both biology and experience between men and women. Yet most research studies were conducted including men only, as if men were generic human beings whose treatment for disease can be generalized to women. This is also true for ethnicity. The white male experience in medicine has been generalized as the only valid model on which to predicate medical teaching and practice.

A survey on medical school curricula taken just a few years ago shows that only 25 percent of medical schools offer training in women's health beyond obstetrics and gynecology. Even these courses are simply electives in many medical institutions. Fortunately, in the past five years, women's health has moved from simply a blip on our national health radar screen to command national attention.

The year 1990 marked the beginning of a decade in which the general public and scientists alike learned about the alarming inequities in women's health. These include a lack of funding for women's health studies, poor access of women to comprehensive health services and a dearth of senior women scientists in our nation's academic and federal research institutions. But the inequities in how women are treated by the medical establishment go back a long time.

In the latter part of the 19th century, we can gain some insight about how closely linked the male model of medicine was with medical research and training. In 1884, Sarah Oran Jewett wrote a book about a country doctor. She wanted to become a surgeon, but her entire world actively worked against her. Women's very physical and mental being made it impossible for them to learn the body of knowledge necessary to becoming a doctor. As one physician said at a national medical meeting during this time, "Women have a small weak brain. Forcing them to learn large amounts of complicated materials would lead to a loss of heat from the uterus and a nation of mad, infertile women."

The climate for women in medicine has obviously improved over the last one hundred years. But it has not improved enough. Women make up only 11 percent of clinical faculty in medical schools, hold fewer than nine percent of the tenured professorships, but are 42 Percent of medical school enrollments. Women's salaries in academic medical institutions are 5 to 11 percent lower than their male counterparts; and among practicing physicians, women's salaries are 30 percent lower for comparable jobs.

The Clinton Administration has moved strongly to correct these ills. Women's health has become a critical part of the overall programs and activities of the Department of Health and Human Services. The President signed legislation requiring that women and minorities be included in all clinical trials supported by the National Institutes of Health, ending a tragic chapter in our nation's medical history. We are also working to rectify other long standing inequities in research and in the conduct of national health care programs.

We must continue writing this new prescription for our health care system and for medical education. Today, we are assessing how women's health issues can be more fully incorporated into medical school curricula. Our office, in collaboration with the National Institutes of Health, the Health Resources and Services Administration and the Association of American Medical Colleges, has sent out a survey to U.S. medical schools nationwide to find out how they include women's health throughout their curricula. The information from this survey will play a valuable role in shaping new medical school curriculum in women's health.

We are also developing a directory of residency training and fellowship programs in women's health for which the Office on Women's Health has conducted a survey of over one thousand training programs that are registered with the American Hospital Association. We will continue to go to our academic medical centers and speak with faculty, administration and students about the barriers they see that women face in gaining a medical education.

But we cannot solve these challenges alone. Policy-makers must set funding priorities. Deans of medical schools must make women's health and cultural competence a priority in their institutions. The private sector must have incentives to produce products that benefit women and minority populations. We must produce more women and minorities who are chairs of departments and tenured professors. Health care related associations and accrediting bodies must require subject area competence from their members. Foundations and other funding institutions must support innovative studies and programs.

A hundred years ago, our medical schools admitted few women and fewer minorities. A century later, we are still working to bring about a health care system that mirrors and responds to our diverse population. This is the challenge we all face. We must meet this challenge if we are to provide quality health care for a changing America.

## **Cultural Competence and Our Medical Education System: The Crossroads**

Clay F. Simpson, Jr., M.S.P.H., Ph.D.  
Deputy Assistant Secretary for Minority Health  
Office of Minority Health (OMH)  
U.S. Department of Health and Human Services

### **Background**

Dr. Clay Simpson is Deputy Assistant Secretary for Minority Health, and Director of the U.S. Public Health Services Office of Minority Health (OMH). OMH coordinates public health service policy, research, and service delivery and education programs that improve health care status and access to services for minority populations. Dr. Simpson's office is a co-sponsor of this conference with the U.S. Public Health Service Office on Women's Health. Dr. Simpson has dedicated his professional career to the improvement of health care for America's racial and ethnic minority populations. In July, 1995, he was appointed Deputy Assistant Secretary for Minority Health. He serves as principal advisor on minority health issues to the Assistant Secretary for Health. Dr. Simpson has received awards from major ethnic minority and national health associations, such as the National Medical Association and the Association of American Medical Colleges, as well as honorary doctorates and humane letters from New England College of Optometry, the School College of Podiatric Medicine, Meharry Medical College. Dr. Simpson earned the Doctor of Science degree from Tuskegee University. Dr. Simpson holds the highest award bestowed by the Public Health Service, the Superior Award.

### **Presentation**

The health field has changed radically in my lifetime. The fact that the rate of change is not diminishing has placed great stress on the structure and performance of both our public and private health care systems. This structural stress is compounded by language and cultural differences. These differences frustrate good health care for women and for patients with limited English proficiency. It is therefore critical that we develop innovative approaches to medical education that will appropriately address the health care needs of minorities and women as our nation's population continues to diversify.

This conference provides a national focus to promote health care for minority populations and women. The issue of education is critical for all of us who work on behalf of special populations. Our physicians-in-training need to know that culturally appropriate interventions increase access to the quality of health care for patients and provide support for the families of these individuals.

At the Office of Minority Health, we recognize the important role that medical teaching plays in shaping health care delivery. We must remain committed to building partnerships and mobilizing needed resources to make our medical institutions more responsive to the needs of women and minorities.

The HRSA sponsored Centers of Excellence in healthy professions education are resources to help build responsive medical institutions. These Centers lay the foundation for improved service to under served communities. They train medical professionals at Historically Black Colleges and Universities and at Hispanic and Native American medical institutions.

The Office of Minority Health supports Dr. Gerald Hill's Center of Excellence for American Indian Education at the University of Minnesota; The Native Hawaiian Center of Excellence at the University of Hawaii at Manoa, where Dr. Doric Little formerly coordinated Student Development; Stanford University's Stanford Center of Excellence headed by Dr. Ron Garcia; and the Native American Center of Excellence at the University of Washington, directed by Dr. Walt Hollow.

These programs increase the number and quality of minority health professionals; enhance the academic performance of the students; improve the schools' capacity to recruit train, and retain minority faculty; and facilitate faculty and student research on health issues particularly affecting minority groups. If we are to deliver quality health care services to individuals from disadvantaged backgrounds, we must continue to work together to address effective health care interventions that focus on the needs of women and bilingual/bicultural communities.

What should we be teaching? We must teach our students to help empower women and under served minorities to take responsibility for their own health. Our students must learn to deliver accurate, up-to-date and culturally sensitive information about disease prevention. Moreover, our students must be able to help empower women and minorities to be active participants in decisions about their health care and treatment options.

How do we work with students? Students need cross-cultural training, medical clerkships, on-site experiences, and motivation to become better health care providers. We must motivate students at the undergraduate and graduate levels, as well as our colleagues, to educate themselves about cultural competence and women's health issues.

How do we provide incentives to faculty to teach curricula that are culturally competent? We must find ways to stimulate faculty to teach the language skills and cultural understanding necessary to bridge the gap between their Western scientific approach to medicine and traditional health practices. We also need to examine ways to reward faculty for their efforts to teach about minority and women's health.

How do we reconcile the need for teaching cultural competencies with the fierce competition for teaching time? I challenge you to think about ways in which we can address these issues. One possible strategy would be to make these issues a part of the licensing procedures for health care providers and accreditation standards for medical schools and teaching hospitals. This conference provides a forum to help us reaffirm our commitment to several urgent goals for educating health care professionals. These goals are:

- ◆ Developing innovations and sharing diverse cultural experiences within the body of medical curricula;
- ◆ Fostering the development of scholarly work about cultural competence and women's health curricula in medical education; and
- ◆ Developing strategies to incorporate cultural competence and women's health curricula into the mainstream of medical education.

Those who are working today on these issues are pioneers. Today, we need to be more resourceful – sharing ideas and resources, evaluating programs, and constantly changing our approaches and perspectives – to improve the health of women and minorities. We must continue to challenge ourselves until we find strategies that work in each of our communities. We must also never forget that we are one nation. What benefits the under served will ultimately benefit us all.

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## **Chapter II. Plenary Sessions**

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## CHANGING MEDICAL EDUCATION FOR THE 21ST CENTURY

**Herbert Pardes, M.D.**

**Association of American Medical Colleges**

### **Background**

Dr. Herbert Pardes is currently the Chairman of the Council of Deans of the Association of American Medical Colleges. At the time of his presentation, he was the Chairman-Elect of the Association of American Medical Colleges and Vice President for Health Sciences and Dean for the Faculty of Medicine of Columbia University College of Physicians and Surgeons. Dr. Pardes was formerly the President of the American Psychiatric Association and the Director of the National Institute of Mental Health. He is one of the nation's foremost medical educators.

### **Presentation**

This is a formidable time for all concerned with the restructuring of our nation's educational, social and health systems. Much national attention has been given in the press concerning health care reform, the health care revolution, exciting new knowledge emerging from the biological and medical sciences, and the problems of appropriate balance between primary care and specialty care. However, there has been little substantive discussion concerning the specifics of what is taking place and how it should impact medical education.

The dramatically changing scene in health care has not been thrust upon us by a new breed of medical professional. Increasingly, knowledgeable medical and health care consumers are driving this revolution. This is creating great pressure for change in our medical education system. The explosion of medical and health knowledge is unparalleled. In the last fifty years, we have learned more in medicine than in all of the previous years. In the next 25 years, we will repeat the process of learning more than we have in all previous years. In the next five years, we will probably map the entire human genome. In addition, modern technology is giving us information about the structure and function of the brain, heart and other organs that is dramatically improving our ability to diagnose and treat the basic causes and physiology of disease. Molecular biology is enabling us to study the most elementary particles of human matter, enhancing our understanding of the body's neurophysical functions and genetic foundations. Medical research has found nearly fifty neurotransmitters and a host of subtypes, increasing our understanding of the extraordinary complexity of the human brain. Thirty years ago we knew about three of those neurotransmitters.

### **The Evolution of Our Medical Education**

There are a number of critical factors affecting the evolution of medical education today:

- ◆ There is a massive restructuring of the health care system with physicians working more as members of a group.

- ◆ The decline in the use of inpatient treatment is accompanied by the locus of care being shifted to outpatient clinical sites.
- ◆ There is an increasingly rapid growth of managed care.
- ◆ There is a dramatic increase in interdisciplinary collaboration.
- ◆ Physicians are increasingly being asked to play more diverse roles, with many more in administrative, oversight and business-related roles.
- ◆ There is much greater concern for the cost of health care.

There are other underlying issues affecting medical education. Physicians and all health care providers have to be increasingly sensitive to the concerns and increased knowledge base of health care consumers. This means medical professionals need to be prepared to respond to more thoughtful and challenging questions. The purchasers of health care are increasingly focused on the quality of care. The evaluation of hospitals on the basis of the outcomes of morbidity/mortality and "report cards" for providers are indicative of this trend. Trends towards managed care, the cost of care and group practice have led to greater physician accountability.

The medical and health care workforce needs to reflect its customer base. This means we must dramatically increase the numbers of women and minorities in the medical and health professions.

### **The Growing Interest in Women's Health**

One of the key factors driving the interest in women's health is that the population is aging and women comprise close to two-thirds of the population 65 years of age and older. There is also a growing recognition of gender differences in health and disease throughout the life cycle. Historically, women's health practice and opportunities for study within medical schools has been limited to the disciplines of obstetrics and gynecology. Changes in how women view themselves and pressure within and from outside the medical profession is changing the study and practice of women's medicine.

Too little attention has been paid to health in the post-menopausal women, including osteoporosis. There is also little research on diseases unique to women or research that includes women in diseases common to men and women. While we may pride ourselves on our technological medical accomplishments, until a year or two ago, women were routinely excluded from clinical drug trials. Something is gravely out of focus with how we perceive our medical and health priorities.

**The Growing Interest in Minority Health** We must pay attention, not only to gender differences, but to ethnic patterns of health care and disease. Regardless of what minority group they belong to, minority women have lower life expectancy rates and more health problems than white women. The differences are greatest in infant and maternal mortality, in the incidence of chronic disease, cancer rates, and in their experience with violence.

New initiatives in women's and minority health must be closely connected to both the policy

arena and the marketplace. We need to teach about the distinctive factors concerning women and minority health, not only in the lecture halls, but also in practice settings where physicians learn to be competent and sensitive generalists and specialists. Physicians and other health care providers must be trained to identify and treat the health problems of the urban and rural under served populations of our country if we are going to make real progress as a nation.

The Federal government has implemented important initiatives to direct efforts in women's health and cultural competence. Many of these programs have been accomplished by the following agencies:

- ◆ The Office on Women's Health under Deputy Assistant Secretary Dr. Susan Blumenthal; the Office of Minority Health under Deputy Assistant Secretary Dr. Clay Simpson; the Office of Research on Women's Health at the National Institutes of Health under Dr. Vivian Pinn; the Council on Graduate Medical Education (COGME).

Other non-government organizations that have made substantial contributions include:

- ◆ The American Medical Women's Association; the National Commission on Women's Health at Columbia University.

In designing medical education, we need to equip physicians with an optimum level of understanding. Some of the people we are training will become physician researchers, clinical practitioners, or have careers in other health-related fields. All must have some basic understanding of modern science, with the capacity to stay informed over the full extent of their professional careers.

### **Trends in Medical Education**

The Robert Wood Johnson Foundation reported a few years ago on the trends and changes in medical education. Their findings document some of the systemic alternations now occurring:

- ◆ The proportion of women in medical schools has risen substantially. Women now constitute 41.9 percent of medical students with over 28,000 women now enrolled.
- ◆ There are a stable number of minorities entering medical school. But, as with women, there are not enough entering the profession nor are there sufficient minority practitioners, or health educators to insure quality health care into the 21st century. Budgetary constraints may undermine the efforts to increase the number of minority doctors and health professionals.

There are several other key trends in medical education. These include:

- ◆ *Changes in the way medical schools develop and implement their core curricula.* Medical schools are shaping their own core curricula. These changes include lessening the separation between basic science and clinical education training, revamping curriculum committees, breaking down departmental barriers and creating unified scientific approaches to eliminate curriculum conflicts.
- ◆ *Changes in curriculum to reflect today's realities.* These include the teaching of medical ethics, training in the behavioral aspects of medicine; teaching medical decision-making, and offering courses about alternative therapies and how culture affects the practice of medicine.
- ◆ *Use of technology to take advantage of opportunities for self-learning and informational resources.* For instance, Columbia University recently began a new department of medical informatics.
- ◆ *Reductions in medical and health care budgets.* Medical educators have to teach and provide health care with much more limited resources.
- ◆ *Increased set of ethical questions.* These range from handling of genetic information to the question of who can give us consent and what kind of consent is appropriate. Conflicts abound regarding abortion, genetic research, the use of fetal material, patient resuscitation and alternative medical therapies. Many academic institutions have instituted expanded ethical efforts to assist physicians in weighing these formidable and sensitive issues.

### **Recommendations for the Future**

Future medical students will need to have a high degree of flexibility in their personal styles; an ability to work with other colleagues; a comfort level with not having exclusive or overwhelming authority; a desire to help; an interest in working in the patient's best interest; a willingness to work with diverse segments of the population; and an ability to understand technology and keep up with changes.

We have record numbers of students entering the health professions. We must do everything we can to make the field attractive and protect against the negative aspects of oversupply. We must re-energize the natural and critical alliance between doctors and patients. This will protect against the giant corporations dictating the pace of change in our health care system. As many business elements impact the health care arena, the quality of care is at times competing with the need for economic efficiencies and the need for medical institutions to maximize their profits. Clinicians working with patients and their families can work together to prevent economics from being the only criteria that determines the quality of care received.

Medical students should recognize that they are entering one of the most extraordinary and gratifying of careers. They are privileged to be doctors. Medical schools should do everything they can to foster and enhance those ideal qualities with which students enter medical school. This is the basis of the Hippocratic Oath. This is an exciting time to be a doctor and a health care professional. However, doctors need to work together with other parts of our society to insure the delivery of quality health service to the rich diversity that defines the American people.

## CHANGING MEDICAL EDUCATION FOR THE 21ST CENTURY

**Henry Foster, M.D.**  
**Professor of Obstetrics and Gynecology**  
**Meharry Medical College School of Medicine**

### **Background**

Dr. Foster is currently a Professor of Obstetrics and Gynecology at Meharry Medical College School of Medicine and consultant to the Department of Health and Human Services. On February 2, 1995, President Clinton nominated Dr. Foster to become U.S. Surgeon General. Although the nomination received a favorable recommendation from the Senate Labor and Human Resources Committee, the nomination came out of committee but was not allowed a vote on the floor. On January 29, 1996, President appointed Dr. Foster as his senior advisor on teen pregnancy and youth issues.

Dr. Foster was previously a Scholar-in-Residence at the Association of Academic Health Centers in Washington, D.C., where he wrote "Gender Shift in the Physician Work Force: Implications for Health Care Reform" funded by the Robert Wood Johnson Foundation. He has held numerous positions with the Meharry Medical College School of Medicine, including Acting President, Chairman of the Department of Obstetrics and Gynecology, Dean of the School of Medicine and Vice President for Health Services. He has written more than one hundred articles on a variety of medical and health topics.

### **Presentation**

In America there is a paradox in access to health care and the delivery of medical services. The U.S. has the best health care providers and the best facilities in the world. This does not however, translate into the best health care outcomes for all Americans. It is important to correct this because equal access to health care is part of the basis upon which democracy stands. While there is a disparity in health care that women and minorities receive in the U.S., those who deliver health care must realize what medical interventions can and cannot do.

There are two major barriers to health care - attitudinal and organizational. Attitudinal barriers reduce the motivation of those who need health care to seek appropriate interventions. These attitudinal barriers are fundamentally cultural. They include superstition, fear, mores, ignorance, fatalism, and isolation. Organizational barriers are systemic impediments for those who are seeking care. They include lack of health insurance, lower incomes, lack of availability of health care providers and facilities, and lower levels of employment. Attitudinal and organizational barriers to health care are interdependent, which is why no medical problem is strictly separable from its socio-economic framework.

The Centers for Disease Control and Prevention's (CDC) prevention estimates show the limitations of purely medical interventions because attitudinal barriers can thwart efforts to improve health care outcomes. The CDC stated that of the ten leading causes of premature death in the U.S. in 1990:

- ◆ 10 percent could have been avoided through improvements in increased access to medical treatment.
- ◆ 20 percent were attributable to environmental considerations.
- ◆ 20 percent were ascribable to biological factors.
- ◆ 50 percent were attributable to individual behaviors.

Of the 50 percent of those who die prematurely, tobacco, sexual behavior, eating habits, sedentary lifestyles, misuse of alcohol and drugs, violence and abuse and other high risk-taking behaviors are the major causes of premature death.

To create better health care outcomes, we must reduce barriers to care - especially those created by health practitioners - and increase health care options. The decline in our health care outcomes is largely a result of a failure to fashion interdependent solutions to providing appropriate health care. This failure shows up in our health statistics:

- ◆ Women in the U.S. rank 16th in life expectancy among industrialized nations.
- ◆ The U.S. ranks between 17th and 20th in the world in infant mortality depending upon what criteria are used.
- ◆ The U.S. teen pregnancy rate of 106 per 1,000 females, 19 years of age and younger, is double that of the United Kingdom, the next highest in the western world.
- ◆ The rate of low birth weight babies for African Americans is four times that of the majority population.
- ◆ Today one in nine American women will develop breast cancer, over two times the rate of the 1960s.
- ◆ Annually, over 100,000 infants die or suffer from birth defects because of sexually transmitted diseases.
- ◆ AIDS is the third leading cause of death among women ages 25 to 44 (according to the latest OWH AIDS Fact Sheet).
- ◆ The rates for anorexia nervosa and bulimia have doubled over the past decade.
- ◆ One thousand three hundred women are murdered by their husbands or boyfriends each year.
- ◆ One hundred seventy thousand women are assaulted in their fifth to ninth month of pregnancy.

Public health interventions can substantially reduce and, in some cases, prevent these conditions from occurring. Population-based public health strategies aimed at heart disease, stroke, fatal and non-fatal occupational injuries, motor vehicle injuries, low birth weight, and injuries and deaths from gunshot wounds suggest that \$69 billion in medical care expenditures could be averted by the year 2000 if appropriate and interdependent health care

interventions are sought and provided.

The following indicates the magnitude of health problems for women in the U.S.:

- ◆ Heart disease kills seven times as many women as does breast cancer each year.
- ◆ Lung cancer now kills more American women than cervical cancer or breast cancer.
- ◆ Half of all women who suffer from heart attacks die within the first year, as compared with 31 percent of men.

While cervical cancer is the second leading cause of death among American women of all ages, it is the leading cause of premature death. While the incidence of breast cancer is lower for African American women than for white women, death rates for breast cancer are higher for African American women. This reflects the failure of educational messages and health care institutions to reach these populations.

Higher incidence of disease is not the only health related statistic that impacts women. Fewer women in the medical and health professions mirrors the lower numbers of medical and health professionals serving these constituencies. This disparity in the health care professions also reflects lower numbers of women and some minorities in the nation's medical schools.

The reason for increasing access for women and minority groups, both in medical educational institutions and to health care services, are both altruistic and pragmatic. Women medical practitioners are more likely to be concerned and sensitive to women's health care needs. The same can be said for minority medical practitioners. However, equal access to medical education and health care is also a moral obligation. It constitutes one of the foundations of a democratic society.

My work "Gender Shift in the Physician Work Force: Implications for Health Care Reform" asks a number of crucial questions we need to address. What is it about health care reform that might make it work? How does health care reform work by gender and by different age groups? What characteristics in the current fee-for-service system have caused our current health care situation? How do different groups view these characteristics?

I do believe the fact that more women are entering the work force will bring about faster health care reforms. However, it should be clear to those who provide health care - especially to the underserved - that the magnitude of our challenge is prodigious. When I think of this challenge, one of my favorite quotes comes to mind: "Nothing in the world can take the place of persistence." Talent will not. Genius will not. Education will not. Persistence and determination alone are omnipotent. The slogan 'press on' has and always will solve the problems of the human race.

## DEMOGRAPHIC TRENDS AND THEIR IMPACT ON HEALTH DELIVERY

**Harold Hodgkinson, Ph.D.**  
**Co-Director for Demographic Policy**  
**Institute for Educational Leadership**

### **Background**

Dr. Harold Hodgkinson is currently Senior Advisor for the American Council on Education and a trustee at Hartwick College. He is also conducting research on demographics and education for the Center for Demographic Policy. He was a member of the Overseers of Regents College in New York, 1986-1995. Between 1983 and 1984, Dr. Hodgkinson held a Federal fellowship to study collaborations between business, higher education and public schools. Dr. Hodgkinson has been awarded 10 honorary degrees.

### **Presentation - U.S. Demographic Trends**

We are fast approaching the time in which minorities will be half of our children. That will happen before the year 2025. A majority of these children will be middle-class. Today, 40 percent of households that are black are also middle class. Twenty-five percent of black households now have higher incomes than the average white household. Another part of this trend is that the population growth for minorities is in the suburbs, not in the inner cities. That means neighborhoods today are more likely to be segregated by income than by race.

The U.S. population shift mirrors the north-south movement of the rest of the world. (See Chart A.) During the 1990s, the white, non-Hispanic population declined in 16 Northern and Midwestern states, while 41 Southern and Western states experienced double digit increases in minority populations.

This shift in population has a tremendous impact upon our economics and politics. California, metro Texas, Florida, Arizona, metro North Carolina, Atlanta, and the southern end of the Boston-Washington corridor account for 95 percent of the nation's growth. These areas picked up new seats in Congress and over \$3 billion in Federal dollars. (See Chart B.) There are additional consequences of growth and population depletion. If growth occurs, growing areas need more health care services, for example. The block grant strategy that passed the Senate indicated that for a growing state, the block grant would be increased by two percent because of growth. If a state's population was declining, the block grant would be cut back by two percent because they had fewer people to have services administered to. This means millions of dollars in either increased or decreased aid to state governments.

Minority population growth and redistribution is a large part of this trend. However, we are having a difficult time creating ways to track minority population growth. Prior to 1960, there was no formal term "Hispanic" used by the Census Bureau. White statisticians who needed a way to account for the rapid expansion of non-black minority populations probably created it. However, few Spanish-speaking Americans call themselves "Hispanic". They are Cuban,

Puerto Rican, Salvadoran, Colombian, Mexican American, or even "Latino ", but not "Hispanic". Lumping Latino groups together runs the risk of folding groups like Puerto Ricans - who are the poorest Hispanic group, with Cubans, who are the richest. These groups also have very different cultures.

Two other trends are household movement and the growth of cities across state boundaries. In five years, 103 million Americans changed houses. Some moved to other states. Others moved a relatively short distance. Even short moves put additional strains on social services when the move is outside the original political jurisdiction. These political jurisdictions have become outmoded as a means for distributing services. The state has been the typical dispenser of health and social services. However, population shifts affect multi-state jurisdictions. For instance, "Cleve-Burg" is a single entity across Ohio and Pennsylvania, where Cleveland and Pittsburgh have grown together. Chicago goes all the way around Lake Michigan. Forty percent of St. Louis is in Illinois. The largest metropolitan area in Arkansas is now Memphis. There are many political barriers to the delivery of social services that are making traditional town-city-county-state divisions obsolete.

### **World Demographic Trends**

There were 5.6 billion people in the world as of 1994; 17 percent of them white. The world's population doubles every 43 years. Africa's population doubles in half that time. That's why Africa - and India - will rapidly rise into prominence. Europe doubles its population in 1,025 years. The reason? White fertility rates are below their population replacement levels. That means the world's population will be nine percent whites by 2010. Whites have to start thinking about themselves as a very small minority. "The Birth Dearth" book suggests that white women give up working and immediately go home, get pregnant and have at least two children - preferably in the same afternoon.

Birth rates, however, are only one component of population growth. The birth rate in Africa is actually down from 6.7 births per female to 6.3. In the past, two children would die in or near birth. Now most survive. That's why the population continues to rapidly increase.

There has been a huge drop in birth rates in parts of Asia and East Asia-from 5.7 to 2.3 during the period from 1963 to 1993. In the industrialized countries, the birth rate dropped from 2.8 to 1.7 over the same time period.

Chart C shows that the fight for resources is not east versus west but north versus south. The nations below the equator doubled their populations the fastest. The nations above the equator doubled their populations the slowest. Ninety-five percent of the world's population growth is below the equator. What this means is that the world adds over 90 million people to its total population every year and 85 million of these occur in developing nations.

## **Trends about Women**

Today most women decide to get a job after completing their education. They delay marriage six years on average and childbirth nine years on average. This explains why birth rates have declined. A woman is unlikely to have ten children if she starts having them at age 31.

Women's access to the workforce has also increased. Men's has declined. Here we are talking about able-bodied men. They are not older men who have retired. This explains the growth in female-headed households, the steep drop in household income and the rise in public expenditures to assist these households. The average household income among female-headed households was \$17,000 in 1994. It is difficult raising a child and keeping yourself afloat on \$17,000 a year. That is why these households require public assistance.

There is another trend that is the foundation for the increase in female-headed households.

For the first time in our history, half of the single mothers are unmarried. In the past the "single mother category" was mostly women who were raising a child after a divorce. Now in half the cases, the woman has never been married. That means we are separating marriage from procreation for a large number of people in the U.S. As a result, the numbers of female-headed households has dramatically increased. Blacks are now 47 percent female-headed households and Hispanics 23 percent. The percentage of poverty among children from two-parent households is also rising. But the poverty level for a single woman raising children by herself is rising much faster. For white, black and Hispanic women, there is equal opportunity to achieve poverty if you have a child and raise it by yourself.

## **Trends about Race and Ethnicity**

In this country, the perceptions of white males in power have defined our thinking about race and ethnicity. But they are clearly inadequate today. Who is "black"? Who is "white"? What does the term "race" actually mean anyway? Does it describe ethnicity? Does it describe national origin? Actually, from an anthropological standpoint the term "race," particularly as reported in our Census statistics, is sheer gibberish.

Here is just one example. We have never had a census that had the same categories for race or ethnicity as the previous census. In the 1960 Census there were only white and non-white categories. This is very much akin to being male, or non-male. Or female and non-female from another point of view.

If we hope to build a culturally diverse and equitable society, we cannot continue to cloud our vision with this rhetoric and baggage. These pronouncements on race were themselves often racist and economically advantageous for those who made the definitions. Yet as we approach the 21st century, our nation is still faced with the challenge of redefining who we are and where we are going. Even as the U.S. white population declines, many of its attitudes and perceptions shape the way in which we think about these issues.

If we are to become a truly pluralistic democratic society, we will have to reframe them. That means changing who we are as well. These issues are at the core of our national history and our destiny.

Part of that destiny may have little to do with black-white relations. Half of all Americans are going to be minority by the year 2050. By 2010, we will have a black population that is smaller than the U.S. Hispanic population. To date, there has been little communication, and reconciliation between these groups. Resolving this new spate of issues is one of our key challenges as we move toward the 21st century.

## PRINCIPLES OF CULTURAL COMPETENCE

**Arthur Kleinman, M.D.**  
**Maude and Lillian Presley Professor of Medical Anthropology**  
**Department of Social Medicine**  
**Harvard University**

### **Background**

Arthur Kleinman, M.D., is Maude and Lillian Presley Professor of Medical Anthropology, Professor of Psychiatry and Chairman of the Department of Social Medicine at Harvard University. Dr. Kleinman directed the World Mental Health Report and he has published over 150 articles and co-authored five books. His work includes Patients and Healers in the Context of Culture (1980), for which he won the Wellcome Medal of the Royal Anthropological Institute; Social Origins of Distress and Disease; The Illness Narratives: Suffering Healing and the Human Condition (1988); and Writing at the Margin: Discourses between Anthropology and Medicine (1995). In 1976, Dr. Kleinman founded a journal entitled *Culture, Medicine and Psychiatry*. A physician and anthropologist, Dr. Kleinman has been elected to the Institute of Medicine of the National Academy of Sciences and the American Academy of Arts and Sciences.

### **Presentation**

There is a triangle of perception basic to understanding how culture affects illness and health care. The three dimensions are culture, social experience and our personal experience. Cultural representations are the images that give meaning to our experiences. Our social experiences make us who we are. They include how we identify ourselves, our language, body motions, habits and gestures. The third is the sum total of our individual experience.

However, cultural competence is not about stereotyping. The worst thing that can be done from an anthropological standpoint is winding up saying things like, "All Hispanics with diabetes act this way, or all Native Americans respond to bereavement in that way."

This kind of stereotyping comes very close to racist attitudes. It is the idea that stereotypical behaviors relate to racial characteristics, something that paved the way to the gas chambers of Nazi Germany. However, there are obvious reasons for taking heterogeneity into account.

I directed a report released by the United Nations called "The World Mental Health Report." This report shows that if you look at men and women in low income societies in Asia, Africa, Latin American and the Middle East, and look at the mental health problems, you see that there are distinctive patterns that cross gender. For instance, if you look at the mental health problems of women and men in these societies, there is much more depression among women. This derives from a norm of violence against women. The result is mental anxiety and depression for women in these cultures.

Treating a patient involves the intersection of the culture of the medical practitioner and the medical institution, the culture of the family, and the specific traditions of medical practice that have evolved within a specific culture. As medical educators, we are usually thinking about only one part of culture, the culture of the professional sector in which we practice medicine. Most health care, however, is not given in the professional sector. Most illnesses are identified and treated in the family sector, making the family literally the largest health care provider in society.

### **The Culture of Medical Education: Imposing the Biomedical Model**

Medical education often overlooks its own culture and the culture of those it treats. Medical students are taught that culture is a uniform set of health ideas and practices and that ethnic minority groups are mini-cultures within the larger society. Students are taught that these minorities have shared practices and ideas that impact medical treatment. What medical students are often not taught is that biomedical culture and their own instilled cultural biases as medical practitioners affect the dispensation of health care.

In most medical schools, biomedicine is considered outside of culture. Nothing could be further from the truth. Medical institutions infuse their culture in their faculty and students. Science itself is a part of culture. The greatest effect of culture on health care is not the culture that the patient brings and not the culture of the family. It is the culture of biomedicine itself. It pervades our practice of medicine and includes the things we take for granted.

From the standpoint of the medical educator, this is frustrating. It suggests that even if we can train medical students effectively to make them culturally competent, the likelihood is very low that they will be able to practice cultural competence given the nature of the current structures of care we have created. That is because within our medical schools there is a fundamental divide between what is taught and the skills that doctors really need to successfully practice medicine. This divide is caused by obeisance to "hard" science and a lack of regard for "soft" science - many of the skills doctors need to work in the real world. It is our own methods of teaching that produce this dichotomy, a gap that we are finding difficult to bridge.

Here's an example. In their medical training, doctors are shown epidemiological data for a particular disease. Then they are shown a picture of the disease. Histological slides follow. Then electron micrographs follow. Students are told that this is the disease pathology. However, this is a grand cultural tautology. It reinforces the fundamental error of "scientific" reductionism: that biology is the bedrock of medicine. Everything else including politics, economics, and culture does not really count. That is why the real world is a shock to many medical students. A sick person comes to us with his or her own world of personal experiences. These are not neat and tidy like the physical sciences taught in the classroom. We must put the illness experience back into the disease process and take into account the patients' world. If we do not, we risk reaching a dead end in our health care practice and in how we teach medicine.

### **Teaching Cultural Competence**

Many medical schools train their students to take a course on social and cultural history of medicine. What we actually teach them is that they will never use this information and these techniques in actual practice. So how do we teach cultural competence that can be useful to medical practitioners? How do we go beyond the simply politically correct idea that we should be sympathetic or sensitive to culture?

For some medical students, we do not. There are about five percent that I like to call "cultural red necks". They came to medical school to become surgeons. There is nothing you can teach them, no matter how good you are. I generally see them in the back of the room reading The Wall Street Journal. I tell them that as long as they read The New York Times, they can stay in the room.

About ten percent of the class I call psycho social. They basically came in with a background of social sciences and the humanities. They want to learn more about culture and medical practice. They need enrichment even beyond their course work. About 80 to 85 percent of a class are the ones you are targeting. They have no views about the importance of culture in the treatment of disease and can be taught to take steps to include culture as an important factor in their treatment of disease. For this group, we teach nothing but process - that is, the process of what we do as doctors and how it is influenced by culture.

I was part of a group that put culture into the DSM IV, a task force on culture and ethnicity for the American Psychiatric Association and the National Institutes of Mental Health. We developed an outline for cultural formulation and this is a very good place to start to develop a practical methodology for taking cultural concerns into consideration in the practice and treatment of disease. There is a straight forward way that one can get at what matters most in any illness encounter. For this purpose, I devised a simple set of questions to ask patients. These include:

- ◆ What do you call your problem/your troubles?
- ◆ What name do you give it?
- ◆ Why do you think your illness started?
- ◆ When did it begin?
- ◆ How severe is it?
- ◆ What do you fear most about your illness?
- ◆ What are the major problems your illness has caused?
- ◆ What kind of treatment do you think you should receive?
- ◆ What are the most important results you hope to achieve from your treatment?
- ◆ What do you fear most about your treatment?

We have to find out if culture is relevant with regard to the patterns of ethnic practices of patients and families. Answers to the following questions can provide some rules of thumb:

- ◆ Does the person have an immigrant or refugee status?
- ◆ Is there little or no formal education?
- ◆ Is there little or no context for understanding western medical practice?
- ◆ Is the patient from a rural area?

None of these criteria is a determinant by itself as to whether the patient may be impacted by cultural concerns. But the answers may give the student and/or the medical practitioner a sense of whether or not culture is going to be behaviorally significant in the treatment process.

Blind or stereotypical application of answers to these questions can surely backfire. Years ago, I trained Harvard medical students to systematically engage the culture of their patients and to ask questions related to the patient's culture. One patient was an older African American man. The medical student asked the patient whether he believed in root work, a set of supernatural beliefs common to poor, rural areas. The problem was that the patient was a graduate of the Harvard Business School and a vice president of one of the largest banks in Boston. That brings us to complex issues of class. Many times when we talk about culture, we mean class. It is crucial to make this distinction. Are we talking about the effects of culture, or poverty, unemployment and limited resources, or are we stereotyping patients based upon the limitations of our own experiences?

We can and must make culture clinically compelling. If we do not, we are going to fail to convey the importance of culture in medical treatment. We now have a window of opportunity. We need to make the most of it.

## **WOMEN'S HEALTH CURRICULA IN MEDICAL EDUCATION: STATE OF THE ART (Part I)**

**Margo Krasnoff, M.D.**  
**Clinical Associate Professor of Medicine**  
**Hertel Elmwood Internal Medicine Center**

### **Background**

Dr. Margo Krasnoff is an Associate Clinical Professor of Medicine at the Hertel Elmwood Internal Medicine Center at the State University in Buffalo, New York. She currently practices at two urban health centers affiliated with the Millard Fillmore Hospital in Buffalo. Dr. Krasnoff has worked for ten years as a general internist and geriatrician and is an active participant in the National Academy of Women's Health and Medical Education.

### **Presentation**

I would like to discuss several important trends in women's health and medical education. First is the role of increasing numbers of female medical students. The percentage of women entering medical school has continued to rise since 1970, reaching 40 percent of the total in 1993. If this trend continues, by the year 2010 women will comprise 30 percent of all allopathic physicians.

Currently, there are greater percentages of women in residency programs, although none is so striking as in Obstetrics/Gynecology (OB/GYN). In 1970, women were 6 percent of practicing OB/GYNs. In the 1990s, women comprised 50 percent of OB/GYN residents. Recently, a major shift has occurred within OB/GYN, which has modified training requirements to include more emphasis on the primary care of women.

Women's health is not synonymous with care provided by female physicians. Reaching out to male students and faculty is very important. These students can serve as effective agents of change within their institutions. In addition, community-based care experiences can afford these students the opportunities to explore illness in a much fuller way than when we taught medical students exclusively in hospital settings. There are a variety of innovative and multi-disciplinary women's health clerkships, electives, residency tracks and fellowships that have all been developed within recent years. In addition, women medical students influence many aspects of their classmates, experiences, both inside and outside the classroom. At Dartmouth, the student chapter of the American Medical Women's Association produced seminars focused on women's issues that routinely attracted male students.

Much more information is available today on women's health than in previous decades. Just a few examples include *The Journal of Women's Health*, published by Mary Ann Liebert, Inc., in New York City, is an excellent peer review journal, which has published research about women since 1992. Several textbooks have also been written. These include Primary Care of Women by Lorna A. Marshall, M.D. and Deborah S. Cowley, M.D. (Appleton & Lange,

Norwalk, CT); Women's Primary Health Care: Office Practice and Procedures edited by Vicki L. Seltzer, M.D. and Warren H. Pearse, M.D., (McGraw-Hill, Inc., New York, NY); and Primary Care of Women edited by Karen I. Carlson, M.D. and Stephanie A. Fisenstat M.D., (Mosby, New York, NY).

There are a growing number of conferences and courses of study focusing on women's health, including The American Medical Women's Association, The Harvard Medical School's course of primary care of women, The University of California at San Francisco's annual course on women's health and others. Practicing physicians can increase their knowledge about women's health care through course work available from these and other institutions.

The increased numbers of women physicians in practice have made their impact on research and clinical care. One consequence has been a concerted effort at the national level to increase research on women's health. There is also a greater awareness and promotion of women's health among medical institutions. Unfortunately, while there are growing data on gender differences and women's use of preventive services and doctor-patient communications, there is little information on the role and affect of women as medical educators.

In 1993, Janet Bickel of the Association of American Medical Colleges (AAMC), published a superb monograph on women's medical programs, "*Building a Stronger Women's Program: Enhancing the Educational and Professional Environment*", (Bickel J., Quinnie R., AAMC, January 1993). This article includes information on women health professionals and information on which medical schools are developing women's health curricula. In 1995, the AAMC also sponsored a conference on educating medical students about family violence and abuse. The proceedings from this conference have been published in the November, 1995 issue of *Academic Medicine*. These materials can serve as a blueprint for those who wish to expand their programs in issues related to women's health. The American Medical Association published a series of pamphlets on domestic violence and it also devoted a special issue in *Journal of the American Medical Association* (JAMA) on this subject.

Mainstream medical journals have also increased their recognition of the importance of women's health issues. In 1995, the New England Journal of Medicine published a clinical problem-solving exercise focused on domestic violence entitled "A Traumatic Experience" They have also published a review article on the care of women who have been raped. These and other articles influence our students' and residents' perceptions of the importance of women's health and our ability to include information on women's health in medical school curricula and in other areas.

The National Academy of Women's Health Medical Education (NAWHME) is another resource. In 1994, the Medical College of Pennsylvania and the American Medical Women's Association formed a partnership to create NAWHME. Under the leadership of Drs. Glenda Donoghue, Sandra Levinson and Lila A. Wallis, this organization is infusing women's health into all phases of the medical education curriculum - undergraduate, graduate and post-graduate.

The participants in NAWHME include directors of women's health medical education

programs, educators who have experience with gender-related education and representatives of medical organizations and regulatory commissions which are responsible for medical education. NAWHME recognizes that in every school there is a different way to organize the curriculum as well as how to update it and change it. The organization published a manual called "Women's Health in the Curriculum: A Resource Guide for Faculty" (NAWHME, 1996).

This includes descriptions of model programs, sample curricula for all levels of study and strategies for overcoming institutional logistical barriers.

The creation of "what-if" role playing, pioneered by Dr. Sandra Levinson, is one technique that can be used in almost any medical school classroom. Through the use of questions, students can think about how a treatment, technique, or a disease can affect women. For instance, students can be asked, "what if the disease you are describing occurred in a woman?" And then a series of other questions like, "How would the presentation differ? How would the course of the illness, its therapy and your management of the treatment process change?" In this way, students can begin to consider disease treatment from different perspectives and faculty can include instruction related to women's physiology in their courses.

## **WOMEN'S HEALTH CURRICULA IN MEDICAL EDUCATION: THE STATE OF THE ART (Part II)**

**Janet Henrich, M.D.**  
**Associate Professor of Medicine**  
**Yale University School of Medicine**

### **Background**

Dr. Janet Henrich is an Associate Professor of Medicine at the Yale University School of Medicine. She has worked at the National Institutes of Health on the development of model curricula for women's health education for integration into medical school curricula.

### **Presentation**

Over ten years ago, the U.S. Public Health Service published the landmark definition of women's health. The U.S. Public Health Service task force defined women's health as diseases or conditions that are unique to, more prevalent, or more serious in women. These diseases also have distinct causes, or manifest themselves differently in women, and have different outcomes and interventions.

This biomedical model has limitations. The Council on Graduate Medical Education (COGME) recently published a report entitled "Women and Medicine," which assesses the trends in the physician work force, as well as trends in undergraduate and graduate medical education and made recommendations to the Secretary of Health and Human Services and Congress.

The report is divided into two parts. The first part is "Physician Education in Women's Health," which is the conceptual framework for thinking about the curricula in women's health. The second part is the development of academic programs in women health. This work identifies the most important health concerns for women in the U.S. It also provides insight into the complex nature of the way women receive care and the content and provision of that care. It examines how physicians are trained to address women's health concerns and describes the limitations of care to adult women. Here are its most important findings:

- ◆ There is a lack of uniform standards of care in women's health.
- ◆ Traditional models of medical education and practices do not adequately address the health care needs of women.
- ◆ Curricula reform and the establishment of innovative academic programs in women's health are essential to changing both the way physicians are educated and how women's health care is delivered.
- ◆ Family practice and internal medicine provide the most comprehensive care to the largest number of women patients.
- ◆ Many physicians in medical subspecialties provide some generalized care to women outside their subspecialty focus.

One of the guiding principles of the COGME report is its advocacy for a change in the paradigm for how medical education and clinical programs for women are delivered. These principles extend women's health beyond the traditional biomedical model and stress the co-equality of the medical, social and emotional needs of women. In addition, the interdisciplinary nature of women's health care is stressed, as well as the participation of women in their own health care decisions. The impact of increasing the number of women health care professionals is also considered.

### **Recommendations for Changing Medical Education**

There are several strategies that we can use to bring about these changes. One, our educational philosophy needs to be re-examined and the content of women's health curricula needs to be redeveloped. The longer that I am involved in women's health and in medicine, I am more and more convinced that it is not just knowledge that we must impart to students. What is as important is the setting in which they learn and passing on our experiences. In addition to restructuring or enhancing existing medical curricula, different clinical models are needed to enhance care for women and to provide better training opportunities for residents and students.

There are several keys that must be addressed if this restructuring is to be more than superficial. The new medical paradigm must be fully incorporated into the teaching programs of our medical institutions; and practitioners who are trained in this way must be accessible to women from all socio-economic status and strata. In addition, we must develop new medical faculty members who have the ability to view women's health issues broadly and creatively and who can serve as role models and advocates to advance women's health research.

## INCORPORATING WOMEN'S HEALTH AND CULTURAL COMPETENCE IN MEDICAL EDUCATION

**Ana F. Nuñez, M.D.**

**Assistant Dean of Generalism and the Community**

**Allegheny University of the Health Sciences College of Medicine**

### **Background**

Dr. Ana Nuñez is currently the Assistant Dean of Generalism and the Community at Allegheny University of the Health Sciences in Philadelphia. Her educational responsibilities include: second year coordinator for the Women's Health Education Project in the Program for Integrated Learning; Course Director for the Women's Health Education Project in the Program for integrated Learning; Course Director for the Introduction to Clinical Medicine course. She has developed and delivered cross-cultural educational training experiences for numerous health professional students and faculty. Additionally, she serves as an advisor to students considering primary care careers.

### **Introduction**

Medical schools have been described as bastions of conservatism. However, my experiences at Allegheny leads me to believe that revising medical curricula to include cross-cultural and gender based issues is do-able. We can be catalysts of change. It is therefore vital that we maintain our focus. The delivery of health services to women and minorities must serve to reinforce, even to our most neophyte practitioners that issues of gender and culture are important. It must become second nature to consider them. This is necessary so that practitioners, will have the skills, expertise, and experience in providing medical services in multi-cultural and multi-gender environments.

As agents of change, I think it is very important that we understand our own classism and racism. What we think and how we act influences the changes we are trying to enact. In addition, we need to shift the paradigm of our medical practice and education from illness to wellness - from intervention to prevention.

Cultural diversity began at Allegheny when it was Hahnemann University in 1992 with a university-based initiative. From the beginning, a multi-disciplinary approach was developed and the curricular changes are now integrated throughout the medical education program.

### **The Allegheny Model**

There are six steps to successful curricular integration and implementation:

- ◆ *Top Down and Bottom Up Support.* Buy-in must be gained from both the newest, least experienced with cultural/gender issues faculty member and from the dean.

- ◆ *An Accurate Needs Assessment from Faculty.* Need is defined as the difference between what is and what ought to be. Inventory must be made of what current resources are available and what faculty perceives to be necessary.
- ◆ *Formation of Teams.* Bring together people into workgroups, including experts and the people who will be responsible for implementing the changes. Integrate basic science faculty with clinicians and teachers with students.
- ◆ *Maximum Utilization and Extension of Resources.* Look within your institution for resources which may be underutilized such as grant writers, public relations people, and affiliated personnel.
- ◆ *Identify the Power Base of Change (both Internal and External).* Gain support from committees and personnel responsible for curriculum. External agencies, including managed care organization, regulatory groups, and public and private foundations may also influence decision making within your institution.
- ◆ *Integrate Change Within the Current System.* Learn how your institution functions and adapts to change. Work within this process, be persistent and flexible.

I would like to share with you some of the progress made under the strong leadership of the Dean and Provost of Allegheny in making advances in incorporating women's and minority health into our curriculum. We have been successful. There are women in the senior leadership of our medical school. Our new dean is a woman. Resources have been brought to bear to bring about change in curricula. There is a centralized educational oversight process to facilitate change. These changes have been phased in over a period of time that people within the institution can handle. This was most easily accomplished within the problem-based learning program - itself a novel idea. Our planning process has included goals and objectives which have included the addition of courses and material focusing on women's health in the more traditional medical school track. This includes, but is not limited to, lectures on domestic violence, breast cancer, reproductive options, and workshops on cultural diversity.

This work was not accomplished without resistance. The feasibility of making these changes was one of the first areas we considered before we pushed for implementation. These changes were successfully made because we had leadership from the top and persistence from those of us who believed that these changes were critical to prepare a new generation of medical students.

People ask: How do we get these changes into a curriculum? I reply that it is like giving birth. In a real sense, those involved in the process are giving birth. This birthing process requires the implementation of a host of changes throughout the institution and for most people, the labor of change is difficult. And then, as the process occurs, there must be monitoring of the progress. This pre-natal care not only allows adjustments as problems occur, but time for the family to adjust to the arrival of change. And family in this case, may include everybody from administrators to faculty to students to the community.

We must find the ability to refocus our zeal into relevance. By this, I mean really under-

standing your institution and how to negotiate changes throughout it. It is good to have energy and be boosters for a cause; however, we need to channel our enthusiasm. We need to work with administrators and faculty members. We need to hear and understand their assessment of the risks involved in making changes. We must address their concerns with appropriate facts and information on how to make these changes possible in the real world. We must also provide examples of results and benefits.

This may be accomplished by developing clinically compelling curricula. It requires the development of multi-disciplinary teams from across the institution and/or outside the institution. By including all members of the family, we all have a stake in and contribute to curricular change. At Allegheny, there was a decision to increase the market share of female patients, which enhanced the role of women's health within the medical school and addressed special concerns of women in the hospital environment.

I need to stress that one of the most important person on your team will be your political insider - that key individual - or individuals - who knows how to negotiate the system. This is the person who understands the structure of the institution, the personalities within it and its resource stream. This person is critical in convincing leadership of the need for change and can assist in streamlining some of the decision-making processes.

Finally, we have heard today that the essential elements in creating change are persistence and passion. I would add to that power - the power of many. I said in my introduction that medical schools have been described as bastions of conservatism. They are. In order to move them, you have to apply pressure from the top and the bottom. Those of us who are change agents need to be aware of the entire process as we create change -important resources, the need for diverse points of view, and the power base - department chairs, course directors, and residency directors. Resources are a very important part of this process - recognize the people who can be critical to your success - including the people you would not normally think of. Making these changes is not easy. But they are necessary if we are to prepare our students for the rapidly changing world around us.

## **CULTURAL COMPETENCE AND WOMEN'S HEALTH CURRICULA IN OSTEOPATHIC MEDICINE**

**Barbara Ross-Lee, D.O.**  
**Dean, Ohio University**  
**College of Osteopathic Medicine**

### **Background**

Dr. Barbara Ross-Lee was appointed Dean of the Ohio University College of Osteopathic Medicine in 1993, the first African-American woman to head an American medical school. She was also the first osteopathic physician to participate in the Robert Wood Johnson Health Policy Fellowship. She has served as legislative assistant for Health to former New Jersey Senator Bill Bradley. After receiving her doctorate in Osteopathic Medicine from Michigan State University College of Osteopathic Medicine (MSU-COM) in 1973, she ran a family practice in inner city Detroit for ten years. Dr. Ross-Lee then returned to MSU-COM where she was appointed associate dean for Health Policy.

In 1994, U.S. Health and Human Services Secretary Donna Shalala, appointed Dr. Ross-Lee to a four-year term on the National Advisory Committee on Rural Health. She also serves on the Institute of Medicine's Committee on the Future of Primary Care. A commissioned Captain in the United States Naval Reserve, Dr. Ross-Lee is a Diplomat of the American Osteopathic Board of Family Physicians.

### **Presentation**

This presentation is grounded in an osteopathic perspective, which means it emphasizes structure, function and outcomes in health care. I am also going to talk about vulnerable populations and how they relate to the culture of health care. Some of my observations will be personal.

In my first year of medical school, my class received a lecture from a clinical faculty member on the diagnosis and treatment of gynecological problems. The only other female student in the class challenged him on several points. The mind set of this practitioner was that all knowledge resided in him and that we were there merely to listen and soak up the "knowledge".

Six years later, I met the same lecturer at a conference. I remembered one patient and asked him about her. She was a 17 year old unwed mother who was pregnant again. After the birth of her fourth child, this doctor inserted an IUD in her without her knowledge or consent.

I have had similar personal experiences. Because of two premature pregnancies, I sought out the most noted expert in high-risk pregnancies in the State of Michigan. One evening, I felt some pain and explained to this eminent doctor that, as a family physician who practiced obstetrics, it was my assessment that my fluid had the odor of amniotic fluid and that I really

wanted him to check. He refused. He explained to me that this could not be the case and that I was just being a little anxious. Four hours later, I was septic and my child was stillborn.

I am not sure that the outcome could have changed. However, this doctor's mind set prevented any other outcome. If I, a family physician, could not prevent this from taking place, what happens to indigent women who are not sophisticated about medical practices? The unfortunate truth is that my experience is not uncommon. Women have frequently been described as a health-vulnerable population. This vulnerability is built into the structure of our health delivery system.

### **Changing The System Will Not Be Easy**

Our culture and the resulting deficiencies in the structure of our health care system make the job of change difficult. Major deficiencies include:

- ◆ First access to our current health care delivery system is often dependent on economic status. This is particularly important for women and minorities because they are disproportionately poor and under insured.
- ◆ Second, our health system's traditionally focuses on reproductive issues as the only issue of importance in women's health. It was not until 1985 that women's health issues were comprehensively redefined at the national level. We owe Margaret Heckler a debt of gratitude. As Secretary of Health and Human Services, she brought national attention to women's health.
- ◆ The third structural deficiency in our health system is that our priority is disease reimbursement with minimal access and minimal opportunity for preventive services. This has significant impact on morbidity and mortality rates for women.
- ◆ Our fourth deficiency is the lack of research in women's health. This leads to therapeutic interventions. NIH studies did not incorporate women sufficiently until 1990. Its first female director, Dr. Bernadine Healy, stimulated the inclusion process.

Over the past ten years we have made progress. We have more and better information and about diseases and conditions that affect women. We have seen greater availability of preventive services, like pap smears and mammograms. We also have a greater inclusion of women in biomedical, biological and behavioral sciences. We have more women entering the traditionally male health professions. In addition, Medicaid and other programs have expanded their access to women and children.

The U.S. Public Health Service's Office on Women's Health, the Health Resources and Services Administration (HRSA) and the National Institutes of Health Office of Research on Women's Health have spent the last two years assessing our medical education curriculum. They have collaborated with the American Medical Women's Association (AMWA) and the National Academy on Women's Health Medical Education (NAWHME) in the development of a new women's health curriculum.

### **Integrating Cultural Competence into the Medical School Curriculum**

Significant challenges still exist and need to be addressed. One challenge that confronts us is the integration of cultural competence and women's health curriculum into our medical education system. We all know about the difficulties in trying to get new content information into our curricula. This is being achieved, but slowly. We must pay attention to how this new content becomes integrated into medical curricula.

By curriculum integration we do not mean tokenism. A few years ago, The State of New York mandated legislatively that all medical students have at least four hours of minority health integrated into their curricula. Many students took this four-hour course at the last minute. This is not what we mean by reinforcement. In order for any curriculum component to be effective, it must be continually reinforced and a component in field training.

There are several other essential areas in which we need to improve, rapidly:

- ◆ *The development of role models.* We need to be prepared to deliver some faculty development or we may wind up losing all of the gains that we have established. Our role models need to be cognitively- and skills-competent as well as culturally sensitive. We must make sure that these competencies are realized in real work environments in practical clinical environments.
- ◆ *Conscious examination of our own medical culture.* We must recognize that we are all victims of our socialization process. We need to find new ways of working with other health professionals and patients to overcome our limitations.
- ◆ *Inclusion of practical opportunities to experience the impact of culture on the treatment process.* Cultural sensitivity or cultural competency is not just what we say, but what we do. Students and practitioners need to work in a variety of culturally diverse settings, in order to learn how to apply cultural diversity in real life settings.

### **Changing Medical Institutions: Opportunities and Challenges**

There are changes going on in the fabric of our medical educational infrastructure. These changes will allow us to be a part of the reassessment of the medical schools' mission as our health care delivery systems change. We are in an era in which workforce strategies will be funded to support learning about cultural sensitivity and cultural competency in the medical environment. Managed care organizations are other settings in which we need to show how cultural competence affects the realities of medical practice. Where is it more appropriate to integrate the objectives of cultural competence and women's health than in these new environments? They are supposed to expand access to care, improve quality, and contain costs. Making these changes is imperative because women are frequently more vulnerable to gender bias resulting in poorer health care. Women also interact with the health care providers more frequently. We take more medications and our overall health status is worse in terms of disability, morbidity, and chronic illness. We must continue to work harder for substantial changes in our health care system - especially in an HMO environment. We cannot allow short-range cost capping to replace longer-term quality of care. If we do, we will have lost the gains of the last decade.

## CULTURAL COMPETENCE FROM A MINORITY PERSPECTIVE

**Dyanne Affonso, Ph.D., F.A.A.N.**  
**Professor and Dean**  
**Neil Hodgson Woodruff School of Nursing**  
**Emory University**

### **Background**

Dyanne D. Affonso, Ph.D., is a Dean and Professor at the Neil Hodgson Woodruff School of Nursing, Emory University and associate professor in the Women's and Children's Division of the School of Public Health. Beginning in the late 1970s, Dr. Affonso conducted research exploring women's experiences with childbirth. Her publication of these important findings resulted in national recognition of her contributions to perinatal health care, including her appointment as the first nurse to serve on the Advisory Council of the National Institute of Child Health and Human Development (NICHD) at the National Institutes of Health (NIH). In this capacity, she was an active participant in the 1980 Consensus Conference on Vaginal Birth after Cesarean, which led to major changes in obstetrical philosophy and practice regarding methods of childbirth. She is the first non-Nordic citizen to be appointed to the Scientific Council of Sweden's Nordic School of Public Health and has been elected into the National Academy of Science's Institute of Medicine and the American Academy of Nursing. Dr. Affonso has served as a reviewer for leading journals on women's health issues and is the author of numerous publications, including Childbearing: A Nursing Perspective which won an American Journal of Nursing Book of the Year Award.

### **Presentation**

I would like to share my work with you concerning post-partum depression and use it and other work to show how culture affects the health care women receive. When I first looked at post-partum depression, clinicians viewed the disease as, "You are either depressed or not." They viewed women as "hunting for a disease."

The British said the level of depression in their population was over six percent. The Americans said the level of depression in the U.S. population was between ten and twelve percent. However, we forgot to look at the experiences of women across the gestational period. Consequently we missed seeing that the symptoms of depression are very much parallel to symptoms of pregnancy.

We do not have post-partum care in this nation. The message is made clear by our health care system to every woman who has a baby. The system says, "You are on your own." There is no time for women giving birth to adapt or cope. You birth your baby. You go home and you are on your own. My article in the "Journal of Women's Health " said we need to look at what it is we are trying to study. We cannot do that without listening to the voices of women.

There is no prenatal care in this nation either. All we have is obstetrical care. Medical institutions tell you to come in and you will receive all this science and technology for what is growing in your womb. Never mind about what you are feeling and thinking during the time your baby is growing.

We do not have first trimester care either. My work with ethnic women says that the first trimester is a very active time. Women make lots of decisions about themselves, such as continuing to smoke or using drugs or taking better care of themselves. It is not enough to only talk about self-esteem and individuality. Women need cooperation from friends, family and community during these times.

With gravid women, it is not only the pregnant self that they have to deal with. Women are pregnant in relation to their family and the society in which they live. That is the real issue with women's health. Women are not just breasts. They are not just their pregnancy. All of what a woman is affects both her treatment and healing processes. Ideally, a woman's environment supports her healing - that is her society, community and family. Often this is the case.

### **Research and Women's Health Care**

Principles of preventive science incorporate the best of scientific knowledge and have to include prospective longitudinal investigations and care giving approaches. Cross-sectional studies in women's health are no longer sufficient. We need to follow people across time because we need to learn about human adaptation and developmental processes.

Using these methods is not standard in medical, nursing and biomedical curricula because we have been hunting diseases too long. As soon as we find a disease, we think it is okay to stop our research. The best example of "disease hunting" I can think of relates to childbearing in the U.S. At one time, six weeks post-partum was the marker for evaluating a woman's health during pregnancy. At that point the status of a women's uterus and ovaries was evaluated. We thought women had fully adapted to their condition and we stopped hunting for diseases. No wonder post-partum depression was on the increase in our society! We forgot that women have to go back and live their lives with their men, families and communities.

My work with white, upper class women in San Francisco has shown that women need time to tell their stories. They need to put things together in a meaningful whole. No wonder we need those prospective longitudinal approaches. Not only for research, but for the development of innovative practice models as well. You have to follow women over time to really understand their decision-making processes. This is something that medical research hasn't really been committed to.

One of the most important things I have learned is that if you want to go beyond simply sensitivity to issues, appropriate public policies must be developed. Public policy works toward the common good and takes into consideration the best of science and knowledge we have. If we are successful, the public policies we develop will set guidelines for curriculum content gain recognition for innovative practice models and research designs and infuse

medical education with a new vision of itself. It will also allow us to provide better care for millions of people.

### **Culture is the Key to Developing a New Health Paradigm**

I am currently studying cultural healing systems. What I found is they have commonalities. In Hawaii, we have hoho pono, a beautiful system for working out anger and frustration. As a result the family can come together in reconciliation. Filipinos have the aragallo and the Japanese have the noconuiti.

They all include rituals and symbols to maintain harmony and balance and ways to reconcile personal conflict. In our current medical paradigm, we do not pay much attention to the lessening of conflict. We search for symptoms of diseases by passing something very important, a patient's reconciliation process.

Each culture has its own ethical foundation. Each has a means for "beneficence," that is, doing good. Each culture practices justice. Each has something called doing no harm - the essence of our own medical practice. You cannot do good if you do not know the definition and practice of goodness. However, the definition of goodness lies outside the individual. It is defined by society. These basic definitions play critical roles in a society's view of "health" and "medical practice".

What we need are new partnerships between the medical community, patients and other institutions because "goodness" does not come from the nurse or the doctor alone. It comes from others within a cultural group or community.

In our society, we knew very little about the people we treat for illness. Out of our own arrogance, we doctors define "health" completely out of the context of the communities in which our patients live. We use databases of statistical information and technology in place of empathy. How can we "do good" if we ourselves don't really know what that means? Indeed, we may be doing harm if we force individuals to conform to medical practices and ways of being that are at odds with their own cultures. We need to combine our excellent technology and scientific knowledge with a more holistic vision of what patient care means.

What we also are not doing in our model for health care and in our curricula, is exhibiting a passion for medical practice. Too many of our young doctors are absorbed in making money. Money is good, but where is the passion for medicine? If it doesn't come from a real desire to provide service to other human beings, all of our technology and science are in vain.

Finally, it is the energy of passion that will guide us to new pathways into the next century. Morbidity and mortality rates and length of stays in hospital are simply not enough. The voices of our patients and patients yet to come are crying out to be heard. You know why we do not hear them? Because they cannot rise above the din of our machinery and the clutter of our hubris. But they are there. And they are not hard to find. Once we find them, we will truly have moved to the next level of medical practice. That is, a practice of medicine in which we combine our technology and knowledge with a true compassion for the people we serve.

## **CULTURAL COMPETENCE FROM A MINORITY PERSPECTIVE**

**Gerald L. Hill, Jr., M.D., Director  
Center of American Indian and Minority Health  
University of Minnesota Medical School  
Minneapolis, Minnesota**

### **Background**

Dr. Gerald Hill, Jr. is currently the Director of the Center of American Indian and Minority Health at the University of Minnesota Medical School. He is also the Director of the University's Center of Excellence, Assistant Professor of General and Preventive Medicine and Adjunct Assistant Professor of the Institute for Health Services Research.

A Klamath Indian from Southern Oregon, Dr. Hill was selected as a Robert Wood Johnson Clinical Scholar and served at the University of California at San Francisco and Stanford University. Since 1985, his primary mission has been to improve medical education for American Indian medical students as well as increase the number of American Indian people entering health careers.

### **Presentation**

Many Native Americans want to become physicians to serve our communities. To achieve this goal, we must go through one of the most intense cultural immersions in existence – medical education. In my opinion, the medical education system has been designed to serve one group of people – those who fit into “the system.” The medical system has little patience for those who do not “fit in”.

Most medical schools do not provide opportunities for us to learn how to deliver services to our communities. Where is there a forum for asking non-biomedical questions in medical school? Where is there a forum to ask critical questions about the relationship between Western-style medicine and traditional Indian medicine? How can we talk about spirits, healing ceremonies or other issues vital to the health of our communities without risking the wrath and ridicule of those who are limited to Western views and medical practices? During my medical school years, I received a total of one hour on Indian health. Because I went to medical school with the intention of practicing medicine in an Indian community, I was forced to seek out experiences which would prepare me to care for Indian people. Even as a first year medical student, it was apparent to me that medical school was not a culturally neutral environment. It is geared to training physicians to work with white middle class populations.

As we move towards integrating cultural and medical practices, we need to develop models of care that respect the culture and traditions they serve.

### **The Health Care Delivery System and Native Americans**

Why is there an Indian Health Service (IHS)? There are no Hispanic nor African American nor Asian American Health Services. The answer lies in the history and present political status of

Native Americans. When the United States consumed our nations, the Federal government took over certain obligations toward Native American nations under a variety of treaties. This political status was the legal foundation for the creation of the Indian Health Service. Reliance on the Indian Health Service, however, does not move us toward cultural competency. We have a "new" model of health care service for Native Americans. This "new" model, which has actually been around since 1976, is based on the partnerships between Indian tribes and outside health care providers. Tribes throughout the country are now contracting with the Federal government and other providers to deliver health services to our populations. This gives us more leeway and leverage in how we use our resources. The result is that the use of our funding is largely in our own hands, as opposed to what somebody in Rockville (the Indian Health Service) may feel we need.

### **The Cultural Isolation of Indian Medical Students**

In 1991, I wanted to develop a cadre of physicians who could take what they learned in their practice back to their communities. This is a different idea from the National Health Service Corps model, which is basically an incentive to get medical students who have federal loans to spend a couple of years in underserved communities. They leave and the cycle of lack of care begins all over again. That is really the way we have been providing services to most minority populations for many years, instead of adequately training people to serve these communities. I moved to Minnesota after my medical training because the University was willing to let me develop programs that would address the specific issues and needs of cultural competency.

People forget about the many things students from other cultures have to deal with. They are trying to master biochemistry, physiology, anatomy, pharmacology, pathology and everything else. They are being immersed in a foreign culture while they are bombarded by a tremendous amount of work. They are largely cut off from their communities. By the time we finish medical school, we know more about serving middle class whites downtown than we know about the practice of medicine in Indian communities. To combat this in the first years of medical school, we offer a deceleration program where students can study for three years instead of two years. There are a couple of reasons for this. One, many of us enter as educationally disadvantaged students and have difficulty taking a full-time medical school curriculum. Two, there really are some cultural factors that we need to deal with; forget about how many things students from other cultures have to deal with.

When we leave our communities to go to college, we leave not only physically, but also socially and culturally. We spend four years away from our communities and then we go to medical school. Not only are we often times totally physically isolated from our communities, but we are also culturally isolated because of the overwhelming nature of medical school. After medical school we have been away from our communities for a total of eight years, and after we complete our three to five year residency programs, we have been away from home between 11 to 13 years. Then we are expected to somehow be able to go back and work within our communities as if we had never left. Think about it, we were adolescents when we left and we spent almost our entire adult lives in schools, immersed in a culture unlike our own. We have changed as people because we have had no continuous direct contact with our

communities for over a decade.

My concern is that we are not training enough physicians to care for Indian populations. There was also the assumption that because we were Native American medical students and came from Indian communities, we automatically knew how to translate western medicine into health care within the social and cultural context of our communities. But nobody trained us to do it. One of the solutions is to develop medical education programs which do not require this kind of cultural and social isolation. At the University of Minnesota, the students do a family medicine preceptorship in their first year at an Indian Health Center. During the first year, they have access to Indian patients in an Indian community and they get to learn a little bit more about what it is they actually came to medical school to do. During the second year, students do rural reservation rotations where they spend several days working in an Indian medical facility with traditional Indian medical practitioners and with teaching staff.

We also have a structured course in Indian health so students can learn about the Indian health care delivery system. We include traditional Indian medicine in our program. We have a cross-cultural workshop where we take students to meet Indian physicians who work with traditional healers. The traditional healers also visit our students and classes. The students visit the communities and learn how western medicine and traditional medicine interact within the real Indian communities. We also have Indian physician mentorships where we place students in the homes of senior Indian physicians. In addition, almost all of our students complete the Indian Health Service Clinical Clerkship and attend the Association of American Indian Physicians Annual Meeting.

### **Increasing the Number of Physicians Serving Native Americans: The University of Minnesota Experience**

During the period 1988 through 1991, the numbers had not changed much in terms of applications from Native American students. However, after we revised the curriculum in 1991 to include cultural competence, we have more than tripled the number of Indian applicants each subsequent year. Now our admittance class is over 18 percent American Indian. These increases have made a substantial difference in terms of curriculum across the entire medical school. In 1994, every Indian student we accepted chose to come to the University of Minnesota even though they were accepted at other medical schools. I believe offering students the ability to work in Indian communities has stimulated student interest and helped us increase both the number of Indian applications and Indians admitted. To help prove this, I asked students what part of the program influenced them to practice in Native American communities. They answered overwhelmingly that it was those aspects of the program that increased their practical participation in clinical and professional settings. This includes the Association of American Indian Physicians Annual Meeting, our cross-cultural medicine workshop, and interaction with practicing Indian physicians and Indian students. These increases in applicants are not coming soon enough to turn around the terrible health statistics we experience as a people.

### **American Indian Mortality: A National Crisis**

Today, 33 percent of all Native Americans die before the age of 45. This compares to 11

percent for the general population and 21 percent for the African American population. This is a major crisis which needs national attention. But there is a general failure to recognize the proportions of this catastrophe, even in the Indian Health Service and other Federal agencies.

It is critical that we do because within every age group up to the age of 65, Indians have higher death rates than the general population and, for some age groups, we have more than twice as many deaths occurring.

The lack of national attention to this health crisis is alarming. All kinds of health and medical resources would be made available if the mortality rates for any state in the country were 33 percent before the age of 45. Immense public and private resources would be made available. Yet, there is no concerted action on behalf of the American Indian community.

Let's take a brief look at this catastrophe. Imagine what it is like to live in communities suffering from a deluge of health problems that lead to early death. Who takes care of the children when the parents die? What is it like for a community to lose husbands, wives, uncles and aunts and even children at young ages? In Indian women, cancer is the second, accidents are the third, and diabetes is the fourth leading cause of death. These are all preventable causes of death. For Indian men, accidents are the second, cancer is the third, suicide is fourth, and liver disease and cirrhosis are the fifth leading cause of death. Our tuberculosis rate is six times the death rate for the general population; and our chronic liver disease and cirrhosis death rates are three times higher. Diabetes is almost three times the death rate of the general population. The accidents and trauma rates for the American Indian population are two-and-a-half to three times the rates for the general population. These rates vary by tribe and region. For instance, the overall death rate for Native Americans is 700 per 100,000 compared with 520 for all U.S. groups. The Aberdeen region in the Dakotas experiences death rates of 1,067 per 100,000 population.

General statistics, however, mean almost nothing when it comes to the development of regional health and treatment plans. For instance, in the Bemidji area or the Aberdeen area, the death rates from heart disease in Indian populations are substantially higher than for all U.S. populations, although the "common knowledge" is that Indians do not die of heart disease. These mortality and disease rates show why increasing the numbers of physicians practicing in Native American communities is so critical. The Indian Health Service recognized the need for increased numbers of physicians and health workers in our communities. However, if we are to recruit, retain and train the needed numbers of physicians, then according to our experience at the University of Minnesota, cultural competence is no longer an add-on to the medical experience. It must be infused into everything we do.

## **FEDERAL PERSPECTIVE ON CULTURAL COMPETENCE AND WOMEN'S HEALTH CURRICULA**

**Jo Ivey Boufford, M.D.**  
**Principal Deputy Assistant Secretary for Health**  
**U.S. Department of Health and Human Services**

### **Background**

Dr. Boufford currently serves as the Principal Deputy Assistant Secretary for Health in the Department of Health and Human Services (DHHS). She is also the chief operating officer of the United States Public Health Service (PHS). Prior to her appointment, Dr. Boufford served as director of the King's Fund College in London, England. She has also served as president of the New York City Health and Hospital Corporation.

### **Presentation**

The Federal government has invested billions of public dollars in building medication. For nearly 25 years, these resources have ranged from a peak of over \$700 million in the late 1970s to as low as \$100 million in the late 1980s. Because of this public investment, it is both appropriate and necessary to ask some key questions concerning the state of our medical education.

### **What are our key problems?**

They are not new.

- ◆ Under-representation of women, minorities and financially disadvantaged students and faculty in medical schools;
- ◆ Poor geographic and specialty distribution of practicing physicians, particularly in poor urban and rural areas; and
- ◆ The need for innovation in medical school curricula, including the introduction of issues such as primary care, geriatrics, behavioral science, humanities, women's health, cultural diversity and managed care.

These are long-standing problems. It is reasonable and appropriate to ask, "What progress has been made?" We are moving ahead to:

- ◆ Include women and minorities in clinical research for diseases that disproportionately affect women and minorities.
- ◆ Increase the number of women and minority in clinical trials; and
- ◆ Invest more to develop the research infrastructure in institutions serving women and minorities.

In addition, while we must continue to address the issue of under-representation there have been increases in enrollments of women to medical schools. Most of these increases, however,

occurred during the late 1970s and early 1980s, when class sizes doubled. Until very recently, the increases in women and minority enrollments had not exceeded the levels reached in previous decades. Further, the percentages of women and minority faculty are still disproportionately low, especially at senior levels. White males still largely hold top leadership positions. After 25 years of women and minority medical doctors in the pipeline, we ought to be doing better. The Council on Graduate Medical Education (COGME) issued a candid report and in relatively stark language cited clear evidence of gender bias in career advancement for women medical faculty members.

Other continuing problems in our system include specialty and geographic inequities in the distribution and lack of trained personnel in some regions. Efforts to correct this problem have been hampered by the economic incentives in our health care delivery system, which has clearly rewarded hospital-based care and specialty-oriented training and care. Curriculum innovation has still not been initiated on a wide enough scale. We have had innovative courses or programs here and there. But systematic fundamental curriculum change has taken place in only a handful of medical education schools. Mainstreaming these innovations will require the convergence of many groups - the medical boards and licensing bodies, deans and faculty members in our medical institutions, national, state and local medical associations, funding sources, etc. While this is a prodigious task, it is beginning to happen. The effect is to accelerate innovation and the kind of leadership that produces fundamental change in the training of a new generation of physicians.

### **The Future Environment for Medical Practice**

There are several keys that should facilitate the growth of women's health and cultural competency in our medical institutions. They are:

- ◆ *The dramatic change in demographics of the U.S. population.* Blacks, Hispanics, Asian/Pacific Islanders and Native Americans represent more than 25 percent of the U.S. population. Projections are as high as 35 percent or more by the year 2020. That does not include immigration from other countries and other cultures. Hispanics alone, now at around nine percent, are projected to increase to 13 percent of the population by 2010. Those of you from large urban areas in Texas or California know that 50 to 60 percent of those populations are now Spanish-speaking. The increasing number of Asian/Pacific Islanders will enlarge these figures.

Within each of these groups, there is a diversity of customs, languages, health status and illness patterns that must be understood by a new generation of medical professionals and by those who service these communities. It is impossible for well-prepared physicians to practice effectively without having the cultural awareness and competence to understand these patients and how they and their families experience illness. No effective treatment plan or preventive regimen can be developed without these cultural competencies. Since half of these minority populations are women, gender is also a critical concern.

- ◆ *Treating the elderly.* There is an increasing predominance of chronic illness, mixed problems of mental and physical well being, and more complex social problems that need to be considered for effective treatment of the elderly. There will also be an increasing need for longer-term and more effective relationships with patients during both periods of health and illness. The effectiveness of these relationships and the outcome of treatment will increasingly depend on the combined cultural and clinical competence of physicians.
- ◆ *The emphasis now is on primary care.* For a long time we've known that 95 percent of all patients who enter our health care delivery system are cared for in an ambulatory, primary care environment. They never reach a hospital. Yet our medical education has focused on producing doctors that receive most of their training to serve in hospitals. One of the reasons for this is that doctors are in control in hospital settings. Their culture dominates. In a hospital, doctors control the links of the patient to family. Layers of physicians and nurses normally prevent patient individuality. Cultural differences between patients are muted or suppressed because everybody takes their medicine at appointed times, eats the same food and wears the same clothes.

In a primary care setting, the patient is in control. They control when and if they take their medicine, whether they follow a treatment plan or whether they come back for treatment at all. What happens depends upon the understanding and respect between doctor and patient. Doctors need to help remove barriers between themselves and their patients. That's why cultural competence skills are so important.

- ◆ *Managed care, with its focus on prevention, is the real engine for change in the health care delivery system.* Business imperatives fuel changes caused by managed care. Plans must attract members and those members have a strong voice in the treatment and care they receive. The revolution caused by managed care is also generating changes in academic health centers and medical schools that are increasingly dependent upon clinical practice income for financial viability.

While there are many legitimate concerns about managed care systems and potential problems with access and quality of care, there are elements in the managed care system that can be

very positive for promoting cultural competence, greater sensitivity to patients and clinical attention to patient differences.

The "mature market" is an example of how the managed care system focuses on its business imperatives. On the West Coast there are already demands for population-specific health plans. These plans are directly aimed at the health, social and cultural needs of the Hispanic population, e.g., Hispanic health plan; and the Asian American market, e.g., Asian American health plans. HMOs, PPOs, etc., have gotten the message that, if they want to be competitive in a very competitive market, they have to meet the needs of special groups of patients or these patients will go elsewhere.

Managed care is helping to make the revolution in health care because it is focused on preventive care. Prevention is more cost effective than hospital or even community-based treatment of illness. For the first time in the U.S., we also have a model for personal health in which there are financial incentives for prevention.

This is critically important for achieving better health because studies show that only 10 percent of morbidity is a result of the 10 leading causes of death. Many of these deaths could have been avoided through improvements in access to medical treatment. Twenty percent of morbidity results from environmental or genetic factors and 50 percent from behaviors such as tobacco use, high risk sexual behavior, eating habits, sedentary life style, alcohol and substance abuse, and violence.

Nothing is more important to the fifty percent of those whose deaths are caused by changeable individual behaviors than doctors and other health professionals who understand clinical risk factors. These doctors and health professionals need experience developing effective cultural and gender relevant preventive strategies to reach these patients

- ◆ *Patients are also becoming increasingly more active and well informed.* The power balance is shifting from professional to patient and it is critical that doctors learn how to facilitate patient decision-making about their care or face growing antagonism and conflict with patients.

In the U.S., we have always had high patient demand and high expectations of our health care system. In a litigious environment the rule of doctors is usually "*when in doubt treat.*" However, patients have become increasingly better informed. They are questioning the effectiveness of procedures. They want to understand how their doctors rate in terms of quality, effectiveness of treatments and their skill level in treating their ailments. Patients also want to know how hospitals rank in regard to quality of care.

### **The Changing Federal Role**

There will be revolutionary changes in the role of the Federal government in health and social programs and in related congressional actions. These changes will dramatically affect the environment in which new generations of doctors will be practicing and the health of women, minorities and children, many of whom are disproportionately poor.

The size of government itself is shrinking. We have already lost 170,000 Federal employees since the beginning of the Clinton Administration. The projection is for a total reduction of 270,000 by 1999. There are still proposals in Congress to eliminate cabinet departments or consolidate other agencies and programs of government. There will be a shift in resources and responsibility to states. In welfare and Medicaid, there will be increasing pressure to end categorical grants and to initiate broader, more flexible programs.

One of the keys to the continuing debate is entitlements. Should the Federal government guarantee certain services to its citizens or leave that decision to the states? The other key is the debate over accountability. Does the Federal government have a role in protecting its citizens to guarantee them access to and equity of services and quality of care? The House and Senate are divided but the role of the Federal government will change dramatically and soon. This means:

- ◆ The Federal government will become a payer rather than a purchaser of health care service.
- ◆ It will be a catalyst for change rather than an administrator of services. The Federal government's continued effectiveness will depend on partnerships with state and local government, the private sector and community-based organizations to use the leverage it has to effect change.
- ◆ Deficit reduction is the overriding public policy goal. It affects all others. Clearly, there is a belief that the economic system must be strengthened. Many in both political parties believe that the reduction of debt is the ticket to medium term and longer-term economic prosperity. Current Congressional sentiment is to find deficit reduction in health and social programs for the poor and disadvantaged. The House and Senate differ in degree, but reductions are being carried out. These reductions are taking place in:
  - ◆ Medicare, by increasing the beneficiary burden for payment.
  - ◆ Medicaid, with loss of some entitlements.
  - ◆ Decreasing the earned income tax credit. This is what supports the incomes of families that are trying to stay off welfare.
  - ◆ Decreasing the availability of educational loans for the financially needy.
  - ◆ Reducing, or in some cases, eliminating food stamp allotments.
  - ◆ Reducing or eliminating access to health and social welfare benefits for legal and illegal aliens.

The choice was made not to take these reductions from defense, from business tax credits, or from agriculture. These legislative changes will create a new environment for the future practice of physicians. Ironically, at a time when we may be turning the corner in our ability and will to train new generations of physicians to relate effectively to a more diverse universe of patients, these very groups are losing their access to health care. These potential changes send a broader social message to young medical students – that society, through its elected officials, has decided that it has no national responsibility for certain groups of its citizens who

are relatively economically disadvantaged.

### **The Federal Government Charge: to Support Physicians Who Are Changing Medical Education to Include Cultural and Gender Competence**

One of the key factors influencing medical student choices is the social ethic of the times. The burst of interest in primary care and community medicine in the 1970 was related to the activism of the 1960s. Despite trends towards social activism, being a doctor still means taking a special and privileged place in society. Doctors have the ability to influence our communities and our nation.

There are many examples of this. Muriel Pettione, a general practitioner and pediatrician with whom I worked, has practiced for the last forty years in Central Harlem and has not only birthed and cared for generations of African American children, but has influenced politicians and celebrities in her fight for better health care in her community.

Martin Boyer, a neurologist I met while living in Europe, was in medical school in the Spring of 1968 when the Russian tanks rolled into Prague and crushed the Czechoslovakian revolution. He turned down an opportunity to leave his country and go to England to finish his medical education. After twenty difficult years, he joined with an interdisciplinary group of nurses, social workers and other health workers to develop and fight for the health care reform proposals of Civic Forum, the party that led the Czech Revolution of 1990. He later became Minister of Health of the Czech Republic.

The core of issues related to women and minority health and cultural competence are key to achieving a real democratic society. President Clinton has said he has “an administration that looks like America.” We, too, need “to look like America” in our medical faculties, our student bodies and our access to care if we are to maintain the promise of democracy. We must come together to promote a better understanding and a more effective partnership between doctors, their patients and the communities which they serve.

We must also support young physicians and the faculties that teach them to begin the curriculum changes in medical education to include cultural and gender competence. This is our charge. We owe it to Drs. Pettione and Boyer and the thousands like them who have spent their lives in service to those in need.

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**Chapter III.**  
**Strategy Development Sessions**

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## **Chapter IV. Response Panel**

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# **Chapter V. Workshops**

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## **Chapter VI. Closing Remarks**

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# **Chapter VII.**

## **Administrative Documents**

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## **CLOSING REMARKS**

Susan I. Blumental, M.D., M.P.A.  
Office on Women's Health  
U.S. Public Health Service  
Department of Health and Human Services

During this conference, we have succeeded in crafting a new face for medical education. The landscape of medical practice has indeed changed. To keep up, medical and health care professionals must incorporate into their practice the behavioral, psychological and environmental factors that influence health. We must also consider the environment in which we practice, including the economic climate, the rise of managed care, the political climate, shrinking resources, the demography of our population and the rapid explosion of scientific advance.

I want to review a few things. The first is curriculum development. We must integrate women's health and cultural competence into our medical education across the life cycle of physicians. We must include information on women's health and cultural competence in basic and clinical science; in lectures and small group training experiences; in continuing medical education, clerkships, in med school exams and in licensing procedures. We must also make post-graduate opportunities in women's health and cultural competence available through continuing medical education (CME) training for practicing physicians.

We need to train our faculty to be sensitive to gender differences and to cultural competence. We must start at the top in making these changes in medical administration. We must work with our students and our patients to make sure that our medical care and medical research is responsive to their needs. We also need more women and minorities in leadership positions as deans of medical schools, as professors, and as policy makers; and we need more women and minority faculty on curriculum, promotion and search committees.

Our medical education must reflect the changing face of our population. Fifty-one percent of our population is women, a full quarter of whom belong to racial and ethnic minorities; our minority population will be a majority before the year 2025. We must mirror these changes in our medical education if we hope to succeed in educating our century's physicians for the 21st century.

Women's and cultural competence health curricula must span from infancy to later life. Our training must include key issues in women and minorities' health, prevention, domestic violence and mental health issues. It must focus on the behavioral, cultural, social, economic and political determinants of health, which extend beyond the traditional biomedical model of disease. We must also incorporate interdisciplinary approaches if we hope to succeed in gaining support from a variety of medical and health disciplines.

Madame Curie, a brilliant scientist who was not admitted to the all-male French Academy of Sciences until she won an unprecedented second Nobel Prize said, "I never see what has been done. I only see what remains to be done." Together, let us do what remains to be done to make medical education responsive to the diverse population of our country. That is our challenge; that is our goal; and that is our promise to you from the Federal government. We pledge to work with you, our private sector partners, to safeguard the health of our population and to safeguard the future of American medicine.

**Tuei Doong, M.H.A.**  
**Office of Minority Health**  
**U.S. Public Health Service**  
**Department of Health and Human Services**

I do want to do one thing before I give some closing remarks. I want to update you on a couple of activities at the Office of Minority Health because of two recommendations that I heard this afternoon. Those recommendations were to increase information dissemination and establish a database on funding resources.

As you may know, the Office of Minority Health operates a Resource Center that has a toll free number. The Resource Center maintains a database on all sorts of Minority Health information. Traditionally, the information has concentrated on diseases that impact all minority populations like cardiovascular disease and cancer. This past year we have added information on the issue of cultural competence. The Resource Center has been collecting information and sources of information on cultural competence. The Resource Center also maintains a funding database, which you can search to find sources of funding both in the Federal sector and in the private sector to fund your projects, which would include in this case curricula development projects or model curricula. And let me also add that the Resource Center is an existing mechanism through which you can share any information that you already have on model curricula that have been developed and evaluated or that show some impact on various schools. This is a source we can use already without adding any additional resources.

We also have an emerging electronic bulletin board that we hope to get online in the very near future. This electronic bulletin board will be accessible to everybody who has access to the Internet through a dial-in basis.

I know it's getting late, but I want to take the opportunity to thank everyone that has participated in this conference, including all the plenary speakers, the moderators, the facilitators, and the workshop strategy leaders. I want to thank all of you for giving us your time and energy, for being with us and helping us develop strategies, which we intend to work on when we get back to the office and continue to work together to see how we can implement them. I want to specifically thank the OWH staff and the OMH staff, especially Dr. Susan Blumenthal for her leadership, Elena Rios for her dedication and hard work, and OMH staff Guadalupe Pachecho and Betty Lee Hawks for their long enduring work and effort, and I know that they are all breathing a heavy sigh of relief because it's over. They can be congratulated for a job well done.

I also want to thank the people that have been behind the scenes and that's our contractor Health Management Resources, Inc. I don't see Carmen in here, but she is the Project Director for the contract that has provided logistical support for this conference. They also need our thanks and appreciation.

In closing, I want to just quote from some remarks that Dr. Simpson had prepared. He said, "You are pioneers in the area of cultural competence and women's health curricula, and we are grateful for your presence here. We are pleased to provide an opportunity to build a cross-cultural network of health professionals dedicated to supporting each other in the hard work that lies ahead if we are to improve the health status of women and minorities. Today and tomorrow women, racial and ethnic populations, sovereign nations and non-reservation Native Americans, States and our partners need to be more resourceful, sharing ideas and resources, evaluating programs, and constantly changing our approach as necessary to improve the health of women and minorities until we find strategies that work in each of our communities. That is our goal at OMH. OMH will continue to commit its people and our resources to these goals. We will explore avenues that can help us to expand our allies. And, most important, we look forward to our efforts to pursue partnership with you in the years ahead."

So, let's move forward, together, solving our problems, together. Thank you very much.

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