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Communities as Teachers: Learning to Deliver Culturally Effective Care in Pediatrics

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ABSTRACT. A patient's culture has an effect on her or his view of illness, decision to seek care, and adherence to treatment plans and follow-up visits. In this article, we describe community-academic partnerships designed to teach improved delivery of culturally effective care conducted in pediatric residency training programs in New York, New York, and San Diego, California. Columbia University–Children's Hospital of New York–Presbyterian focuses most of residents' cultural-training experiences within 1 community program, a home-visitation program (Best Beginnings) with which residents work in various capacities throughout residency. The University of California, San Diego and Naval Medical Center San Diego use a series of cultural "immersion experiences" as a primary method. The creation of community-academic partnerships for the purpose of service and training can be a critical asset in the development of culturally effective care training: community partners become teachers and local communities serve as classrooms. *Pediatrics* 2005;115:1160–1164; *community medicine, cultural competence, cultural sensitivity, culturally effective care, culture, graduate medical education.*

ABBREVIATION. CHONY, Columbia University–Children's Hospital of New York–Presbyterian.

A patient's culture has an effect on his or her view of illness, decision to seek care, and adherence to treatment plans and follow-up visits. Cultural differences may be inadequately addressed during visits with health care professionals and seriously affect the treatments planned for the patient and family.^{1–6} Many accreditation and professional organizations have developed policies for providing care to a population in the United States

that is increasingly diverse and subject to social disparities. They call for mandatory training of all health care professionals to ensure that they are equipped with the knowledge and skills necessary to deliver culturally responsive services. The Pediatric Residency Review Committee requires training in the multicultural dimensions of health care.⁷ The American Academy of Pediatrics has a policy statement outlining the education and training issues for culturally effective pediatric care. They define culturally effective care as:

"the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions. Such understanding should take into account the beliefs, values, actions, customs, and unique health care needs of distinct population groups. Providers will thus enhance interpersonal and communication skills, thereby strengthening the physician-patient relationship and maximizing the health status of patients."⁸

One method for teaching residents about the delivery of culturally effective care is to rely on local community partners to act as teachers and experts of their own cultures. In this model, community partners draw on the strengths of their communities.

In this article, we describe community-academic partnerships designed to teach improved delivery of culturally effective care conducted in pediatric residency training programs in New York, New York, and San Diego, California. Columbia University–Children's Hospital of New York–Presbyterian (CHONY) and the University of California, San Diego, in partnership with the Naval Medical Center San Diego, have developed training in community pediatrics through grants from the Anne E. Dyson Community Pediatrics Training Initiative. Improved delivery of culturally effective care is a major element in each program's community pediatrics curriculum.

The 2 sites use experiential learning or 1 of its variants, service learning, to form the theoretical foundation for curriculum development and teaching. David Kolb's theory of experiential learning is based on learning occurring in 2 dimensions: perception of information (ranging from concrete experience to abstract conceptualization) and processing of information (ranging from active experimentation to reflective observation). Taking these 2 continua together forms a cycle of learning, moving from experience to reflection, generalization, and application.⁹

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Fig 1. Michelle Mayer, MD (center), a pediatric resident, and Dodi Meyer, MD (right), a faculty member, conduct a home visit to twin patients and their family.

TEACHING CULTURALLY EFFECTIVE CARE IN NEW YORK

Training in culturally effective care in the CHONY program involves not only an increased familiarity with the cultural practices and beliefs of the Washington Heights, New York, community, but recognition of provider culture and potential bias. The Washington Heights community has a high Latino concentration (75%); the predominant group is Dominican immigrants. It also has an extraordinarily high density of children (20 000 per square mile); one third of all residents are <18 years old. The community suffers high levels of poverty, deteriorated housing, and poorly performing schools.

Community pediatrics training occurs throughout the 3 years of residency as part of the ambulatory blocks in years 1 to 3 and within the community pediatrics block in the second year. The program at CHONY focuses most of the residents' experiences within 1 community agency, Alianza Dominicana, in which the residents provide service to the agency's participants, learn about the context in which this service is being provided, go on home visits, discuss books that portray cultural clashes in a health care setting, and participate in staff development. They learn from the community about local health beliefs and cultures. Reflection and debriefing about these experiences are done jointly in conjunction with a pediatric faculty member and community partner.

Residents are introduced to Alianza Dominicana through 1 of its programs, Best Beginnings, which is a home-visitation program that promotes healthy

lifestyles and prevents family violence. The program is modeled after the Healthy Families America program.¹⁰ Community pediatrics faculty members meet with the Best Beginnings program director to establish goals, objectives, and modes of delivery for participants served by the agency. Family-support workers act as teachers. Together with the family-support workers, residents choose a health care topic of benefit to the families they serve to be discussed at their scheduled visit during their last week of the rotation. It is during this talk that workers are asked to openly discuss individually and community-held health beliefs. Differences between patients' and physicians' expectations for treatment of a particular disease are discussed. Throughout this block, residents join support workers in home visits of newborns enrolled in the program, and the residents follow these infants in their continuity clinic for the duration of their training. Residents do home visits for other children from their continuity clinics as well (Fig 1). In Appendix 1, a resident describes a home visit and its effect on her understanding of culture and ability to deliver culturally effective care. The cultural differences she experiences extend beyond ethnicity and involve the differences between city and suburban upbringings, economic security and insecurity, and the medical and nonmedical ("real-world") community.

During their second year, residents return to the program to teach prenatal classes to expectant mothers. They also participate in monthly "narrative-medicine" sessions with agency staff.¹¹ At these meetings, participants discuss the complexities of case management and communication strategies between members of the medical system and people with other culturally informed health-belief systems. Pediatric faculty and community partners take turns in leading the discussion. To date, specific books read and discussed include *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures* by Anne Fadiman¹² and *Autobiography of a Face* by Lucy Grealy.¹³

At the end of each block in which specific training is provided on culturally effective care, residents complete preformatted reflection cards on which they are asked to identify lessons learned and ways in which they could apply their new knowledge to patient care. These responses are classified into ≥ 1 of 5 categories: community resources, clinical skills/knowledge, cultural awareness/communication skills, empathy/sympathy for patient/family, and change in professional attitude (Table 1). First-year residents' reflections showed that most of the learning gained during time at Best Beginnings was

TABLE 1. Categorization of Learning for Selected Experiences in New York

Site	Community Resources	Clinical Skills/ Knowledge	Cultural Awareness/ Communication Skills	Empathy/ Sympathy for Patient/Family	Change in Professional Attitude
Best Beginnings (<i>n</i> = 18)	16	9	0	2	3
Narrative medicine (<i>n</i> = 8)	0	0	8	2	4
Home visit with faculty (<i>n</i> = 23)	4	18	14	8	10



Fig 2. Dan Hershey, MD (left), a University of California San Diego pediatric resident, learns how to play peon, a guessing game, from an American Indian youth.

within the category of community resources. Second-year residents' reflections showed increased awareness and attitude change in the cultural-awareness/communication-skills domain. Within this category, reflections showed understanding of both the cultural clashes between the medical institution and community agency and the cultural differences that occur in relation to individual health beliefs. Home visits with faculty during the ambulatory-block experiences provided the broadest array of learning experiences, with particular learning seen in cultural awareness/communication skills as well as clinical skills/knowledge.

TEACHING CULTURALLY EFFECTIVE CARE IN SAN DIEGO

Community pediatrics training at University of California, San Diego and Naval Medical Center San Diego occurs in 4 venues: a 4-week community-based block rotation, a 2-year longitudinal project, primary care continuity-practice components, and 4 half-day immersion experiences per year. Community-academic partnerships form the foundation for all of these components. Teaching to improve delivery of culturally effective care includes experiential

learning during the block rotation, self-reflection, case-based discussions, a cultural film and theater series, impact readings, and debriefings with a medical anthropologist, transcultural nurse, and other faculty members.

In the immersion experiences, community partners and residents work together to plan and teach about culturally effective care. Specific learning objectives addressing a particular community's history, beliefs, and practices, all of which can affect health, are identified. An experiential learning session, with involvement of community partners to teach a large group of residents, is then arranged.

In the first 4 years of the San Diego community pediatrics training program (July 2000 to June 2004), 16 immersion experiences were implemented in communities in the San Diego region. Eleven were cultural-immersion experiences based on ethnic communities, with 4 hosted by (and focusing on) Latino communities, 2 by Native American communities (Fig 2), 2 by African refugee and immigrant communities, and 1 each by the Hmong, Filipino, and Arab communities. Five cultural-immersion experiences did not focus on ethnic communities, including a military community experience, homelessness in San Diego, youth in the dependency system, and 2 cultural-simulation experiences.¹⁴

Evaluation of each immersion experience is performed by using an anonymous survey completed immediately after participation in the program. The survey consists of questions that assess the overall value of the experience and open-ended questions requiring the residents to reflect on the most important items learned and how they will incorporate these items into their practices. Surveys for each immersion experience are analyzed by using descriptive statistics and then summarized for feedback to the community partners and faculty involved.

Overall, residents rate the cultural-immersion experiences highly (mean scores: 3.4–4.8 on a 5-point Likert scale), and many agree that these experiences will benefit them in their future careers (Table 2).

In addition, resident narrative responses (here from both the San Diego and New York programs) (see Appendix 2) support the learning about culture achieved through community-based exposures.

TABLE 2. Evaluation of Cultural-Immersion Experiences in San Diego

Themes	Overall Value of Experience, mean*	Frequency of Using Experience More Than Occasionally in Future Role	Respondents, <i>n</i>
Latinos—public health in Tijuana	N/A	N/A	N/A
Barona band of Mission Indians	3.6	11.8%	17
Hmong community	4.6	28.6%	14
African immigrants	4.7	31.4%	35
Sycuan band of the Kumeyaay Nation	3.9	35.3%	17
Latinos—pediatric care in Tijuana	3.4	33.3%	16
African refugees	4.5	70.6%	17
Latinos—migrant health	3.7	70.6%	17
Filipino	3.8	71.4%	21
Latinos—impact of the US/Mexico border	4.4	45.0%	20
Understanding the Arab world	4.8	53.6%	28

* Scale: 1 indicates waste of time; 3, somewhat valuable; 5, very valuable. N/A indicates not applicable.

CONCLUSIONS

There is not a significant body of literature describing curricula for residents that addresses teaching culturally effective care, outcomes, and evaluation. Many of the programs described occur within the hospital or clinic setting in which expert physicians teach residents the necessary skills to deliver quality culturally effective care. Some, but relatively few, published reports describe culturally effective care curricula for medical students,¹⁵⁻¹⁷ nursing students,¹⁸ and practicing physicians¹⁹ that occur outside of traditional clinical settings. Several challenges may arise in such community-academic partnerships established for the purpose of education, including the need for communication between the partners, a commitment from high levels in each organization to facilitate resource sharing and problem solving for challenges faced, and an assessment of learning from frontline staff and learners.²⁰ Factors that strongly influence the effectiveness of community-academic partnerships include the creation and nurturing of trust, respect for a community's knowledge, and continuous flexibility, compromise, and feedback.²¹

By going out into the community, residents are exposed to the community's perspective of culture and health care delivery as well as its effect on the health of children and families. The creation of community-academic partnerships for the purpose of service and training can be a critical asset for the development of culturally effective care training; community partners become teachers, and local communities serve as classrooms. Such experiences are important in our attempts to provide the most effective care for the children and families we serve.

APPENDIX 1: "COMING TO THE TABLE": A PEDIATRIC RESIDENT'S HOME VISIT

R.D. is similar to many of the toddlers I see in continuity clinic: he lives in the part of Manhattan known as Washington Heights, his parents are recent immigrants from the Dominican Republic, and his mother worries that he does not eat enough. When he was diagnosed with iron-deficiency anemia, I gave his mother, Lydia, a list of iron-rich foods, asked her to reduce the amount of milk she fed him, and recommended that she make an effort to gather the whole family at the table for meals. I thought that perhaps this would make mealtime more enjoyable and R.D. would eat more.

Lydia repeated my instructions back to me at each visit, but R.D.'s anemia persisted. Uncertain how to proceed, I prescribed him iron. Then, early in the summer, I had the opportunity to visit his home.

Walking out of the hospital and through the Heights is like walking through a street festival at any time of year, but in the summer the neighborhood is especially rich with activity. Vendors sell papayas, sorbet, and *dulce de leche* from their carts, and discount items sprawl across the sidewalk; kitchenware, children's toys, and lingerie are all piled high. Men on ladders shout into megaphones: "Se vende ropa! A mejor precio!" The neighborhood is its own world, a tropical island in the middle of New York City.

I have often wondered what life is like in this neighborhood of bodegas, cantinas, and *envio* businesses devoted solely to sending money home. I wondered what it would be like to live in a building like R.D.'s with a botanica next door and the apartment numbers handwritten onto the doors.

An elderly woman opened the door before I could knock. "Doctora?"

"Yes," I said.

She shooed me inside. "Can you imagine?" she said, over her shoulder. "This young girl is a doctor." She threw up her arms, as if to say, "what will they think of next?"

I had typed up a plan for Lydia, including my oft-repeated instructions ("sit at the table with the whole family at least once a day"), but when I entered the apartment, I shoved those instructions deep into my pocket. The apartment, roughly the size of my living room, had no table. There was a small, plastic table in the corner where 1 child sat eating cereal, but no place where a family of 5 might sit together and eat. The rest of the furniture was composed of a bunk bed, a bed for the parents, and a few chairs that the children rushed to set in place for us. R.D. sat in his mother's lap, a bottle of milk firmly applied to his lips. "His babysitter says he needs a lot," she explained with embarrassment. She gestured to the elderly woman, who had moved into the kitchen to prepare dinner.

Seated in a lawn chair in R.D.'s tiny apartment, leaning my notepad against the windowsill, I thought about my earlier conversations with Lydia. Of course, my advice to her was based on my own suburban preconceptions; a table was a large structure, big enough to seat a family. For that matter, a babysitter was a teenager who never gave parenting advice. Our ideas about very basic concepts were so different that it was as if, although I speak Spanish, we were not speaking the same language. It was as if I needed a translator to understand the inner workings of her life.

The truth is, every doctor must act as his or her own translator, and we do this every day. When we try to ascertain how well a child is truly feeding, or how often, we take emotional cues from parents and try to shape them into absolute facts. Similarly, to capture the sociocultural context of our encounters with patients can be an enormous challenge.

Walking into R.D.'s home, I saw him through a lens that I might never have accessed in the office. I understood Lydia's polite repetition of my instructions, and the impossibility of carrying them out. To understand was an enormous relief.

My frame of reference is worlds away from the bustle of Washington Heights, but it does not mean that I can't learn to speak to my patients on every level they will share with me. And now that R.D.'s family has let me into their home, I will listen more carefully for the things in which each family believes, the people in their lives, and the places they live, down to the very kitchen table that no good doctor can take for granted.

APPENDIX 2: SELECTED RESIDENTS' REFLECTIONS ON TRAINING EXPERIENCES

"I think the most useful aspect was letting [community members] give us advice about a lot of common problems and mistakes."

"I learned that people outside of medicine do not understand that we have a culture of our own. We were able to discuss this culture and how we can enable understanding of cultural competency in both ways."

"I learned the basis of being culturally competent is to be patient."

"I also learned more about the environment of and challenges faced by my patients and their families and the services that they need."

"I realized that things I take for granted (eg, a steady source of income) can be a real obstacle in attaining medicine, food, [and] adequate supervision."

"Home environment and family structure have a greater role in health care than most medical care we provide."

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