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Cultural Competence Education for Students in Medicine and Public Health

Report of an Expert Panel

Joint Expert Panel Convened by the
Association of American Medical Colleges and the
Association of Schools of Public Health

July 2012

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For additional information, contact

- Alexis Ruffin | *alruffin@aamc.org*
  Director, Medical Education, Association of American Medical Colleges
- Elizabeth M. Weist | *eweist@asph.org*
  Director, Special Projects, Association of Schools of Public Health

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Introduction

The Association of American Medical Colleges (AAMC) and the Association of Schools of Public Health (ASPH) charged an expert panel of educators with identifying a set of competencies appropriate for learners in disciplines of both medicine and public health to prepare culturally competent practitioners. The competencies are designed to enable faculty in medical schools and graduate schools/programs of public health to standardize curricula, benchmark student performance, and prepare graduates for culturally competent practice. The panel additionally provided recommendations for embedding cultural competence education within and across curricula of medicine and public health, highlights of exemplary case studies, and a road map for the future.

Though recommendations in this report will be of primary use to faculty and administrators developing and administering curricula in schools of medicine and schools/programs in public health, faculty in other health professions schools and those in health science departments may find the competencies and educational strategies to be similarly applicable to their programs of study.

In order to maximize applicability between the health professions, the competencies are organized by the general domain areas of knowledge, skills, and attitudes. As an example of discipline alignment with accreditation requirements, a crosswalk of the competencies offered here with the general domains adopted by the Accreditation Council for Graduate Medical Education is offered in the appendix. Though content proposed in this report can be found in both the accreditation language and educational literature of medicine and public health, the competencies articulated are meant to offer emphasis to the nexus shared by the two disciplines.

The AAMC/ASPH partnership to develop the joint report offered here, "Cultural Competence Education for Students in Medicine and Public Health: Report of an Expert Panel," represents the second such issuance of joint educational recommendations. In spring 2011, the AAMC and ASPH, both as founding members of the Interprofessional Education Collaborative (IPEC) with four other educational associations, published "Core Competencies for Interprofessional Collaborative Practice."

Acknowledgements: The panel wishes to acknowledge Dr. Maureen Lichtveld for her role in catalyzing the formation of this panel and providing invaluable guidance to the co-chairs in development of the report. The panel is also grateful for the support of the following individuals during the course of this initiative: Dr. Carol Aschenbrener, chief medical education officer, Association of American Medical Colleges (AAMC); Dr. David Acosta, FAAFP, chair of the AAMC Group on Diversity and Inclusion and associate dean of multicultural affairs at University of Washington School of Medicine; Dr. Harrison Spencer, president and CEO, Association of Schools of Public Health (ASPH); and Dr. Marla Gold, chair of the ASPH Diversity Committee and dean of the Drexel University School of Public Health.

In memoriam: The AAMC and ASPH appreciate the contributions of Dr. Jessie Satia, associate professor, departments of nutrition and epidemiology, special assistant to the dean for diversity, at the UNC Gillings School of Global Public Health.

Report of an Expert Panel

Most health professionals intuitively make the connection between medicine and public health, yet these disciplines still largely operate as "silos" (Maeshiro et al., 2010; Interprofessional Education Collaborative, 2011). However, examples of successful joint educational efforts do exist and include M.D./M.P.H. programs, work in community health centers and neighborhood clinics, and collaboration in community-based participatory research.

The AAMC and ASPH have made deliberate, synergistically beneficial investments to deliver graduates capable of functioning across the respective disciplines of medicine and public health. For example, in the aftermath of the September 11th terrorist attacks, both organizations acted on the urgency to equip students in medicine and public health with basic skills and knowledge related to disaster preparedness (Association of American Medical Colleges, 2003). Regional medicine-public health education centers encouraged cross-fertilization by providing opportunities for medical schools and residency programs to collaborate with public health partners, including schools and graduate programs in public health (Maeshiro et al., 2010).

Interdependence Between Medicine and Public Health

Beyond intuitive connectivity, key drivers in developing this joint panel were the increasing realization of the interdependence of both disciplines and the recognition that cultural competence is a critical, influencing factor common to all forces of change in health care and public health. The panel's recommendations for improving cultural competence education can be leveraged in a three-pronged fashion:

- As a prerequisite for transdisciplinary holistic practice.
- To accelerate team-driven, community-based health care, programs, services, and policies.
- As a stimulus to advance health disparities research and increase disease prevention outreach.

As one of many approaches each organization is taking toward the ultimate aim of eliminating health and health care disparities, the set of core competencies developed by this unique collaborative partnership and published in this report embraces the commonalities of both disciplines and is therefore appropriate for medical and public health students.

Initiative Description and Goals

Cultural competence is defined in the broader context of diversity and inclusion as "the active, intentional, and ongoing engagement with diversity to increase one's awareness, content knowledge, cognitive sophistication, and empathic understanding of the complex ways individuals interact within systems and institutions" (Milem, 2005).

The target audiences, therefore, for the competencies outlined in this report include students in schools of medicine prior to their graduation with a Doctor of Medicine (M.D.) degree and students in graduate schools of public health or graduate programs of public health prior to their graduation with the Master of Public Health (M.P.H.) degree or related master's degree.

The panel's recommendations aim to ensure that students acquire cultural competencies in their chosen fields to prepare them for successful practice, including the development and delivery of appropriate health care and population health programs, services, and policies for an increasingly diverse U.S. population. This population includes those currently medically underserved and those whom the public health system has more difficulty reaching with programs, services, and policies.

The panel anticipates that its recommendations will be of primary use to faculty and administrators who decide on curricula in schools of medicine and in schools of and programs in public health. Faculty in other health professions schools and those in health science departments may wish to review the competencies and recommendations in this report in light of their own objectives for cultural competence in the education of their students.

The joint panel's recommendations have a goal of fostering innovations in the development of educational experiences that integrate culturally competent knowledge, skills, and attitudes. The panel views cultural competence as a signature topic in the education of medical and public health students leading to a greater appreciation of its application in practice and how it can be ultimately integrated at the individual and community levels.

Background

Learning to communicate with patients, families, communities, and fellow professionals in a culturally competent manner helps to reduce disparities and promote enhanced health and wellness. (Gebbie et al., 2003) Ample evidence exists documenting the role of cultural competence in addressing health disparities (Betancourt et al., 2003; Brach & Fraser, 2000; Goode et al., 2006). The ability to practice in a culturally competent manner within the frame of reference of one's patient(s) and/or the community of interest improves the delivery of appropriate care and enhances the likelihood that programs, services, and policies will be relevant to diverse populations. The benefit is twofold: an improvement in health outcomes and a corresponding reduction in health disparities.

An evolving multiracial, multicultural, and multilingual society makes strengthening the cultural competence of the health workforce even more imperative. Global and national entities have stated that by embracing their own cultural diversity and differences across practice settings and showing respect for the patients and population they are attending, health care teams achieve multiple benefits for both themselves and the communities they serve.

Such outcomes include:

- Breaking down of professional barriers.
- Building of trust.
- Enhancing appreciation among practitioners of each other as valuable colleagues.
- Increasing effective coordination and delivery of patient/population-centered care, programs, services, and policies (Frenk et al., 2010; IPEC, 2011).
- Accelerating innovation and promoting excellence by engaging diversity (Nivet, 2011).

Although recognition is increasing that culturally competent, team-based care may represent a more efficient approach to providing effective health services and to achieving improved health outcomes and sustained well-being, the health workforce lacks the knowledge and skills to realize this transformation fully. The AAMC and ASPH have collaborated for two decades on these and other issues of common concern to both associations (Gemmell, 2003). Through the joint panel, the AAMC and ASPH have embraced the challenge of exploring cultural competency in the curricula of schools of medicine and schools of public health and will seek to build upon the recommendations outlined in this report.

Methods

In May 2009, an 11-member panel, along with invited staff and observers, met to discuss issues in cultural competence education and to draft related competencies for medical and public health students using existing curricula, related competencies, and key recommendations from national reports and other literature in its assessment. Following this in-person meeting, a core writing team comprising the project co-chairs, a single panel member representing both the medicine and public health perspectives, and one staff member each from the AAMC and ASPH communicated via e-mail and telephone to develop consensus, to align the competencies with Bloom's taxonomy of educational outcomes as revised by Krathwohl (2002), and to assign the competency statements into major areas of KSAs (knowledge, skills, and attitudes).

A representative from the panel displayed the draft competency statements in a poster session during the AAMC- and CDC-sponsored 2010 Patients and Populations: Public Health in Medical Education conference in Cleveland, Ohio (Lichtveld, 2010). The conference was supported by the AAMC-CDC cooperative agreement and helped to highlight its Regional Medicine-Public Health Education Centers (RMPHEC) initiative, an effort to integrate public/population health and prevention education into medical school and residency curricula through partnerships with local and state public health agencies and other public health partners. Conference attendees provided comments and feedback, and the core writing team reviewed and carefully considered the input.

The core writing team presented a revised draft to the full panel for review and approval, as well as solicited feedback from the constituent chairs of the AAMC's Group on Diversity and Inclusion and ASPH's Diversity Committee. Intended for release on both the AAMC and the ASPH Web sites, the report will be available for mutual and derivative use by both association communities.

Building Blocks of Cultural Competence Education

Schools of medicine and public health have each undertaken efforts to include cultural competence in their respective curricula. For example, to address cultural competence specifically in the medical curriculum, the AAMC convened experts in 2006 to develop a detailed list of content elements essential to teaching cultural competence in the medical school curriculum. These key content areas were incorporated into a curricular evaluation tool, the Tool for Assessment of Cultural Competence Training or TACCT, which medical schools can use to assess the cultural competence content in their curriculum (Association of American Medical Colleges, 2006; Lie, 2009). The University of Washington developed a set of core principles for cultural competence for medical education outlining learner objectives and outcomes focused on awareness, knowledge, skills, and advocacy (Acosta, 2010). Maeshiro et al. (2010) also described population health competencies for graduating medical students.

In some instances, techniques and approaches from public health are helping to inform medical education with ecological models that place patients within larger environments, thus enabling future medical providers to work on resolving issues beyond the traditional model of individual care. A recent report, for example, argued that the "perspectives and findings that flow from the behavioral and social sciences serve to prepare medical school graduates for comprehensive, patient-centered practice and provide the conceptual framework needed to address complex societal problems that have direct bearing on health and health care disparities" (Association of American Medical Colleges, 2011).

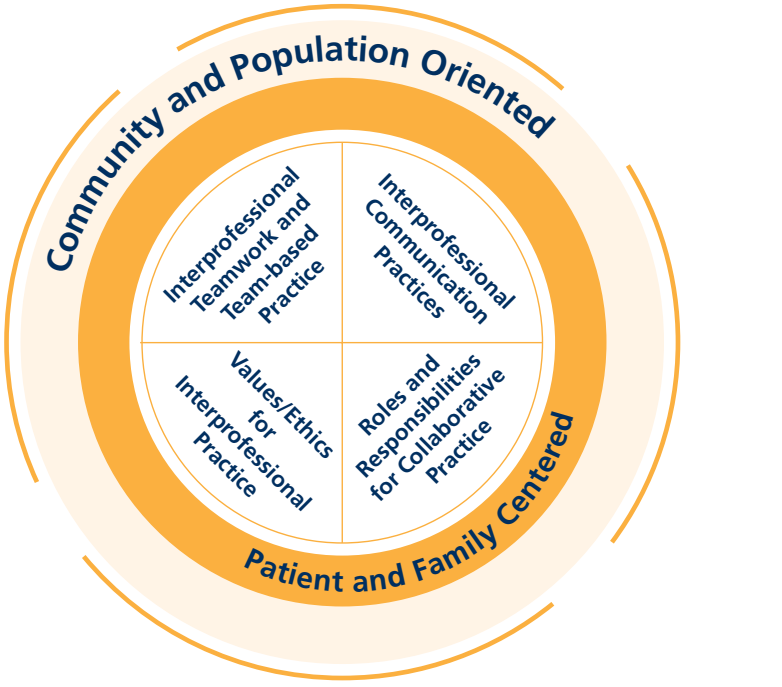
Similarly, ASPH, with support from the Kellogg Foundation, published recommendations for infusing cultural competence into the curricula of accredited public health schools (Association of Schools of Public Health/W. K. Kellogg Task Force, 2008). This effort was intended to address the role of the public health practice community in eliminating racial and ethnic health disparities. The desired overarching outcome was that public health practitioners involved in advocacy, policy, disease prevention, and health promotion would know the differences in the health beliefs, practices, behaviors, attitudes, and outcomes of diverse populations.

Core Competencies for Improving Health and Health Care

Demonstrable evidence of the value of and need for interprofessional education is documented in a joint expert panel report issued by six national education associations of schools of the health professions. *Core Competencies for Interprofessional Collaborative Practice* (Interprofessional Education Collaborative, 2011) delineates four domains of core competencies for preparing future health professionals to provide integrated, high-quality care to patients within the nation's current, evolving health care system:

1. Teams and Teamwork
2. Values/Ethics for Interprofessional Practice
3. Roles/Responsibilities
4. Interprofessional Communication

These four domains, populated by competencies and subcompetencies, describe essential behaviors across the domains and illustrate the common frame of reference regarding cultural competence required by both medicine and public health students at the pre-licensure/pre-certification points in their educational continuum.



The Learning Continuum pre-licensure through practice trajectory

Reprinted with permission from Interprofessional Education Collaborative Expert Panel. (2011). Core competencies for interprofessional collaborative practice: Report of an expert panel. Washington, D.C.: Interprofessional Education Collaborative.

Competency Statements

The proposed competency sets reflect the nexus of medicine and public health cultural competence education and are intended to help embed cultural competence knowledge, skills, and attitudes in medical and public health education and practice. The competencies build on other existing discipline-derived efforts—as mentioned before, the Tool for Assessing Cultural Competence Training (TACCT) as well as the master's degree in public health core competencies outlined in the "Diversity and Culture" domain developed by ASPH (Association of Schools of Public Health, 2006). Deliberately designed to apply to the education and practice of medicine and public health in an interdependent, holistic fashion, this effort is distinguished from previous ones.

While competencies articulated by accrediting bodies in medicine and public health may very well address content presented here, either in a general or specific manner, this exercise was undertaken to examine principles of cultural competence as the overlay of identifying areas of knowledge, skill, and attitude common between the two professions.

The anticipated performance outcome for both student populations is a whole-person, patient-centered approach embedded in a community-wide and population-wide setting. The competency set proposed here is not intended to be implemented in its entirety; rather, schools of medicine and public health have ample flexibility to tailor curricula anchored by specific competencies, while assuring opportunities to benchmark student performance. The competencies are deliberately broad, allowing for the integration and tailoring not only within the scope of practice, but also within educational strategies and modalities relevant to the progressive stages of learning in medicine and public health.

The competencies are categorized in three domain areas: knowledge, skills, and attitudes. Some competency statements are "bridging" in nature, naturally linking more than one of the three domains and are thus designated with an asterisk. While some of the included competencies are general and apply broadly (e.g., role and function of a local health department) bridging competencies are explicated here for the purpose of emphasizing the interconnectedness of the three domains.

It bears repeating that the target audiences for the competencies outlined below are students in schools of medicine prior to their graduation with a Doctor of Medicine (M.D.) degree and students in graduate schools of public health or graduate programs of public health prior to their graduation with the Master of Public Health (M.P.H.) degree or related master's level degree.

Since the M.P.H. is considered a prerequisite for the Doctor of Public Health (Dr.P.H.) degree, students seeking their Dr.P.H. degree are encouraged to obtain the competencies listed below as a foundation for advanced work at the doctoral level. (Thus competency requirements for the Dr.P.H. subsume competencies required for the M.P.H. degree or its master's level correlate.) These competencies also are applicable as a basis for acquiring cultural competence among seekers of other doctoral degrees, such as the Doctor of Philosophy (Ph.D.) and the Doctor of Science (Sc.D.).

Cultural Competencies Common to Medical and Public Health Students

** competencies bridge more than one domain—Knowledge, Skills, and/or Attitudes*

Knowledge (Cognitive competencies)

At the completion of the program of study, students will be able to:

- Define cultural diversity including language, sexual identity, age, race, ethnicity, disability, socioeconomics, and education
- Differentiate health, health care, health care systems, and health disparities
- Identify cultural factors that contribute to overall health and wellness*
- Describe the influence of culture, familial history, resiliency, and genetics on health outcomes
- Examine factors that contribute to health disparities, particularly social, economic, environmental, health systems, and access
- Identify health disparities that exist at the local, state, regional, national, and global levels
- Recognize that cultural competence alone does not address health care disparities
- Describe the elements of effective communication with patients, families, communities, peers, and colleagues*
- Describe strategies to communicate with limited English proficient patients and communities
- Describe the role of community engagement in health care and wellness
- Assess the impact of acculturation, assimilation, and immigration on health care and wellness
- Articulate the role of reflection and self-assessment of cultural humility in ongoing professional growth
- Describe both value and limitation of evidence-based literature on understanding the health of individuals and communities
- Articulate roles and functions of local health departments and community partners, to include capabilities and limitations*

Skills (Practice competencies)

At the completion of the program of study, students will be able to:

- Identify one's own assets and learning needs related to cultural competence
- Incorporate culture as a key component of patient, family, and community history
- Integrate cultural perspectives of patient, family and community in developing treatment/interventions*
- Apply (community) constituent /patient-centered principles to earn trust and credibility
- Conduct culturally appropriate risk and asset assessment, management, and communication with patients and populations
- Contribute expertise to culturally competent interventions
- Communicate in a culturally competent manner with patients, families, and communities
- Employ self-reflection to evaluate the impact of one's practice
- Work in a transdisciplinary setting/team
- Demonstrate shared decision making
- Analyze illness conditions and health outcomes of concern at the patient and community levels
- Engage community partners in actions that promote a healthy environment and healthy behaviors
- Communicate with colleagues, patients, families, and communities about health disparities and health care disparities
- Establish equitable partnerships with local health departments, faith and community-based organizations, and leaders to develop culturally appropriate outreach and interventions*

Attitudes (Values/beliefs competencies)

At the completion of the program of study, students will be able to:

- Demonstrate willingness to apply the principles of cultural competence
- Appreciate how cultural competence contributes to the practice of medicine and public health
- Appreciate that becoming culturally competent involves lifelong learning
- Demonstrate willingness to assess the impact of one's own culture, assumptions, stereotypes, and biases on the ability to provide culturally competent care and service
- Demonstrate willingness to explore cultural elements and aspects that influence decision making by patients, self, and colleagues
- Demonstrate willingness to collaborate to overcome linguistic and literacy challenges in the clinical and community encounter *
- Appreciate the influence of institutional culture on learning content, style, and opportunities of professional training programs

Collaborative Learning Experiences

Successful shared learning opportunities already serve as a rich foundation for cultural competence education in medicine and public health. For example, students participating in multidisciplinary team-based service learning projects may experience firsthand how one another's interdependence and expertise lead to a more successful health outcome. Such learning projects often serve high-risk populations challenged by multiple health conditions and a persistent or historically disproportionate burden of health disparities.

For both medicine and public health students, a multitude of additional shared learning opportunities exist, including the following:

- Study of a health condition or disease entity that affects both fields (e.g., obesity).
- Community-based interventions focused on measuring improvement in health outcomes.
- Projects illuminating the central role of cultural competence in promoting healthy behaviors and, ultimately, sustained well-being.
- Team-based activities to enhance quality and patient safety.
- Problem-based learning experiences showcasing medicine–public health collaboration in which both groups contribute important subject-matter content and disciplinary methods (e.g., adverse health effects related to environmental exposures, cancer screening and early detection).
- Cross-listing courses between health professions schools in the same system.
- Open educational resources, publication services, and other mechanisms for sharing teaching and assessment tools (e.g., MedEdPORTAL®).

MedEdPORTAL®

www.mededportal.org

- An open education resource and publication service provided by the Association of American Medical Colleges in partnership with the American Dental Education Association.
- Features approximately 2,000 peer-reviewed educational resources that span the continuum of medical and dental education.
- Includes a growing international reach of more than 10,000 health education institutions from more than 190 countries.
- Up to 1,000 MedEdPORTAL publications accessed each week by users across the globe.

MedEdPORTAL maintains a rigorous peer-review process based on standards used in the scholarly publishing community. Each submission is scrutinized by editorial staff and independent reviewers using a standardized review instrument grounded in the tenets of scholarship. Published authors receive a formal citation for their accepted publication.

MedEdPORTAL publications are considered by many to be scholarly works that may support faculty advancement decisions.

Selected MedEdPORTAL Cultural Competence Resources*

• Medicine Resources:

Elliott, D., St. George, C., Signorelli, D., & Trial, J. (2010). Stereotypes and Bias at the Psychiatric Bedside—Cultural Competence in the Third Year Required Clerkships. MedEdPORTAL ID: 1150

Elliott, D., Schaff, P., Woehrle, T., Walsh, A., & Trial, J. (2010). Narrative Reflection in Family Medicine Clerkship—Cultural Competence in the Third Year Required Clerkships. MedEdPORTAL ID: 1153

• Public Health Education Resources:

Marion, G., Crandall, S., Hildebrandt, C., Walker, K., Gamberini, B., & Spangler, J. (2009). Tobacco Ties. MedEdPORTAL ID: 3138

Marion, G., Hildebrandt, C., Crandall, S., & Kirk, J. (2011). Esther Hines: Culturally Competent Collaboration to Manage Diabetes. MedEdPORTAL ID: 8368

** See Appendix C: Selected MedEdPORTAL Resource Abstracts for expanded abstract narratives.*

Road Map for the Future

This joint panel has undertaken an unprecedented first step in working together across disciplines to identify essential competencies for culturally appropriate medical and public health education. Subsequent activities the panel suggests for preparing culturally competent medical and public health practitioners and for reducing health disparities while promoting enhanced health and wellness include:

- Promoting faculty skill in competency-based education (CBE).
- Integrating application of the competencies.
- Cultivating an agenda for research and scholarship.
- Employing case studies (disseminating existing case studies and creating novel ones).
- Identifying strategies for translating curriculum to practice settings.

Each of these recommendations is addressed briefly below.

Promote Faculty Skill in Competency-based Education

Although this report is focused on building students' cultural competence, transdisciplinary faculty development must be addressed as a core implementation strategy. A systematic approach to advancing the cultural competence of faculty members themselves must be integral to any curricular transformation to achieve sustained success in cultural competence education. Some early opportunities include the collaborative development of case studies, courses, seminars, and brown-bag lunch sessions which explore interprofessional competencies and issues in cultural competence, and working with faculty peer mentors.

Faculty development in creating, adapting, implementing, and evaluating CBE is strongly recommended. Most faculty members have been trained in traditional lecture formats and, consequently, many resort to the same tried-and-true presentation styles in their current teaching. Competency-based education, however, is best achieved through more interactive, student-centered, pedagogical principles (Calhoun et al., 2011).

Special attention to building faculty expertise in enabling student acquisition of attitudinal competencies is warranted. Attitudes represent special abilities that develop over time; faculty may need to implement a more sequenced system of benchmarks to assess students' attitudes at the beginning, middle, and end of a particular educational program.

Faculty support in evaluating student acquisition of competencies is also recommended. Building a consensus on objective evaluation methods of attitudinal change is particularly challenging. Special resources should be provided to help faculty develop and use rubrics for evaluating student attitudes. The Health Beliefs Attitudes Survey (HBAS), for example, has been used successfully in introductory clinical medicine courses to determine positive changes in students' attitudes on issues relating to cultural competency (Crosson et al., 2004).

Therefore, curriculum planning needs to include not only a means of integrating competencies into faculty's instruction, but also a broader array of student-centered evaluation techniques to ensure that students leave the discrete learning experience, as well as graduate from a program, having demonstrated competence in the desired areas. See the ASPH Learning Taxonomy Levels for Developing Competencies & Learning Outcomes Reference Guide (also known as the Reference Guide) for information about aligning competencies with instruction and evaluation (Association of Schools of Public Health, 2011b).

Integrate Competencies

As drafted, the cultural competence education set was specifically constructed so that undergraduate medical and graduate public health programs have the ability to adopt all or part of the proposed model. Experience and integration into the learning setting will bring further understanding about effective incorporation strategies. Developing demonstration projects could further assist schools with faculty deliberation about how to incorporate the competencies into teaching and learning, as well as testing competency-based curricula at their local level. At the institutional level, strong and clear administrative support for both CBE and cultural competence is critical for the sustained application of these recommendations.

Cultivate Research and Scholarship Agenda

Schools that opt to integrate the competencies into curricula may begin by mapping the model against their existing course requirements to expose content gaps and indicate areas of needed redress in the academic program. In some cases, adding content, methods, and learning experiences will help to round out the educational program; in other instances, adding content will fill gaps caused by a lack of evidence-based research in a particular area.

Employ Case Studies

Case studies, particularly those drawn from real life, offer students excellent opportunities to translate learning into frontline culturally competent practice. A means for sharing existing case studies and a mechanism for creating new studies from real-world experiences would greatly aid faculty in educating students to become culturally competent providers and practitioners better equipped to meet the needs of their patients and populations.

Resources such as the Milestones in Public Health course (Association of Schools of Public Health, 2011) and MedEdPORTAL.org are rich sources for case study materials. The medicine and public health case study examples that follow were developed by panel members to serve as illustrations of integrating cultural competence as an overlay to an educational resource.

Illustrative Case Study Examples

ILLUSTRATIVE CASE STUDY EXAMPLE Public Health

Quintero v. Encarnacion

Adapted from Material Prepared by Thomas A. LaVeist, Ph.D. and Cheri Wilson, M.A., M.H.S., C.P.H.Q.

Case Background for M.P.H. Student

In 1983, Rita Quintero, a Mexican native, was found wandering the streets of a Kansas town. She was dressed oddly, seemed not to have bathed recently, and was not able to communicate except for a few Spanish words. She was taken into protective custody, and doctors determined that she was mentally ill and in need of treatment. She was involuntarily committed and remained hospitalized until 1995. During her commitment she was treated against her will with psychotropic drugs. Although Spanish interpreters occasionally attempted to explain the treatment plan to her, Quintero was unable to understand because of her limited grasp of Spanish.

After a time, a patient advocacy group took interest in her case; through their efforts it was learned that she was, indeed, a citizen of Mexico but not a native Spanish speaker. Instead, she was found to be a member of the Tarahumara Indian tribe of Mexico. Her appearance, dress, and behaviors, which had been described as odd and indicative of mental illness, were actually traditional aspects of her culture. She had only a limited grasp of Spanish because she was a native speaker of Ramuri, a tribal language. After a Ramuri interpreter was located, she was released and allowed to return to Mexico. With the assistance of the patient advocacy group, she filed a legal action against the doctors and the state of Kansas.

The doctors argued that they had fulfilled their obligation to obtain informed consent, albeit in English and Spanish, before treating her. However, the 10th Circuit Court of Appeals held that "if the patient's capacity to understand is limited by a language barrier, and the physician proceeds without addressing this barrier… the physician may be liable for failing to obtain informed consent from the patient." (Source: Quintero v. Encarnacion, Lexis 30228, 10th Cir. 2000).

Questions

1. How could the court and the health care team have determined Ms. Quintero's language needs?
2. Think back to the last time you worked with a population that had communication barriers, such as limited English proficiency (LEP), deafness or hardness of hearing, or visual impairments, or worked with individuals with tracheostomies, low levels of health literacy, etc.
    a. Explain how you would overcome communication barriers with these populations.
    b. If a patient was treated and received medical or surgical procedures, lab or radiologic tests, medication, etc., how can you be certain that the patient understood and provided informed consent?
3. How could the health care team have been more culturally competent to prevent this patient from being involuntarily committed for 12 years?
4. How could the health care organization have been better prepared to address diverse patient population needs?
5. Rather than making assumptions about Ms. Quintero's mental status, with whom could the health care team have consulted to learn more about her customs, behaviors, and health beliefs?

ILLUSTRATIVE CASE STUDY EXAMPLE Medicine

Teaching Case for Using Epidemiologic and Practice Data for Breast Cancer Screening

Prepared by Desiree Lie, M.D., M.S.Ed.

Case Problem for Clerkship Student or Resident

You care for a multiethnic population with varying levels of risk for breast cancer. Data suggest that African American women present with more aggressive cancers and at a later stage. The practice guidelines from the American Cancer Society, the American College of Obstetrics and Gynecology, and other national organizations do not offer guidance on ethnicity or race as a risk factor. How would you modify your risk assessment strategy to optimize screening for your own practice?

Potential Solutions

One strategy for practice-level quality improvement is to examine local or regional data on breast cancer incidence and mortality by race, geography, and other factors not accounted for by national practice guidelines (data are available from the U.S. Centers for Disease Control and Prevention, or CDC). Another strategy is to maintain vigilance for new literature identifying disparities in breast cancer outcomes, particularly studies identifying underlying factors accounting for the disparities. Such factors might include variations in patient attitudes, biases, fears, or limited health literacy that lead to delayed use of preventive services, including surgery after diagnosis, and to low adherence to recommended treatments such as chemotherapy.

Application Exercise

Locate data on breast cancer outcomes for your practice and community. Identify what you consider the highest risk factors for late diagnosis and treatment of breast cancer. Examine practice guidelines for breast cancer screening from a national organization (such as the U.S. Preventive Services Task Force, or USPSTF). Consider improving your practice outcomes (detection and treatment of breast cancer) using the following questions:

1. How might you modify the practice guidelines for your own practice?
2. How might you communicate a message about the importance of screening to high-risk patients within your community?

Disseminate Existing and Developing Case Studies

Public Health Case Studies Resource Center

ASPH has developed a free, user-friendly Public Health Case Studies Resource Center (www.asph.org/casestudies/) where both public health academics and professionals can post and access case studies contributed by schools and programs of public health. It offers a case study on cultural competency titled *Providing Culturally Appropriate Services in a Changing Community*.

iCollaborative

The AAMC has launched iCollaborative (www.aamc.org/icollaborative), a centralized online resource service designed to foster an online community for curriculum enhancement and faculty development exchange. Posted content in the iCollaborative is dynamically cross-indexed with relevant resources in the AAMC's journal *Academic Medicine* and **MedEd**PORTAL.

Create New Case Studies

Using the set of cultural competencies as a road map, transdisciplinary teams of medical and public health faculty can work together to create new case studies that explicitly address curricular gaps, such as outlined in the sample below.

In a team meeting at the end of a busy day, a colleague working in a (medical or public health) clinic serving a large number of patients from immigrant backgrounds expresses frustration about patients with limited English proficiency (LEP) who require more time to evaluate, seem less engaged, and appear less willing or able to follow through with the recommended interventions, saying: "It's obnoxious that they're in America but don't even bother to learn English."

Questions for the Learner:

- What are the professional and emotional challenges that providers face when working across language and cultural barriers?
- What are the factors that contribute to your colleague's perspective? (Consider cultural factors, bias, values, resource constraints, burnout, etc.).
- What are the challenges that immigrant patients and populations face when trying to access quality medical and public health services?
- How would you address your colleague's comment?
- What can be done to help improve your colleague's ability to work with patients with LEP?
- What commitments can you make to enable you and your colleagues to give quality care to culturally diverse patients?

Identify Strategies for Translating Curriculum to Practice Settings

Demonstrated strategies that optimize experiential learning and longitudinal exposure serve to reinforce critical principles of patient-centered culturally appropriate health care. Medical and public health students have opportunities to experience culture in a multidimensional fashion—through their own culture; through the culture of medicine and the cultures of other professionals with whom providers interact; and through patients' perspectives of the socio-cultural experience of the health system. These experiences occur in a variety of settings, such as in small groups, in problem-based learning teams, in ambulatory settings, and in interprofessional team-based longitudinal clinics. Such opportunities better equip emerging health professionals to examine the social and behavioral factors that influence health.

Service learning, practica, internships, capstone experiences, and other learning opportunities familiarize students in public health and medicine early on with the socio-cultural context of health and factors influencing health disparities. In these settings, students not only gain a better appreciation of community needs and assets, but also build relationships with the stakeholders they serve. Cultural competencies mastered through such experiences help to infuse theory with practice and, consequently, enrich student learning with real-world, population- and systems-level encounters.

Conclusion

The Expert Panel on Cultural Competence Education for Students in Medicine and Public Health convened on the notion that cultural competence education serves as an effective crossover topic area for the mutual benefit of students in both disciplines. Meaningful integration of cultural competence curricula will be the real barometer of the panel's success. It is the intention of the joint panel that the competencies set forth in this report function as touchstones for faculty and administrative efforts to standardize curricula, benchmark student performance, and better prepare graduates for culturally competent practice. Anticipating that individual programs have unique areas of focus, the panel encourages faculty and administrators in such programs to adapt this competency model to their particular mission, educational goals, and instructional objectives. The panel offers its recommendations to embed cultural competence education within and across medicine and public health curricula, highlights of exemplary case studies, and the road map for the future to assist schools of medicine and public health in preparing a cadre of culturally competent practitioners for the health workforce. Ultimately, culturally competent team-based practice must involve professionals, as well as those they serve, to improve health and well-being and to reduce health disparities.

APPENDIX A: Mapping to ACGME Core Competence Domains

Prepared by Robert Englander, M.D., MPH
Senior Director, Competency-Based Learning and Assessment, AAMC

With the paradigm shift in medical education focusing on competency-based outcomes (Carraccio, C., et al, 2002) the predominant framework within the U.S. is the Accreditation Council for Graduate Medical Education (ACGME) core domains of competence (ACGME, 2011), widely used by undergraduate medical education (UME) programs, required of graduate medical education (GME) residency programs, and adopted by the American Board of Medical Specialties for its maintenance of licensure program.

The medicine and public health cultural competencies have been mapped below to the ACGME's six domains of competence.

Medical Knowledge

- Identify cultural factors that contribute to overall health and wellness.
- Describe the influence of culture, familial history, resiliency, and genetics on health outcomes.
- Describe the values and limitations of evidence-based literature on understanding the health of individuals and communities.

Patient Care

- Incorporate culture as a key component of patient, family, and community history.
- Integrate a patient's/family's/community's cultural perspective(s) in developing treatment/interventions.
- Demonstrate shared decision making.
- Contribute expertise to culturally competent interventions.

Interpersonal and Communication Skills

- Describe the elements of effective communication with patients, families, communities, peers, and colleagues.
- Describe strategies to communicate with limited English proficient patients and communities, such as working with trained medical interpreters or translated materials.
- Apply (community) constituent-/patient-centered principles to earn trust and credibility.
- Communicate in a culturally competent manner with patients, families, and communities.
- Communicate with colleagues, patients, families, and communities about health disparities and health care disparities.
- Demonstrate willingness to collaborate to overcome linguistic and literacy challenges in the clinical and community encounter.
- Demonstrate willingness to apply the principles of cultural competence.

Professionalism

- Articulate cultural humility, cultural diversity, and cultural competence and their roles in ongoing professional development.
- Appreciate how cultural competence contributes to the practice of medicine and public health.
- Demonstrate willingness to explore cultural elements and aspects that influence decision making by patients, self, and colleagues.
- Appreciate the influence of institutional culture on learning content, style, and opportunities of professional training programs.

Practice-Based Learning and Improvement

- Articulate cultural humility and its role in reflection and self-assessment.
- Assess the impact of acculturation, assimilation, and immigration on health care and wellness.
- Identify one's own assets and learning needs related to cultural competence.
- Employ self-reflection to evaluate the impact of one's practice.
- Appreciate that becoming culturally competent involves lifelong learning.
- Demonstrate willingness to assess the impact of one's own culture, assumptions, stereotypes, and biases on the ability to provide culturally competent care and service.

Systems–Based Practice

- Differentiate health, health care, health care systems, and health disparities.
- Examine factors that contribute to health disparities, particularly social, economic, environmental, health systems, and access to quality health care.
- Describe the role of community engagement in health care and wellness.
- Identify health disparities that exist at the local, state, regional, national, and global levels.
- Articulate the roles and functions of local health departments, community partners and organizations, to include capabilities and limitations.
- Conduct culturally appropriate risk and asset assessment, management, and communication with patients and populations.
- Work in a trans-disciplinary setting/team.
- Analyze illness conditions and health outcomes of concern at the patient and community levels.
- Engage community partners in actions that promote a healthy environment and healthy behaviors.
- Establish equitable partnerships with local health departments, faith and community-based organizations, and leaders to develop culturally appropriate outreach and interventions.
- Recognize that cultural competence alone does not address health care disparities.

APPENDIX B:
Entrustable Professional Activity

The "entrustable professional activity" (EPA) descriptions that follow represent examples of linking the cultural competencies outlined in the knowledge, skills and attitudes domains in this report to the six competency domains identified by the Accreditation Council for Graduate Medical Education. These examples are intended to demonstrate, in an integrated fashion, how selected competencies in this report satisfy EPAs, to provide culturally competent care to families and community. (ten Cate, 2005; ten Cate and Scheele, 2007)

Prepared by Robert Englander, M.D., M.P.H., Senior Director Competency-Based Learning and Assessment, Medical Education, AAMC

Entrustable Professional Activity

Provide care that is culturally competent to individual patients and families by:

- Demonstrating the necessary knowledge requisite to culturally competent care (e.g., identifying cultural factors that contribute to overall health and wellness; describing the role of community engagement in health care and wellness; describing the influence of culture, familial history, resiliency, and genetics on health outcomes; describing factors that contribute to health disparities, particularly social, economic, environmental, health systems, and access to quality health care).
- Incorporating culture as a key component of patient and family history (e.g., communicating in a culturally competent manner with patients and families; conducting culturally appropriate risk and asset assessment, management, and communication with patients; analyzing illness conditions and health outcomes of concern to the patient; demonstrating strategies to communicate with limited English proficient patients , such as working with trained medical interpreters or translated materials; demonstrating willingness to collaborate to overcome linguistic and literacy challenges in the clinical encounter; and practicing cultural humility to understand how one's own background affects the relationship with the patient and family).
- Incorporating culture as a key component of the evaluation and treatment plan (e.g., integrating a patient's/family's/community's cultural perspective(s) in developing treatment/interventions; demonstrating shared decision making; communicating about health disparities and health care disparities and applying patient-centered principles to earn trust and credibility; Demonstrating willingness to explore cultural elements and aspects that influence decision making by patients, self, and colleagues).

Prepared by Maureen Y. Lichtveld, M.D., M.P.H. (Special Advisor),
Professor and Chair, Freeport McMoRan Chair of Environmental Policy,
Department of Global Environmental Health Sciences, Tulane University
School of Public Health and Tropical Medicine

Entrustable Professional Activity

Address community-based health disparities in a culturally competent manner by:

- Demonstrating the necessary knowledge requisite to culturally competent public health actions (e.g., identifying cultural factors that contribute to overall health and wellness; describing the role of community engagement in health care and wellness; describing the influence of culture, familial history, resiliency, and genetics on health outcomes; describing factors that contribute to health disparities, particularly social, economic, environmental, health systems, and access to quality health care).
- Incorporating culture as a key component of population and community health (e.g., assessing the impact of acculturation, assimilation, and immigration on health care and wellness; conducting culturally appropriate risk and asset assessment, management, and communication using a systems-driven approach; and analyzing illness conditions and health outcomes of concern at the community level).
- Incorporating culture as a key component of addressing health disparities (e.g., working in a trans-disciplinary setting/team to identify health disparities at the local, state, regional, national, and global levels; engaging community partners in actions that promote a healthy environment and healthy behaviors by establishing equitable and sustainable partnerships with local health departments, faith and community-based organizations, and leaders to develop culturally appropriate outreach and interventions, which maximize community assets).

APPENDIX C: Selected **MedEd**PORTAL® Abstracts

1. Stereotypes and Bias at the Psychiatric Bedside — Cultural Competence in the Third Year Required Clerkships

Resource type—curriculum

Description—didactic and student reflection and feedback learning experience

Cultural competence education begins with a focus on building cultural self-awareness and acquiring cultural knowledge as the first stages in a developmental process that leads to cultural competence. The explanatory model of illness and the philosophy of patient-centered care should guide this progression. Cultivating effective cross-cultural communication skills requires an understanding of culture that includes both the physician's and the patient's perspectives. Building on a foundation of cultural awareness, knowledge, and skills that students have acquired during Years 1 and 2, this clinical curriculum provides an opportunity for students to continue to refine their cultural competency clinical skills as they practice their medical interpretation skills at the bedside.

Citation: Elliott, D., St. George, C., Signorelli, D., & Trial, J. (2010). Stereotypes and bias at the psychiatric bedside—cultural competence in the third year required clerkships. MedEdPORTAL. Available at: www.mededportal.org/publication/1150

2. Narrative Reflection in Family Medicine Clerkship — Cultural Competence in the Third Year Required Clerkships

Resource type—curriculum

Description—narrative reflection exercise and joint capstone project

This resource incorporates cultivating effective cross-cultural communication skills, which requires an understanding of culture that includes both the physician's and the patient's perspectives. Building on a foundation of cultural awareness, knowledge, and skills that students have acquired during the pre-clinical curriculum, this exercise provides an opportunity for students to continue to refine their narrative reflection skills as they interact with patients in the clinical setting. During the family medicine clerkship, students participate in learning activities that allow them to explore the rich opportunities of thoughtful reflection and narrative practice. During the clerkship orientation, students participate in a formative narrative reflection exercise. During each of the subsequent weeks of the rotation, students complete an electronic journal entry that is focused on the patient-physician interaction based on their clinical encounters. During the last week of the clerkship, students demonstrate their ability to reflect on patient care through a final project that is shared with faculty and fellow classmates in a faculty-led wrap-up discussion.

Citation: Elliott, D., Schaff, P., Woehrle, T., Walsh, A., & Trial, J. (2010). Narrative reflection in family medicine clerkship—cultural competence in the third year required clerkships. MedEdPORTAL. Available at: www.mededportal.org/publication/1153

3. Interpreter Cases for Cultural Competency Instruction

MedEdPORTAL PEER REVIEWED

Resource type—case

Description—instructional cases series

This collection of five cases is based on real clinical scenarios that reflect the challenges of clinical encounters using interpreters. The cases are of different levels of difficulty and can be administered to medical students and residents as practice (teaching) cases. They use interactions that involve both history-taking and counseling. One case (smoking cessation) includes behavior and self-reflection checklists that allow summative assessment of student skills in the use of interpreters.

Content includes:

1. Generic communication checklists
2. Checklists specific to the clinical situation and task (e.g., history-taking)
3. Standardized patient checklists for student performance
4. Interpreter checklist for student performance
5. Student self-assessment/reflection checklist

The checklists may be used as a way to improve performance and to trigger discussion about the challenges of encounters involving interpreters.

Citation: Lie, D. (2006). Interpreter cases for cultural competency instruction. MedEdPORTAL. Available at: www.mededportal.org/publication/205

4. Interpretation at the OB/GYN Bedside — Cultural Competence in the Third Year Clerkships

MedEdPORTAL PEER REVIEWED

Resource type—case, presentation, evaluation tool

Description—Cultivating effective cross-cultural communication skills requires an understanding of culture that includes both the physician's and the patient's perspectives. Building on a foundation of cultural awareness, knowledge, and skills that students have acquired during the pre-clinical curriculum, this exercise provides an opportunity for students to continue to refine their clinical skills as they practice medical interpretation at the bedside. This clinical experience in medical interpretation is designed for implementation during the third year required OB/GYN clerkship. After a brief didactic review on the use of medical interpreters, students are assigned to care for a woman with limited English proficiency (LEP) through the course of her labor. Following the clinical encounter, students are assigned to write a reflection (from two points of view) to assist them with reflecting on their skills in providing care to LEP patients. Faculty-led small-group discussions use these essays to discuss the students' clinical encounters. Finally, evaluation of student mastery of interpretation skills is made by an objective structured clinical exam (OSCE) during the final week of the clerkship.

Citation: Trial, J., Elliott, D., Lauzon, V., Lie, D., & Chvira, E. (2010). Interpretation at the OB/GYN bedside—cultural competence in the third year clerkships. MedEdPORTAL. Available at: www.mededportal.org/publication/1148

5. Tobacco Ties

Resource type—video

Description—"Tobacco Ties" is a nine-minute video of a patient-centered tobacco cessation interview.

The "Tobacco Ties" video and facilitator guide are designed to be used formatively to instruct clinicians and health professions learners about how to use culturally sensitive, patient-centered communication skills effectively to counsel patients to stop using tobacco.

Note: This resource consists of separate pieces of content. You may need to visit the Web site, download resource files, and request additional information from MedEdPORTAL staff to access the full publication.

Citation: Marion, G., Crandall, S., Hildebrandt, C., Walker, K., Gamberini, B., & Spangler, J. (2009). Tobacco ties. MedEdPORTAL. Available at: www.mededportal.org/publication/3138

6. Esther Hines: Culturally Competent Collaboration to Manage Diabetes

Resource type—video

Description—"Esther Hines" is an 11-minute video with facilitator guide designed to be used formatively to instruct providers and health professions learners how to apply culturally responsive, patient-centered communication skills effectively to counsel patients on blood sugar control and weight loss.

This resource consists of separate pieces of content. You may need to visit the Web site, download resource files, and request additional information from MedEdPORTAL staff to access the full publication.

Citation: Marion, G., Hildebrandt, C., Crandall, S., & Kirk, J. (2011). Esther Hines: Culturally competent collaboration to manage diabetes. MedEdPORTAL. Available at: www.mededportal.org/publication/8368

References

Accreditation Coucil for Graduate Medical Education. (2011). *Common Program Requirements.* Retrieved from ACGME: www.acgme.org/acWebsite/dutyHours/dg_dutyhoursCommonPR07012007.pdf

Acosta, D. (2010). *Core guiding principles for cultural competence for medical education, version 2.0.* Seattle: University of Washington School of Medicine.

Association of American Medical Colleges. (2006). *Tool for assessing cultural competence training.* Retrieved from AAMC: www.aamc.org/initiatives/tacct/

Association of American Medical Colleges. (2011). *Core Behavioral and Social Science Foundations for Future Physicians: Report of an expert panel.* Washington, D.C.: AAMC.

Association of American Medical Colleges. . (2003). *Training future physicians about weapons of mass destruction: Report of the expert panel on bioterrorism education for medical students.* Washington, D.C.: AAMC.

Association of Schools of Public Health. (2006). *Master's degree in public health core competency model, version 2.3.* Retrieved from ASPH: www.asph.org/publication/MPH_Core_Competency_Model/index.html

Association of Schools of Public Health. (2011). *An instructor's guide to case-study instruction in the Milestones in Public Health course.* Washington, D.C.: ASPH.

Association of Schools of Public Health. (2011). *Learning taxonomy levels for developing competencies and learning outcomes reference guide (Reference Guide).* Washington, D.C.: ASPH.

Association of Schools of Public Health/W. K. Kellogg Task Force . (2008). *Schools of public health goals towards eliminating racial and ethnic health disparities.* Washington, D.C: ASPH.

Calhoun, J. G., Wrobel, C. A., & Finnegan, J. R. (2011). Current state in U.S. public health competency-based graduate education. *Public Health Reviews, 33*(1), pp. 148–167.

Carraccio, C. e. (2002). Shifting paradigms: From Flexner to competencies. *Academic Medicine, 77*(5), pp. 361-367.

Crosson, J. C., Weiling, D., Brazeau, C., Boyd, L., & Soto-Greene, M. (2004). Evaluating the effect of cultural competency training on medical student attitudes. *Family Medicine, 36*(3), pp. 199–203.

Fraser, C., & Brach, I. (2000). Can cultural competency reduce racial and ethnic health disparities? A review and conceptual model. *Medical Care Research and Review, 57*(1), pp. 181–217.

Frenk, J., Chen, L., Bhutta, Z. A., Cohen, J., Crisp, N., Evans, T., & Zurayk, H. (2010). Health professionals for a new century: Transforming education to strengthen health systems in an interdependent world. *The Lancet, 376*(9756), pp. 1923–1958.

Gebbie, K., Rosenstock, L., & Hernandez, L. M. (Eds.). (2003). *Who will keep the public healthy? Educating public health professionals for the 21st century.* Washington, D.C.: National Academies Press.

Gemmell, M. K. (2003). *History of the association of schools of public health.* Washington, D.C.: Association of Schools of Public Health.

Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). *The evidence base for cultural and linguistic competency in health care.* New York: The Commonwealth Fund.

IPEC: American Association of Colleges of Nursing, American Association of Colleges of Osteopathic Medicine, American Association of Colleges of Pharmacy, American Dental Education Association, Association of American Medical Colleges. (2011). *Core Competencies for Interprofessional Collaborative Practice.* Washington, D.C.: Interprofessional Education Collaborative.

J.R. Betancourt, A. G.-F. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), pp. 293-302.

Krathwohl, D. R. (2002). A revision of Bloom's taxonomy: An overview. *Theory into Practice, 41*(4), pp. 212–218.

Lichtveld, M. Y. (2010). Cultural competence education for students in medicine and public health. *Poster abstract: Patients and Populations: Public Health in Medical Education Conference .* Cleveland, OH: Association of American Medical Colleges and the Centers for Disease Control.

Lie, D., Boker, J., Crandall, S., DeGannes, C., Elliott, D., Henderson, P., & ...Seng, L. (2009). *A Revised Curriculum Tool for Assessing Cultural Competency Training (TACCT) in Health Professions Education.* Retrieved from MedEdPORTAL: www.mededportal.org/publication/3185

Maeshiro, R., Johnson, I., Koo, D., Parboosingh, J., Carney, J. K., Gesundheit, N., & Cohen, L. (2010). Medical education for a healthier population: Reflections on the Flexner report from a public health perspective. *Academic Medicine, 85*(2), pp. 211–219.

Milem, J., Chang, M., & Antonio, A. (2005). *Making diversity work on campus: A research-based perspective.* Washington, D.C.: Association of American Colleges and Universities.

Nivet, M. A. (2011). Commentary: Diversity 3.0: A necessary systems upgrade . *Academic Medicine, 86*(12), pp. 1487–1489.

Quintero v. Encarnacion, No. 99-3258 (UNITED STATES COURT OF APPEALS 10th Circut November 29, 2000).

ten Cate, O. (2005). Entrustability of professional activities and competency-based training. *Medical Education, 39*(12), pp. 1176-1177.

ten Cate, O. Scheele. (2007). Viewpoint: Competency-based postgraduate training: Can we bridge the gap between theory and clinical practice? *Academic Medicine, 82*(6), pp. 542-547.

Expert Panel [1]

Linda A. Alexander, Ed.D. (Co-chair), Associate Dean for Academic and Student Affairs (2005-2010). Currently Associate Professor of Health Behavior, Department of Health Behavior, University of Kentucky College of Public Health.

Donna D. Elliott, M.D., Ed.D. (Co-chair), Professor, Pediatrics, Associate Dean, Student Affairs, Keck School of Medicine, University of Southern California.

Sylvia Bereknyei, Dr.P.H. candidate, Research Assistant, General Internal Medicine, Program Manager, Coordinating Center at Stanford, Stanford University School of Medicine.

Joe Dan Coulter, Ph.D., Professor, Department of Community and Behavioral Health, College of Public Health; Department of Anatomy and Cell Biology, Carver College of Medicine, The University of Iowa.

Thomas A. LaVeist, Ph.D., Professor, Health Policy, Director, Hopkins Center for Health Disparities Solutions, Johns Hopkins Bloomberg School of Public Health.

Maureen Y. Lichtveld, M.D., M.P.H. (Special Advisor), Professor and Chair, Freeport McMoRan Chair of Environmental Policy, Department of Global Environmental Health Sciences, Tulane University School of Public Health and Tropical Medicine.

Desiree A. Lie, M.D., M.S.Ed., Clinical Professor, Department of Family Medicine, University of California, Irvine.

Tricia Penniecook, M.D., M.P.H., Dean, Loma Linda University School of Public Health.

Jessie Satia, Ph.D., M.P.H., Associate Professor, Departments of Nutrition & Epidemiology, Special Assistant to the Dean for Diversity, UNC Gillings School of Global Public Health. (Deceased).

Hendry Ton, M.D., M.S., Assistant Clinical Professor, Psychiatry, Director of Education, Center for Reducing Health Disparities, University of California, Davis.

Janet L. Trial, Ed.D., C.N.M., M.S.N., Clinical Instructor, Director, Professionalism in the Practice of Medicine, Keck School of Medicine, University of Southern California.

Observers

Ignatius Bau, J.D., Director, Health Systems, The California Endowment.

Roy Weiner, M.D., Associate Dean, Clinical Research & Education, Tulane University Health Sciences.

Ann Steinecke, Ph.D., Senior Program Specialist, Diversity Policy and Programs, Association of American Medical Colleges.

AAMC/ASPH Staff

Alexis L. Ruffin, M.S., Director, Curriculum Innovation Initiatives, Association of American Medical Colleges.

Elizabeth M. Weist, M.A., M.P.H., C.P.H., Director, Special Projects, Association of Schools of Public Health.

[1] *Titles and affiliations at empanelment*