Who’s in Our Neighborhood? Healthcare Disparities: Experiential Education for Residents

Carl Patow, MD, MPH, MBA, FACS, Debra Bryan, MEd, Gail Johnson, MS, BSN, CCRN, CPHQ, CHSE, CHSOS, Eugenia Canaan, MALS, Adetolu Oyewo, MD, Mukta Panda, MD, Eric Walsh, MD, James Zaidan, MD, MBA

1Clinical Learning Environment Review Program, Accreditation Council for Graduate Medical Education, Chicago, IL 2Department of Collaborative Learning, HealthPartners Institute for Education and Research, St. Paul, MN 3Department of Clinical Simulation, Institute for Education and Research, Regions Hospital, St. Paul, MN 4Ciel Global, LLC, Minneapolis, MN 5Department of Emergency Medicine, Emory University School of Medicine, Atlanta, GA 6Department of Medicine, University of Tennessee College of Medicine, Chattanooga, TN 7Department of Family Medicine, Oregon Health and Science University, Portland, OR 8Department of Anesthesiology, Emory University School of Medicine, Atlanta, GA

Background: Residents and fellows frequently care for patients from diverse populations but often have limited familiarity with the cultural preferences and social determinants that contribute to the health of their patients and communities. Faculty physicians at academic health centers are increasingly interested in incorporating the topics of cultural diversity and healthcare disparities into experiential education activities; however, examples have not been readily available. In this report, we describe a variety of experiential education models that were developed to improve resident and fellow physician understanding of cultural diversity and healthcare disparities.

Methods: Experiential education, an educational philosophy that infuses direct experience with the learning environment and content, is an effective adult learning method. This report summarizes the experiences of multiple sponsors of Accreditation Council for Graduate Medical Education–accredited residency and fellowship programs that used experiential education to inform residents about cultural diversity and healthcare disparities. The 9 innovative experiential education activities described were selected to demonstrate a wide range of complexity, resource requirements, and community engagement and to stimulate further creativity and innovation in educational design.

Results: Each of the 9 models is characterized by residents’ active participation and varies in length from minutes to months. In general, the communities in which these models were deployed were urban centers with diverse populations. Various formats were used to introduce targeted learners to the populations and communities they serve. Measures of educational and clinical outcomes for these early innovations and pilot programs are not available.

Conclusion: The breadth of the types of activities described suggests that a wide latitude is available to organizations in creating experiential education programs that reflect their individual program and institutional needs and resources.

Keywords: Cultural competency, healthcare disparities, internship and residency, problem-based learning

Address correspondence to Carl Patow, MD, MPH, MBA, FACS, Accreditation Council for Graduate Medical Education, 515 N. State St., Suite 2000, Chicago, IL 60654. Tel:(804) 625-9939. Email: cpatow@acgme.org

INTRODUCTION

Language, culture, and community can have a significant impact on the delivery of care to patients and on their clinical outcomes. For example, cultural preferences may influence patients’ decisions about access to care, engagement with healthcare professionals, and receptiveness to the care that is recommended or provided. Cultural and linguistic preferences may influence patient willingness to comply with physician instructions. Residents and fellows encounter patients from many cultures in their clinic and inpatient experiences. These healthcare professionals often have limited understanding of the cultural, racial, and ethnic communities in which their patients live. Furthermore, because of the residency matching process, residents may be selected to train in communities about which they have little personal knowledge.

Training available to residents and fellows in the specific cultural and community factors that might influence care is most often provided in the form of generic cultural competency modules. Other formats, such as experiential education, offer additional means to enhance learner interest and knowledge.

Faculty physicians at academic medical centers are becoming increasingly aware of the importance of recog-
nizing cultural preferences of the patient populations they serve and are interested in developing experiential education programs related to healthcare disparities for residents and fellows. However, limited information is available about the various formats that have been used for these activities. This report offers selected examples of innovative experiential education approaches designed to increase resident, fellow, and faculty physician understanding of cultural and community preferences for healthcare.

METHODS

We describe 9 examples of innovative experiential education activities, each characterized by the participation of residents in an activity that seeks to improve their understanding of patients from cultures and communities under their clinical care. The activities vary in length from minutes to months, in complexity, and in resource requirements. The models presented are drawn from 4 sources. The HealthPartners Institute for Education and Research in St. Paul, MN, developed 6 of the models. The other 3 models are from educational programs at the Oregon Health and Science University in Portland, OR, University of Tennessee College of Medicine in Chattanooga, TN, and Emory University School of Medicine in Atlanta, GA. The models were presented at the Accreditation Council for Graduate Medical Education (ACGME) annual education conference in March 2014. In many cases, these models were included in larger educational constructs about patient and community culture that included additional didactic sessions and online learning.

The examples were selected based on faculty member and educational leadership reports of their effectiveness in familiarizing the target audience of residents, fellows, and faculty members with the demographics and health needs of the communities they serve. Characteristics of the communities in which these models were deployed varied widely but in general reflected urban centers with diverse populations. The selection purposefully represents a broad spectrum of potential educational formats to stimulate reflection, creativity, and innovation by faculty and administrators at academic medical centers and teaching hospitals who are considering implementing their own programs. The models were not selected with regard to similarities in objectives, resource requirements, outcome measures, or documented results. These efforts are early innovations or pilot programs, and, as such, are not presented to represent validated or optimal approaches to resident and fellow education on healthcare disparities.

EXPERIENTIAL EDUCATION MODELS

The 9 innovative experiential education models described here represent the efforts of multiple independent institutions to educate residents, fellows, and attending physicians about the population diversity and preferences for care in the communities they serve. The models are presented in a sequence of relative increasing complexity, with increasing resource requirements, preparation time, and administrative oversight (Table).

### EXPERIENTIAL EDUCATION MODELS

<table>
<thead>
<tr>
<th>Model</th>
<th>Targeted Learners</th>
<th>Learning Objective(s)</th>
<th>Relative Complexity</th>
<th>Community Engagement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cultural sites</td>
<td>Residents, fellows, faculty</td>
<td>Knowledge of community</td>
<td>Moderate</td>
<td>Yes, individual patients</td>
</tr>
<tr>
<td>House calls</td>
<td>Residents, fellows</td>
<td>Cultural awareness, clinical care</td>
<td>Moderate</td>
<td>Yes, individual patients</td>
</tr>
<tr>
<td>Geographers’ tour</td>
<td>Residents, fellows, faculty</td>
<td>Knowledge of community</td>
<td>Moderate</td>
<td>No</td>
</tr>
<tr>
<td>Cultural films</td>
<td>All health professionals</td>
<td>Clinical cultural awareness</td>
<td>High</td>
<td>Yes, as actors, screenwriters</td>
</tr>
<tr>
<td>Community partnerships</td>
<td>Residents, fellows</td>
<td>Health advocacy</td>
<td>High</td>
<td>Yes</td>
</tr>
<tr>
<td>Extended collaborative</td>
<td>All health professionals, community members</td>
<td>Cultural understanding, clinical outcomes</td>
<td>High</td>
<td>Yes, as team members</td>
</tr>
</tbody>
</table>

*Developed by HealthPartners Institute for Education and Research, St. Paul, MN.
*Developed by Oregon Health and Science University, Portland, OR.
*Developed by University of Tennessee College of Medicine, Chattanooga, TN.
*Developed by Emory University School of Medicine, Atlanta, GA.

Clinical simulations (eg, rapid-response team training) can readily include care for a simulated patient from an ethnic community. In the model developed by HealthPartners Institute for Education and Research, the simulation mannequin is dressed with culturally appropriate clothing and made to verbalize or talk in a foreign language. Introducing a language barrier provides an immediate communication challenge for the responding health profes-
sionals in the training environment. Midway through the
scenario, an additional challenge is presented: the patient’s
family, portrayed by community volunteers or by the
simulation center staff, suddenly appears. The simulated
family introduces additional challenges based on cultural
preferences and linguistic barriers. The postsimulation
debriefing includes cultural considerations such as deci-
sionmaking by family proxy, preferences for resuscitation,
and obtaining informed consent in another language. A
simulation center community advisory council informs the
content of the scenario to increase authenticity in the role-
play and to guard against stereotyping.

**Treasure Hunt**
The family medicine program of Oregon Health and
Science University challenged residents with a community
treasure hunt. Serial clues led resident teams to historic,
cultural, and other notable sites to familiarize them with the
community, its cultural composition, and its relationship to
the medical center and family medicine facilities.

**Community Organizations**
For residents and fellows interested in a longitudinal
experience in cultural medicine, individual participation with
community health organizations offers an in-depth oppor-
tunity. These organizations frequently are engaged in
providing healthcare services, counseling, or health advocacy.
Residents participate in organizational meetings and assist
with health-related activities and mentoring. In the
model developed by HealthPartners Institute for Education
and Research, the length and depth of residents’ interac-
tions vary based on available time, interests, and opportu-
nities for learning.

**Cultural Sites**
Residents and fellows in St. Paul, MN, were provided with
an opportunity to better understand the Hmong culture
through a visit to a Hmong market. The market’s merchants
sell ethnic foods, cultural goods, and traditional health
remedies. Most merchants were Hmong women in tradi-
tional dress, speaking their native languages. Teams of 4
residents and an interpreter were transported to the market
by bus and were asked to purchase traditional remedies for
common medical conditions. The residents spent 1 hour in
the market, talking with the Hmong salespeople through
interpreters and purchasing herbs, roots, and other natural
remedies. The learning activity exposed residents to a
community located close to the hospital and the community
members’ preferences for traditional medicines. The visit
also stimulated interest in potential toxic reactions to herbal
medications that were discussed by an emergency depart-
ment physician who is a toxicologist.

**House Calls**
The University of Tennessee College of Medicine spon-
sored a resident house call experience, Bringing Back the
Black Bag, in which residents cared for patients in their
home environment. The patients were selected from ZIP
codes close to the hospital and comprised a cohort that was
diverse in many regards such as cultures, demographics,
and beliefs. The initiative was part of a comprehensive
diversity and disparities educational program of the internal
medicine residency program.

**Geographers’ Tour**
A mobile experience familiarized residents with commu-
nities near Regions Hospital in St. Paul, MN. Two geography
professors were engaged to analyze racial and cultural
demographic data and hospital admissions data for the
communities surrounding the hospital. Residents and the
geographers rode tour buses through those communities,
identifying hot spots for emergency department admissions
and familiarizing residents and fellows with areas of the city
that have concentrations of ethnic populations. During the
3-hour bus tours, the geographers discussed the social
determinants of health for the different neighborhoods. The
tours were followed by a didactic presentation on the
geography and social history of the city.

**Cultural Films**
Film or video is a durable educational format that can
provide insights into the preferences of ethnic patients
through narratives presented in an authentic cultural
context. To highlight ethnic and cultural differences in
access and use of the care system, the HealthPartners
Institute for Education and Research produced 4 films, each
based on a screenplay written by an author from 1 of 4
cultures: Hmong, African American, Latino, and Somali.
Acted by professionals and talented amateurs under the
guidance of a professional director, the plays were
professionally filmed. Prior to viewing the films, resident
audiences were informed that the stories were written from
the perspective of 1 author about a fictional family and were
intended for discussion. The films vary in length from 8-40
minutes and are available on the internet.

**Community Partnerships**
At Emory University School of Medicine in Atlanta, GA, the
Urban Health Initiative includes several sponsoring institu-
tions, city government, hospitals, and community partners.
Its goal is to improve health and decrease disparities of care
in diverse and underserved populations in the city. An in-
the-field learning experience for residents includes struc-
tured education regarding legislative and community
advocacy, effects of social determinants on health, and
improved familiarity with patients. Residents are paired with
a mentor who guides them through the experience and
assists them in completing a publishable project.

**Extended Collaborative**
Residents participated in a large-scale institutional qual-
ity-improvement collaborative to improve healthcare equity
of preventive health services and learn about cultural
influences and systems approaches to improving care.
The year-long collaborative, called The EBAN Experience
and developed by the HealthPartners Institute for Education
and Research, included teams of residents; health profes-
sionals; and Hmong, African American, Somali, and Latino
community members. The teams studied preferences for
care, access issues, and disparities in health outcomes for
preventive health initiatives such as immunizations and
cancer screenings. The teams demonstrated improved
clinical outcomes through serial quality improvement cycles.  

DISCUSSION

Experiential education—an educational philosophy that infuses direct experience with the learning environment and content—is particularly well suited for active learning, a modality that is preferred by the generation of learners currently in medical school and residency.  

The wide variety of educational activities described here reflects the needs of learners, learning objectives, and available institutional resources. Faculty considering the use of experiential education are encouraged to select methods that meet their learning needs or to experiment with innovative formats that engage learners and communities, promote mutual understanding of the factors leading to healthcare disparities, and lead to possible solutions. The effectiveness of any of these methods may vary by location and institution. Clinical and educational outcomes are not available for these early innovations and pilot programs, and return on investment is not known.

These models are, in most cases, early efforts and may not represent the optimal means for addressing cultural awareness and healthcare disparities for a specific set of learners or a community. However, they offer preliminary insight into the scope of potential interventions that use experiential education to impart an understanding of cultural preferences for care. They offer guidance in planning and development of curricula and to evaluate the effectiveness of educational activities described here reflects the needs of learners, learning objectives, and available institutional resources. Faculty considering the use of experiential education to impart an understanding of the factors leading to healthcare disparities for a specific set of learners or a community. However, they offer preliminary insight into the scope of potential interventions that use experiential education to impart an understanding of cultural preferences for care of a cultural group may require a relatively simple educational intervention with reinforcement, whereas engaging community members with health professionals to change clinical protocols to reflect cultural preferences requires significantly more administrative leadership, enlistment of community representatives, serial meetings, and a much longer timeline. Resource availability is also a consideration. Each of the 9 models has different resource requirements including preparation time, educator expertise, use of simulators or transportation resources, and length of participant involvement.

CONCLUSION

The experiential education models presented are examples of learning activities developed to improve resident understanding of patient and community cultural preferences for healthcare. The 9 models are the work of early innovators, and further studies are necessary to fully understand the appropriateness of individual models to meet educational outcomes, promote community engagement, and improve the effectiveness of clinical outcomes.

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Debra Bryan is now an independent healthcare consultant in Eden Prairie, MN.

REFERENCES