UNITED STATES of CARE

# The Integration of Culturally Responsive Care in Medical Education

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In serving patients with diverse identities, it is critical that providers are responsive to patient's unique needs that may be affected by the social and cultural groups to which they belong. One way to ensure that these needs are met is the widespread implementation of culturally responsive care (CRC) in medicine, which starts with its integration into education for health professions. Educating health professionals about cultural responsiveness is especially important considering the severe underrepresentation of certain racial and ethnic groups in some health professions, such as Black, Indigenous, and Hispanic people in the physician workforce.

Major bodies that oversee medical education have committed to integrating cultural competence in the training of future physicians. Similarly, in other health professions (e.g., dentists, nurses, physician assistants, behavioral health providers), cultural competence is often required for accreditation and sometimes integrated in the profession's code of ethics. However, the requirements for education of health care professionals is usually not standardized, meaning that curricula may vary greatly from school to school. The top medical schools in the United States vary in the range of their incorporation of cultural competence in education, with some having specific courses dedicated to it, others making it a value instilled in their physicians, and several scarcely mentioning it in their curriculum. In recent years, medical students have rallied for a change in medical education that makes doctors aware of their responsibility to respond to the needs of all their patients, but the effectiveness of medical schools' responses is waiting to be seen.

Medical education is a crucial and early point for the concept of culturally responsive care to be introduced because physicians can better understand the concept and how it can be practiced, especially for physicians who practice in states that do not require CRC in continuing education modules. There is great need for reform in the way we prepare and educate physicians and other health professions to work with people historically marginalized by the U.S. health care system. This issue brief provides an overview of how training on culturally responsive care is integrated into medical education at various universities, highlighting gaps and opportunities for future action.

## Background

In a country as diverse as the United States, providing effective care across a variety of cultures is of utmost importance so that each person who seeks medical care is able to feel certain that they will receive quality care regardless of their identity. Providing culturally responsive care in health care makes care equitable.

**Culturally responsive care (CRC) is an effort by medical providers to acknowledge and recognize all aspects of their patient's identities when providing care.**

**Providing culturally responsive care also includes having respect for the way patients' intersectional identities shape their experience and care needs.**

**Similarly, there has been a focus on culturally competent care (CCC), which is the ability to provide care in cross-cultural settings in recognition of both the provider's and patient's identities—essentially exhibiting cultural competence.**

Though culturally competent care is a step forward, culturally *responsive* care can serve more people because providers take a more active approach to providing appropriate and effective cross-cultural care by putting their cultural knowledge into practice through tailoring their actions to best serve the patient's unique needs.

Historically, culturally competent and culturally responsive care have not been a focus in medical education, but in recognition of the importance of having culturally responsive physicians providing care, major bodies overseeing medical education and residency training have begun implementing this in curriculum requirements. The Liaison Committee on Medical Education (LCME)–the body which accredits medical education programs in the U.S.–made cultural competency a standard to be taught in medical education in 2000, requiring medical students to understand how culture affects medicine and "address gender and cultural biases in health care delivery, while considering first the health of the patient." Having the accrediting body for medical schools make CCC a required topic for medical education makes it clear that CCC is a necessary skill for successful medical practice. The Association of American Medical Colleges (AAMC) and the Accreditation Council for Graduate Medical Education (ACGME), bodies that influence medical school education (including admissions) and residency standards, respectively, have also taken steps alongside the LCME to increase the importance of CCC in doctor-patient interactions.

The AAMC created the Tool for Assessing Cultural Competence Training (TACCT) to help schools implement the LCME's culturally competent care standards. TACCT is an optional self-assessment for medical schools that evaluates the quality of the cultural competence education in their curriculum and identifies areas for improvement. The AAMC is also making efforts to increase cultural competency within the pool of incoming medical students by making this one of the qualities that their members look for in applicants. Applicants are encouraged to have experiences that expose them to diversity and integrate themselves in cross-cultural settings with the hope that they become culturally competent, and more importantly, culturally responsive physicians. In line with these efforts, the ACGME (the medical residency accrediting body) has made cultural competency part of 3 of its 6 core competencies for graduate medical education. This sets a standard for residencies to prioritize the inclusion of cultural competence in their education.

Currently, these governing bodies (LCME, AAMC, ACGME) have made it clear that doctors need to have cultural competence, a step toward cultural responsiveness. It seems that their standards, however, are lacking the prioritization of cultural responsiveness in addition to cultural competence.

## Diversity in Health Care: Why is it important and where do we currently stand?

Medicine has a diversity problem: the racial and ethnic demographics of the current physician workforce do not mirror those of the general U.S. population. An analysis of the statistics published by the AAMC and Kaiser Family Foundation suggests that Black, Indigenous, and Hispanic doctors are severely underrepresented in medicine. The table below compares the racial composition of physicians with the general population.

**The Underrepresentation of Certain Minorities in Medicine: Based on AAMC (2019) and Kaiser Family Foundation (2021) data**

| | White | Asian | Black | Hispanic | Indigenous |
|---|---|---|---|---|---|
| **Physician Workforce** | 56.2% | 17.2% | **5%** | **5.8%** | **0.3%** |
| **General Population** | 58% | 6% | 12% | 19% | 1% |

Having a more representative workforce is crucial to ensure that patients receive equitable care. Because patients interact with a variety of health care providers in a variety of ways, having representation across all health care professions is important. Based on research from Penn Medicine, an underrepresentation of certain ethnic and racial groups in medicine puts patients that belong to these populations at a disadvantage. Patients in the Penn Medicine study reported having a better experience when they were seen by a provider of the same race.

Implicit racial bias is a significant concern in medicine, as it can contribute to disproportionate negative health outcomes and create health disparities for certain races. These findings make it clear that it is important to increase the diversity of the physician

workforce by encouraging people of different races, ethnicities, and additional identities to pursue medical education and become physicians. This will serve to increase people's access to culturally responsive providers that can meet their specific needs. A targeted solution for better health care with the *current* demographic composition of our workforce may lie in culturally responsive care, where doctors are taught to question their biases, are educated on the way that identities inform their perspective, and put this into practice when providing care.

Creating a diverse pool of providers may become more challenging due to the end of race-conscious admissions, a result of the recent *Students for Fair Admissions v. Harvard* decision. For example, a study of 21 public medical schools in 8 states demonstrates that the number of Black, Hispanic, Indigenous, Native Hawaiian, and Pacific Islander students decreased 5% within 5 years of a state ban on Affirmative Action. A similar decrease should be expected at the national level. The expected impacts of the *Students for Fair Admissions* decision emphasizes the need for culturally responsive doctors who can provide equitable care to diverse populations.

## Implementation of Culturally Responsive Care/Cultural Competence in Medical Education

The implementation of CRC and CCC education in medical schools varies greatly by institution. To evaluate the variation in the current integration of CCC and CRC education, this report reviews the curricula of the top 5 medical schools overall (which all happen to be private institutions) and the top 5 public medical schools as determined by the 2023-2024 U.S. News & World Report rankings of the top research medical schools. The table below list the schools that were examined in this research.

| Top 5 Medical Schools Overall | Top 5 Public Medical Schools |
|---|---|
| 1. Harvard University | 1. University of California-San Francisco |
| 2. Johns Hopkins University | 2. University of Michigan-Ann Arbor |
| 3. University of Pennsylvania (Perelman) | 3. University of Pittsburgh |
| 4. Columbia University | 4. University of Washington |
| 5. Duke University | 5. University of California-Los Angeles (Geffen) |

**Source:** 2023-2024 U.S. News & World Report Rankings of Top Research Medical Schools

## *Top 5 Medical Schools Overall*

Despite being recognized as the top research medical schools in the country, the integration of CRC and CCC education in the top 5 medical schools is inconsistent. Some institutions have a dedicated sequence of courses to teach CRC and CCC, while others are more focused on efforts outside of the classroom and provide little public detail about the implementation of CRC and CCC curriculum, despite having a public commitment to diversity, equity, and inclusion (DEI).

Notably, the medical programs at Harvard University and the University of Pennsylvania include classes explicitly designed with AAMC guidelines in mind and seem to be influenced by the TACCT tool. Duke University similarly incorporates CRC and CCC in their curriculum through a sequence of courses.

- Harvard University has a series of courses on CCC, specifically teaching students how to be aware of their identities, reflect on the culture of Western Medicine, interact with patients of differing identities, provide cross-cultural care, and recognize the nuances that gender, socioeconomic status, race, ethnicity, sexuality, and spirituality bring to medicine. Information on Harvard's courses was published in 2005, but it is unclear how the implementation may have changed over the years.
- The University of Pennsylvania covers CCC in "Introduction to Clinical Medicine" courses, which are meant to teach cross-cultural clinical skills; address TACCT standards on health care disparities, cultural backgrounds, and biases; emphasize the importance of diversity in health care; assist students with navigating patient interactions involving an interpreter; help students acknowledge their biases in patient interactions; and encourage respect of the traditional healing practices and beliefs held by the patient. Information on the University of Pennsylvania's courses was published in the early 2000s, but it is unclear how the implementation may have changed over the years.
- Duke University has integrated CCC into its curriculum through a series of courses on navigating the doctor-patient relationship across different patient beliefs and identities, understanding the effect of health disparities and sociocultural experiences on health outcomes, and approaching situations with patients with cultural humility. In addition to these courses, the Duke program is built on the idea that the patient is the most important component of clinical care ("Patient FIRST Curriculum"). Students are taught to address racism and health disparities, be aware of cultural determinants of health, and learn how to be an inclusive provider.

CRC and CCC work at Johns Hopkins University and Columbia University seems to be largely focused outside of the classroom and the curriculum itself, differing greatly from the approach of the aforementioned universities.

- The Johns Hopkins University School of Medicine starts its students off with a three-day course where they learn about addressing personal bias in health care delivery, cultural competency, health care disparities, and the social needs of patients. They are also taught in a public health course to be "effective advocate[s] for improving the health and health care of populations [served]," which is an encouragement of culturally responsive medicine, though CRC itself is not explicitly mentioned. These are the only publicly available courses in their core curriculum that seem to address CRC and CCC. In response to the social justice events of 2020, Hopkins also announced a three-year virtual unconscious bias training course, though the details of this are not publicly available.
- Similarly, information about CRC and CCC in the curriculum at the Columbia University Vagelos College of Physicians and Surgeons is sparsely available. However, Columbia has posted "Guidelines for Promoting an Anti-Bias and Inclusive Curriculum," which references that physicians are taught to recognize their biases during training. Columbia mentions a commitment to promote cultural competency through the hiring of diverse faculty and has implemented public health into its curriculum by covering, where it covers topics such as health equity, social determinants of health, and population health, which could be perceived as cultural competency.

Overall, while some of the top medical schools have thoughtfully integrated aspects of CRC and CCC into their curriculum, others are yet to make this an important component of their curriculum.

## *Top 5 Public Medical Schools*

Some of the top public medical schools reviewed – those affiliated with the University of California-San Francisco (UC San Francisco), University of Michigan-Ann Arbor, and the University of California- Los Angeles or UCLA (Geffen) – incorporated CRC into their core values by making cultural competence a trait for graduating students to possess and assembling committees to ensure that this is upheld throughout the schools of medicine.

- As of June 2023, the UC San Francisco School of Medicine has instituted the Evaluation Plan for Anti-Oppression Education, which holds the school accountable for dismantling portions of its curriculum that may be considered oppressive and traumatic for people with marginalized identities. In addition, their program has integrated the objectives of "Professionalism" and "Interpersonal & Communication Skills," which promote CRC and CCC in their graduates. Specifically, these objectives require students to demonstrate sensitivity and responsiveness to patient identities and effectively communicate with patients and families of marginalized cultures and backgrounds. They also mention implementing DEI in their curriculum, but specifics of this initiative are not provided.

- The University of Michigan reports to provide its students with "tools and resources to serve diverse patients…[and] pursue research questions about equity and inclusion" through their medical education, and incorporates education on health disparities and cultural competency in the first year of medical school (M1). They have developed a committee to provide suggestions for the implementation of these topics in the first year, called the Curriculum for Health Disparities and the Underserved (CHDU) Committee.

- The curriculum at the David Geffen School of Medicine at UCLA has recently been remodeled to create humanistic and ethical physicians that are respectful of diversity in backgrounds and motivated by a sense of social justice. Several of the school's values (Interpersonal Communication Skills; Ethics, Professionalism, and Professional Identity; Leadership and Interpersonal Teamwork; Social Justice and Advocacy) emphasize teaching students to effectively communicate cross-culturally and be culturally responsive by demonstrating an awareness of social justice and being patient-centered advocates. Specific details on the remodel to their curriculum are unclear.

On the other hand, the University of Washington and the University of Pittsburgh have created specific courses at their medical schools that teach about CRC and CCC.

- The University of Pittsburgh has a series of courses that immerse students in everyday challenges faced by their future patients, increase awareness of the influence of culture and identity on treatment decisions, teach about social and behavioral determinants of health, emphasize cultural competence and humility in clinical experiences, and provide the opportunity to learn foreign languages to enhance cross-cultural care.
- The University of Washington has a two-part course that covers themes related to cultural competence and allows students to explore humanism in medicine, DEI, and determinants of health. In addition to coursework, part of the school's vision is to raise culturally sensitive doctors and its goal is to provide the skills to provide effective culture-informed care. Students are evaluated on cultural competency and cultural sensitivity skills as part of the Professional Development Assessment.

Overall, CCC and CRC appear to be important standards upheld in the education at the top public medical schools, though their methods of implementation vary.

## *Racial Justice in Medical Education*

Despite efforts made by many schools to prioritize CRC and CCC in their education, student advocates report that their implementation is falling short. White Coats for Black Lives (WC4BL) is a student advocacy organization committed to antiracism that reviews

the presence of antiracist efforts at medical schools and calls them to a higher standard in the form of a Racial Justice Report Card (RJRC), with metrics originally created by students from the Icahn School of Medicine at Mount Sinai.

WC4BL's RJRCs rate medical schools on their commitment to antiracism initiatives and systemic change in the medical system based on scores from their own medical students through an evaluation of their curriculum, resources for marginalized students, commitment to BIPOC communities, and policing practices on campus. The first edition of the RJRC chose schools that received the most funding from the National Institutes of Health (NIH) and in more recent iterations, the number of medical schools has expanded. Currently, RJRCs exist for the academic years 2017-2018, 2018-2019, and 2020-2021, with the most recent edition evaluating the performance of 26 medical schools. Schools that have received the highest scores include Harvard University, University of Michigan, Washington University in St. Louis, George Washington University, and Tufts University School of Medicine. It is important to note that these top scorers received a B-, with the exception of the Tufts University School of Medicine, which is the only medical school to ever receive an A+ and a passing score on the 2020-2021 edition of the RJRC. Tufts is a unique institution as it checks every major box that the RJRC asserts is necessary to be a truly antiracist school.

Tufts has integrated antiracism, CCC, and CRC into its curriculum for every year of medical school through the Perspectives in Medicine Course, which focuses on ethics, the patient experience, public health, and the health care system as a whole. Through this course, students are taught culturally competent care, advocacy, care for the underserved, health disparities, health determinants, cross-cultural care, and social justice in medicine. In addition to its curriculum, Tufts takes actions outside of the classroom to enforce antiracism and reward those who are committed to CRC through its Anti-Racism Committee, which seeks to promote change at the institution and hold it accountable, and through the Innovations in Diversity Education Awards (IDEAS) program, which provides financial support to faculty who create interventions to promote antiracism, cross-cultural medicine, and increasing diversity in medicine. Based on its score on the RJRC, students at Tufts report seeing antiracism in practice at their school. Considering the poor scores on RJRC, with Tufts as an exception, medical schools have a long way to go despite their current efforts.

## What does Culturally Responsive Care look like for practicing physicians?

Physicians are often required to complete additional modules of training, known as Continuing Medical Education (CME), to stay up to date with current topics in medicine and continue to build their skill set. CME can be a good solution to ensure all physicians are equipped with the tools needed to serve all of their patients.

Five states – Washington, California, Connecticut, New Mexico, and New Jersey – have passed legislation requiring cultural competence training for physicians. Additionally, 32 states have implemented cultural competence training for health care providers that meet the National Culturally and Linguistically Appropriate Services (CLAS) standards, which were developed by the U.S. Department of Health and Human Services Office of Minority Health to improve the quality of cross-cultural health care delivery and promote health equity.

- California requires that its health care staff receive mandatory cultural competency training that is congruent with CLAS standards and puts special emphasis on the need to have linguistic diversity in health service provision and a diverse workforce.
- Connecticut has similar standards, requiring their providers to have cultural competence training that focuses on the cultural and spiritual needs of the diverse populations served in health care settings which, like California, also emphasizes linguistic diversity.
- Washington State holds the standard that those in health professions must receive cultural competence training that promotes multicultural health awareness and encourages a focus on educating providers about health disparities across several identity groups (e.g., race/ethnicity, immigration status, sexuality, disability, socioeconomic status, rurality).
- New Mexico's cultural competence training requirement for health care professionals encourages providers to practice medicine in a way that is respectful of differing patient backgrounds to decrease health outcome disparities.
- Lastly, New Jersey expands its cultural competence training requirements that focus on tailoring care to the diverse needs of the patient population to include other health professions (dentists, podiatrists, medical and dental graduates) in addition to practicing physicians.

The Accreditation Council for Continuing Medical Education, which oversees CME standards for medical associations with physician members like the American Academy of Family Physicians (AAFP) and American Academy of Pediatrics (AAP), has not explicitly required that modules include CCC or CRC training, simply requiring that CME providers address "factors beyond clinical care that affect the health of populations." The CRC gap in CME standards makes training largely a responsibility of the state and employers.

It is important to also acknowledge that the lived experience of practicing physicians can also equip them to be culturally responsive. This is the case for many foreign medical graduates who are now doctors practicing in the U.S. Many of these doctors come from

countries where they have not received formal CRC education as part of their medical education, but they report that their cultural experiences help them relate to underserved populations in the U.S., even cross-culturally. Doctors who are foreign medical graduates make up 25% of the physician workforce and often have cultural similarities with their patients which enhances cultural understanding in the doctor-patient relationship.

## The integration of CRC in the education of other health professions

Providing CCC and CRC training to all health care professionals helps ensure access to care that meets the needs of critically important populations. However, standards of training vary among different health care professions

### *Nurses and Nurse Practitioners*

Education on CRC and CCC has become a priority for many health professions and extends even to expectations held by their governing boards. As part of the framework established by the American Association of Colleges of Nursing (AACN), baccalaureate, master's, and doctoral nursing programs are required to educate future nurses on culturally competent care. The AACN Code of Ethics also emphasizes that it is a nurse's obligation "to respect the biopsychosocial, cultural and spiritual integrity of people" in care delivery. Similarly, these standards apply to nurse practitioners whose education is also regulated by the AACN. In addition to requirements held by the nursing educational governing body, hospitals are required to offer modules on cultural competence to be accredited by the Joint Commission, an accrediting body for several health care settings. Part of the curriculum includes Culturally Competent Nursing Modules from the Office of Minority Health.

### *Physician Assistants*

Similar to nurses, physician assistant (PA) accrediting bodies encourage integration of cultural competence into PA curriculums and make cultural competence a pillar of practice. Several PA governing bodies co-signed and released the "Competencies for the Physician Assistant Profession" in 2005 (updated in 2012), which mentions a commitment to cultural competence as a theme of physician assistant practice. Part of these competencies is professionalism which includes sensitivity and responsiveness to patient identities with "self-reflection, critical curiosity, and initiative." Additionally, the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) requires PA educational programs to instruct on patient counseling that is culturally sensitive and teaches PA students how to provide medical care in a way that serves diverse populations.

### *Dentists*

Dental education is required by the American Dental Association (ADA) Commission on Dental Accreditation (CODA) to train future dentists to have the skills necessary to be

"competent in managing a diverse patient population." According to CODA, dentistry programs must also have service/community-based learning to encourage the creation of a "culturally competent oral health care workforce." The American Dental Education Association (ADEA) also has guidelines on ways that schools can promote diversity, equity, and inclusion in their curriculum. However, American dentist Dr. Cathy Hung noted in 2021 that the requirements for learning about diverse dental patient populations lack standardization and may differ depending on the institution.

### *Behavioral Health Professionals*

Behavioral health professionals – such as social workers, psychologists, Licensed Professional Counselors (LPC), and Marriage and Family Therapists (MFT) – are also held to standards to teach future practitioners about CRC and CCC. The National Association of Social Workers (NASW) holds social workers to a standard of CCC, which is included in their code of ethics and licensing exam. Social workers are sometimes required to be patient advocates and aware of systemic oppression. In a similar vein, LPC programs require that their graduates "reflect current knowledge and projected needs concerning counseling practice in a multicultural and pluralistic society" with a special focus on cultural diversity, an understanding of the roles of spirituality and heritage on worldview, and awareness of systems of oppression. The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) requires that MFT graduates understand how diversity and globalization influence community perspectives and treat patients of all identities (e.g., race, ethnicity, sexual, gender, age, disability status) with respect and dignity, holding their programs to the standard of providing resources to work in diverse environments and having a commitment to teach about marginalization of underserved communities with a focus on the responsibility of MFTs to address oppressive systems in practice.

Requirements for psychologists in training are less comprehensive than those of the aforementioned behavioral health providers. The standard held by the Commission on Accreditation (CoA) for graduate psychology programs is simply that psychologists should have "knowledge, awareness, sensitivity, and skills when working with diverse individuals and communities who embody a variety of cultural and personal backgrounds and characteristics."

## Are institutions responding to recent efforts to improve medical education?

Following a recent refocus on social justice issues in the wake of the murder of George Floyd in 2020, medical students have been calling on their institutions to engage in antiracist education and center racial inequities in medicine in their curricula. Many student protests called for greater discussion of racial health disparities; more efforts for diversity

and inclusion; and increased implementation of antiracist training for faculty, staff, and students. Since these protests, medical schools have made efforts to incorporate antiracism in their programs. For example:

- In direct response to these protests by their students, the University of Central Florida College of Medicine implemented a diversity ambassador program to help connect prospective students to students of color to discuss experiences.
- In 2020, Johns Hopkins School of Medicine made efforts to call further attention to the detrimental effects of racial bias in medicine by announcing a three-year anti-bias training for students and trainees to teach students, practicing physicians, and staff how to recognize unconscious bias and the byproducts of structural racism that might arise in health care provision. However, further details of this program are not readily available online.
- The Icahn School of Medicine at Mount Sinai has encouraged medical schools to implement antiracism in their curriculum through the Anti Racist Transformation in Medical Education Program. In 2021, they partnered with 11 medical schools – including the schools of medicine at Columbia University and Duke University – to provide virtual education on building a community of practice that will lead to lasting systemic change in the presence of racism in the medical system. The curriculum seems to lend itself to CRC as it **encourages programs to move past simple "knowledge transfer" to taking actions in health care to decrease bias in care**.

Pursuits to improve medical education by students continue to gain traction. One commendable example is the 2023 effort made by students at the Icahn School of Medicine at Mount Sinai to encourage medical school curriculums to acknowledge segregation in the health care system. As students note, insurance gaps exist in the Black community when compared to their White counterparts, which has led health care to be much less accessible for Black patients. This is particularly prevalent in New York City, where the Icahn School of Medicine is located. Students have advocated for a curriculum that discusses and instructs about racial segregation in health care, calls on future physicians to reflect on their identities and their interactions with clinical medicine, and envisions what it might look like to disrupt the status quo. Icahn students reported their recommendations in an article published in the American Medical Association (AMA) Journal of Ethics. The Icahn School of Medicine itself has been extremely responsive to this initiative by their students, even commending their students in a post about their article and implementing this curriculum in its course offerings.

Despite these instances of successful responses by medical schools to the concerns of their students, many medical schools do not meet the standards of social justice that are called for by advocates. It is important to note that in the 2020-2021 school year, which

followed the antiracism protests of 2020, the student-run advocacy organization White Coats for Black Lives gave only one school a passing score in their Racial Justice Report Card. Many of these schools still have a long way to go in implementing the structural changes that students want to see.

## Conclusion

As the U.S. continues to become more demographically diverse, medical care must be inclusive and responsive to the specific needs of all individuals and communities. In addition to increasing diversity in the health care workforce, prioritizing culturally responsive medicine can cater to the needs of diverse and marginalized populations. Educating physicians and health care professionals on using their knowledge of culturally responsive care can better tailor care to the individual.

Reform in CRC education is an important topic for all providers, as being culturally responsive is important to provide care in every profession. All providers benefit from being culturally responsive. Research shows that nurses report finding value in CRC training as it has helped them understand how their biases affect patient care and made them more mindful of how they treat patients with diverse identities. Having CRC as the standard for all professions is increasingly important as more identity groups are represented in the U.S. patient population.

Medical schools have made varying efforts to integrate cultural competence in medical education through their curriculum, but many have failed to encourage future physicians to take a more active role in cultural competence. Further, the results of the WC4BL Racial Justice Report Cards suggest that many are falling flat in providing an education that decreases inequity in care and trains doctors to care for populations historically marginalized by the U.S. health care system, despite calls from medical students to do so. More than two decades after LCME introduced cultural competence as a standard for medical education, many schools have not made caring for diverse populations central to their curriculum, failing to prepare future physicians to provide adequate care to people of all identities in the populations they serve. While new physicians must have training on CRC and CCC as they enter the health care profession, it is critical that physicians who were never taught CRC and CCC in medical school are also taught it as part of their continuing medical education.

Though many health professions have implemented requirements for CRC and CCC in their training, their framework has not been largely standardized. As stated by Dr. Cathy Hung, what each future professional is being taught can vary from school to school.

**Without increased specificity about classes that should be offered and what exactly should be taught, our current system is set up to produce future health care providers that are not equally equipped to serve diverse populations.**

Medical schools must be held responsible for educating doctors in a way that serves *all* patients, by making CRC a central, standardized, and transparent component of medical curricula and requiring CRC-related CME for all doctors. Behavioral health care professionals, nurses, PAs, and dentists also lack standardization and specificity in their cultural competence education requirements, which makes the abilities of each practitioner to engage in CRC unequal, to the disadvantage of their patients.

**All health professions would benefit from increased standardization of their curricula to ensure that all providers are adequately equipped to serve their diverse patient populations.**

As policymakers examine approaches aimed at reducing disparities and increasing access to care, they should consider policies specifically aimed at improving people's access to culturally responsive care, especially policies that would institute more comprehensive CRC training requirements for health care professionals.

## Appendix A: Further Reading

1. White Coats For Black Lives: Racial Justice Report Cards
2. AAMC's Tool for Assessing Cultural Competence Training (TACCT)
3. Journal Article on Implementation of CCC in Medical Education (Jernigan et al., 2016)
4. Mount Sinai Students Call for Education on Segregated Care in Medicine

## Appendix B: Glossary

### *Definitions*

- **Culture:** The customs and norms of a specific social or ethnic group.
- **Culturally Responsive Care:** An effort by medical providers to acknowledge and recognize all aspects of their patient's identities when providing care.
- **Cultural Competence:** Having knowledge of different cultures and identities that can be used when interacting with different populations.
- **Cross-cultural:** Having experiences with people that identify differently socially or ethnically
- **Culturally Competent Care:** The ability to provide care in cross-cultural settings in recognition of both the provider's and patient's identities.
- **The Liaison Committee on Medical Education (LCME):** The body which accredits medical education programs in the United States.
- **The Association of American Medical Colleges (AAMC):** The body that influences medical school education (including admissions).
- **The Accreditation Council for Graduate Medical Education (ACGME):** The body that accredits graduate medical education (residencies) in the United States.
- **Tool for Assessing Cultural Competence Training (TACCT):** A tool created by the AAMC to help schools implement the LCME's educational standards for cultural competence.
- **Racial Justice Report Card (RJRC):** An advocacy tool that reviews the presence of antiracist efforts at medical schools and calls them to a higher standard through a rating based on student data. The Racial Justice Report Card was created by the student advocacy organization White Coats for Black Lives.
- **Continuing Medical Education:** Modules taken by physicians to stay up-to-date with the current topics and practices in their field.

### *Acronyms*

- **CRC:** Culturally Responsive Care
- **CCC:** Culturally Competent Care
- **LCME:** The Liaison Committee on Medical Education
- **AAMC:** The Association of American Medical Colleges
- **ACGME:** The Accreditation Council of Graduate Medical Education
- **TACCT:** Tool for Assessing Cultural Competence Training
- **DEI:** Diversity, Equity, and Inclusion
- **RJRC:** Racial Justice Report Card
- **WC4BL:** White Coats For Black Lives
- **CME:** Continuing Medical Education
- **CLAS:** National Culturally and Linguistically Appropriate Services
- **AACN:** American Association of Colleges of Nursing

- **PA:** Physician Assistant
- **CODA:** American Dental Association Commission on Dental Accreditation
- **LPC:** Licensed Professional Counselor
- **MFT:** Marriage and Family Therapist