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Education

CULTURAL COMPETENCY TRAINING IN EMERGENCY MEDICINE

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□ **Abstract—Background: The Emergency Department is widely regarded as the epicenter of medical care for diverse and largely disparate types of patients. Physicians must be aware of the cultural diversity of their patient population to appropriately address their medical needs. A better understanding of residency preparedness in cultural competency can lead to better training opportunities and patient care. Objective: The objective of this study was to assess residency and faculty exposure to formal cultural competency programs and assess future needs for diversity education. Methods: A short survey was sent to all 168 Accreditation Council for Graduate Medical Education program directors through the Council of Emergency Medicine Residency Directors listserv. The survey included drop-down options in addition to open-ended input. Descriptive and bivariate analyses were used to analyze data. Results: The response rate was 43.5% (73/168). Of the 68.5% (50/73) of residency programs that include cultural competency education, 90% (45/50) utilized structured didactics. Of these programs, 86.0% (43/50) included race and ethnicity education, whereas only 40.0% (20/50) included education on patients with limited English proficiency. Resident comfort with cultural competency was unmeasured by most programs (83.6%: 61/73). Of all respondents, 93.2% (68/73) were interested in a universal open-source cultural competency curriculum. Conclusions: The majority of the programs in our sample have formal resident didactics on cultural competency. Some faculty members also receive cultural competency training. There are gaps, however, in types of cultural competency training, and many programs have expressed interest in a universal open-source tool to improve cultural competency for Emergency Medicine residents.** © 2017 Elsevier Inc. All rights reserved.

□ **Keywords—cultural competency; emergency medicine training; diversity**

INTRODUCTION

It is well known that disparities in health care and health access can pose a threat to the well-being of particular populations (1). Specifically, care for those of different races, ethnicities, gender identity and sexual orientation, and limited English proficiency has been documented in the literature as varying significantly (2,3). African Americans are more likely to suffer from preventable ophthalmologic diseases, such as diabetic retinopathy and glaucoma, and are less likely to receive sight-curative treatments (4). Those of Latino descent, adjusted for age, gender, and pain scale, receive less adequate analgesia than their non-Latino counterparts (5). According to the U.S. Census Bureau, 21.1% of Americans speak a language other than English at home (6). However, patients with limited English proficiency receive an interpreter with a physician only 14–17% of the time (7). Differences in one's social determinants of health contribute to poorer cardiovascular, diabetic, and cancer outcomes (2). According to the most recent National Healthcare Quality and Disparities Report, few

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disparities in care have been eliminated over the past decade (3).

The Centers for Disease Control and Prevention Healthy Communities Program and Healthy People 2020 has set benchmarks for reduction of health disparities among those of diverse backgrounds (1,2). The Accreditation Council for Graduate Medical Education (ACGME) is attempting to heed these goals in Graduate Medical Education (GME). The ACGME Clinical Learning Education Review established Pathways to Excellence in an attempt to advance clinical learning to better health care quality (8). Health Care Quality Pathway 5 focuses on reducing health disparities by encouraging that residents, fellows, and faculty receive training in cultural competency and are able to identify clinical site-specific goals to reduce health disparities (8).

Cultural competency has been described as a "system that acknowledges and incorporates the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs" (9). Teaching cultural competency in residency may be beneficial; small-scale studies have shown that such interventions increase resident cultural sensitivity (10,11).

The level of cultural competency education has not been established in Emergency Medicine (EM). Because it is a diverse field in terms of composition of racial and ethnic representation, limited English proficiency, and gender and sexual identity or orientation, EM should be the most equipped to reduce variations in care (12). The objective of this study was to assess residency and faculty exposure to formal cultural competency programs in EM and assess future needs for diversity education.

METHODS

A short online survey was devised by a physician-led group at different stages of the GME process, including an EM program director, medical student clerkship director, medical school director of office of diversity inclusion and community partnership, and an EM resident at one academic emergency department (ED) that is home to a 3-year residency program.

The eight-question survey included one demographic question (3- vs. 4-year program) and seven topical yes/no/unsure questions. Each topic had further questions and space for open-ended input. The survey was modeled on Mendoza et al.'s integral *Pediatrics* investigation consisting of a diversity and inclusion survey of pediatric residency directors (13).

Through the Council of Emergency Medicine Residency Directors (CORD) listserv, 168 ACGME program directors, excluding our own institution, were identified.

Table 1. Characteristics of ACGME EM Residency Program and Cultural Competency Inclusion

Characteristics	N = 73
Length of program	
3 years	78% (57)
4 years	22% (16)
Do you have a cultural competency curriculum?	
Yes	68% (50)
No	30% (22)
Unsure	1% (1)

ACGME = Accreditation Council for Graduate Medical Education; EM = Emergency Medicine.

The short survey was sent to the CORD Program Director listserv twice and program directors were asked to respond. Two additional individualized e-mails were sent to nonrespondents. Duplicate responses were omitted. Program-specific responses were confidential and only names of respondents were known for follow-up purposes. The survey data collection form was managed by RedCap. We used descriptive and bivariate analysis of the results. We used 95% confidence intervals (CI) and chi-squared test for the comparison of proportions. p-Value < 0.05 was considered to be statistically significant.

The study questionnaire and methodological protocol was reviewed by the Institutional Review Board and determined exempt from further review.

RESULTS

Of the 168 ACGME residency programs that were e-mailed, the response rate was 43.5% (73/168). Respondents were Program Directors or their program leadership team, including Associate and Assistant Program Directors. Table 1 shows the breakdown of 3- vs. 4-year programs, and the percentage of residency programs that included cultural competency in residency program education. In Table 2, the type of educational program included and the modality of training are shown.

Table 2. Of Residency Programs With Cultural Competency Education, Inclusion Demographic, and Type of Training

	N = 50
Type of educational program included	
Race/ethnicity	86% (43)
Gender identity and sexual orientation	66% (33)
Patients with LEP	40% (20)
Social determinants of health	68% (34)
Modality of training provided	
Web-based modules and lectures	22% (11)
Lectures/didactics	90% (45)
Journal club	20% (10)
Other (sim, community immersion)	10% (5)

LEP = limited English proficiency.