

The Institutional Context of Multicultural Education: What Is *Your* Institutional Curriculum?

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Abstract

Recently revised accreditation standards require medical schools and residency training programs to integrate multicultural training into their curricula. Most multicultural training models concern the educational outcomes of individual trainees who have received digestible “units” of multicultural education or “cultural competence” training designed for trainees’ individual consumption. Few have taken a critical perspective on how an individual trainee must learn, change his or her behavior, and sustain that behavioral change within a specific institutional context.

The authors discuss the educational impact of one’s institutional learning

environment—the institution’s ethos, teachers, modeling, policies, and processes—on the multicultural education of physician trainees. A usable conceptual model is offered with which educators can identify those dimensions of one’s “institutional curriculum” that may enhance or obstruct trainees’ optimal learning and behavior change regarding issues of multiculturalism in medicine. Comparisons are drawn to the recent medical literature concerning professionalism education and the hidden curriculum. Distinctions are drawn between overlapping areas of planned, received, intended, and unintended learning and values, as communicated from faculty, attendings,

and residents to students. Ways of maximizing ideal learning and minimizing unintended consequences are discussed.

The goal is for medical educators to be able to ask, What is the institutional curriculum of my training program regarding issues of race, difference, etc? What elements of that institutional curriculum can be recaptured and reclaimed as consistent with and supportive of tenets of excellent patient care for all?

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There is a clear call for the integration of multicultural education and antibiotic training into undergraduate medical education and residency programs.^{1–5} Recently revised Liaison Committee on Medical Education (LCME) standards also encompass this dimension of physician education within models of professionalism that accredited training institutions must demonstrate.¹

The predominant model of multicultural education entails giving individual trainees information regarding cultural bias and cultural knowledge. The pedagogical approach is to enhance individuals’

cultural knowledge levels, self-awareness, and technical communication skills, ideally transforming their behavior with patients.^{5–8} Other programmatic models provide episodic or ongoing opportunities for critical dialogue regarding issues of race, culture, and difference.^{9–12}

Most multicultural training models and the majority of discussions in the medical education literature concern educational outcomes for individual trainees who have received digestible “units” of multicultural education or “cultural competence” training designed for their individual consumption. Few have taken a critical perspective on how that individual trainee must learn, change his or her behavior, and sustain that behavioral change *within a specific institutional context*.^{9,10,12,13} To this extent, many medical educators have been “diagnosing” what is lacking in the isolated, individual trainee, largely apart from how the training institution works intentionally or unintentionally to obstruct, contradict, facilitate, sustain, and/or sabotage that trainee’s optimal personal and professional development regarding issues of race, culture, or other differences in the clinical encounter. The

goal has been to “fix” or “fill up” what is lacking in that trainee, but, in many cases, educators remain silent or ignore those ongoing institutional factors that can contradict their excellent multicultural lessons and antibiotic activities and dampen their intended effects.

Business models exist for how to manage diversity within health care institutions, including those detailing developmental stages of institutional multicultural development.^{6,13} There are also discussions of how clinicians can advocate for patients and improve the status quo within suboptimal institutional environments.^{12,14} Betancourt¹⁵ even offers a recent discussion of how academic medicine centers might remedy health and health care disparities within their own delivery systems through cultural competence initiatives.

In this article, we discuss the educational impact of one’s institutional learning environment—the institution’s ethos, teachers, modeling, processes, and policies—on the multicultural education of its physician trainees. We offer a usable conceptual model with which medical educators, program planners, and institutional leaders and administrators

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can identify these positive and negative institutional “lessons” and hidden curricula to which trainees might be exposed on a daily basis. We identify those elements held in common with the recent, burgeoning literature on professionalism and the “hidden curriculum” in medical education.^{16–23}

Our goal is for medical educators to be able to ask, What is the “institutional curriculum” of my training program regarding issues of race and difference? What elements of that institutional curriculum can be recaptured and reclaimed as consistent with and supportive of the tenets and goals of excellent patient care for all? The ultimate goal of this discussion is to produce the most effective and high-quality lessons in the multicultural education of physicians.

The Institutional Curriculum

One useful schema for the task of institutional assessment comes from the curricular evaluation model developed by Coles and Grant.²⁴ We have adapted it (Figure 1) to conceptualize the institutional curriculum regarding

multicultural education that is being “taught” within any given institution.

Coles and Grant²⁴ depict a curriculum as three overlapping circles: the “curriculum on paper,” the “curriculum in action,” and the “curriculum as the student or trainee experiences it.” For a given multicultural initiative, the “curriculum on paper” may include what might be part of a course syllabus or reading materials, or what program planners have written up in grant proposals, including learning objectives and planned educational exercises.

The “curriculum in action” is defined as how the curriculum on paper appears in practice, for better or worse. The curriculum in action includes what is successfully implemented from the curriculum on paper in resultant formal educational sessions and informal moments of both educational and values transmission. Such sessions include what actually is covered in the course of lectures, small-group sessions, and other activities outlined in the curriculum on paper. The curriculum in action also encompasses that which program

planners did not plan or intend to communicate to learners about multicultural issues, including informal or spontaneous dialogues or “lessons” related to the curriculum on paper and its implicit values.

Finally, the curriculum from the students’ perspective is defined by the lessons students read and see acted out, intentional or not. It is what students and trainees come to believe most strongly they should be doing or focusing on, within the context of the hundreds of things they could potentially learn from an idealized curriculum on paper. It is closely tied to a training institution’s or medical school’s written and unwritten reward system.

We take this model a step further, as did Coles and Grant,²⁴ but now in specific relevance to multicultural curricula in medical education. Each of the areas is sectioned by the overlapping of the three general components and labeled in Figure 1 as (A) through (G). This gives us more insight into the different components of one’s own institutional curriculum regarding issues of multiculturalism, race, racism, and difference. In an honest and ongoing deconstruction of both easily identifiable as well as hidden components of one’s institutional curriculum, medical educators can identify areas for improvement and strategies for intervention. Again, we can specifically begin to ask and then answer, *What is our institutional curriculum, and what can we capture and reclaim as consistent with and supportive of our multicultural tenets and goals?*

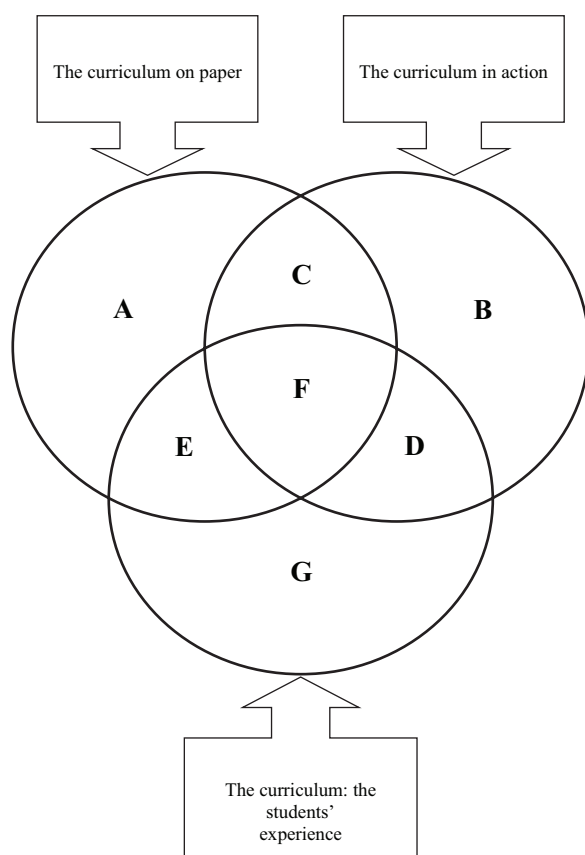


Figure 1 Institutional curriculum model for multicultural education. Adapted from Coles and Grant²⁴ and used with permission.

The Institutional Multicultural Curriculum, From (A) to (G)

What we planned was also taught and learned

Beginning with the ideal, area (F) represents what we planned and hoped would be taught both in formal curricular activities and in the informal relations and discussions with the teaching faculty, in the resources available to trainees, in the mode and timing of public leadership of administrators, in formal written policies regarding patient care, and in the processes trainees and patients see in the minute-by-minute working of the institution. Running in and around these circles is an ethos, or philosophy, of both equitable patient care and respectful, collegial relations with fellow employees that makes for a dynamic learning organization regarding issues of

equity and multiculturalism.^{12,13,25} In short, area (F) defines *that area which we want to maximize*, wherein what one hoped would be taught is actually taught and modeled and is, ultimately, learned (experienced and internalized) as such by the trainee.^{17,18}

Formal curricular elements we wanted to present, but couldn't/didn't

Area (A) defines multicultural curricular goals that may have been written in a grant proposal or syllabus, or otherwise mandated, but did not get put into action and, thus, were not experienced by the students. Reasons for this “failure” are all too familiar to medical educators: a lack of resources to implement the teaching of a certain principle or skill, be it a lack of time, money, or trained personnel. For instance, cross-cultural role-playing or small-group dialogue sessions may have been part of the multicultural curriculum on paper, but lack of expertise or money to train enough small-group facilitators may have precluded this important aspect of the planned curriculum.^{11,12} This curricular ideal is, thus, never put into action, nor does the trainee experience it.

Undesirable behavior not directly experienced by trainees

Area (B) represents that which was spoken or acted out by “teachers” (faculty, senior residents, nursing staff, administrators) but was not intended as part of the curriculum or was even contradictory to the tenets of the multicultural curriculum on paper. For instance, some faculty members may disdain or resent multiculturalism in medical education. They might not buy into its value or urgency as central to excellent medical care. Perhaps the implementation of a formal multicultural curriculum means their area of expertise in basic or clinical sciences is to receive less time in the undergraduate medical or residency curriculum. To the extent, however, that they do not come into contact with students and/or do not communicate or model these suboptimal lessons and values to students, in contrast to area (D), these incongruities in philosophy and professional modeling fortunately may not be immediately experienced by trainees.

We must note that it is difficult to imagine, in an organizational community, that even indirect influences, contradictory to formal curricular statements of value,

would not eventually touch trainees, despite our diagram's depiction.

“Learning environments”^{16–18} do not “pop” into being only when students are physically present. They are made and reproduced over time, affecting not only students or trainees, but teachers as well. Inasmuch as those newest to the medical profession—medical students—undergo a socialization to values that ultimately dictate clinical behavior within a given organizational structure, Hafferty,^{16(p406)} perhaps the most-often-cited scholar of medical schools' hidden curricula, has described the medical school itself as a “moral community.”

We say again that it is, therefore, difficult to imagine that attitudes skeptical of and adversarial to multicultural tenets, albeit held by those not with direct student contact, would not eventually affect those same students. We as teachers are lifelong learners with human limitations. We have a limited amount of energy to resist or contradict internalizing our colleagues' cynicism, skepticism, and resentment. We all suspect that politically charged and value-laden initiatives such as multiculturalism and professionalism are always just a couple steps from institutional chopping blocks, in contrast to technology, research, and other revenue-producing activities of this moral community. And because medical educators traditionally include senior faculty members, junior faculty members, fellows, residents, and interns, the professional hierarchy prescribed for us to climb and survive generally dictates that we actually *not* explicitly or overtly risk offending those with whom we have disagreements regarding social ideology or clinical practice.

What a conundrum! The point here is that our diagram may suggest that some “teachers” and role models of clinical practice and values-based teaching may be safely out of students' and trainees' spheres of influence; yet, the implications for diagnosing, remediating, and optimizing our institutional curriculum nonetheless demand that we give attention to minimizing the area depicted as (B) in our diagram. We will have more to say about the strategy of organizational transformation later in this discussion of optimizing our institutional curriculum regarding multiculturalism and equitable health care.

Excellent intent, but effects not immediately felt by students

Area (C) represents those components of the curriculum's written goals and ideals that have indeed been put into motion but have not yet been directly experienced by students or trainees. Such would be the case in Welch's²⁶ offering of multicultural training to administrators and department heads at University of California–San Francisco School of Medicine. Welch not only developed a training course specifically for department heads, but secured the dean's agreement to write and sign a letter of support and encouragement, presumably facilitating department heads' decision making, and at least communicating a new emphasis in the institution's priorities. Employees were released from departmental duties to attend training that would help them become better leaders and administrators in how the institution had been reenvisioned to run in its new model of multiculturalism and equity. However, the impact of that learning by institutional leaders may not immediately trickle down to and be experienced by a given group of students. Certainly, the expectation would be that area (C) would become area (F), as the impact of a change in the knowledge, awareness, and skill of institutional leaders makes its way to trainees and, perhaps, as department heads work towards recruiting and retaining a more diverse department faculty, respond to departmental crises, or encounter opportunities for transformation of departmental values into practical action.

Another example of area (C) might be an institution's commitment to mentoring and developing the talents of racially and ethnically underrepresented K–12 students within the geographic region of the training institution.^{27,28} It may be years before that long-term commitment to the institution's immediate community becomes apparent to the trainees within the institution, by way of a more diverse medical school, residents, or even faculty, made up of such “homegrown” local talent. When success does occur, the educational atmosphere would be enriched with the relevant life experiences and perspectives that enhance both the institution's service to its catchment area and its training of the next generation of physicians. When these long-term goals are realized, area (F) is enhanced.

Curriculum not intended, but nonetheless experienced by students

Area (D) represents perhaps the most frustrating section of this diagram and, thus, deserves an extended discussion. This area reflects aspects of one's institutional curriculum not intended by or consistent with the formal curriculum on paper but, nonetheless, taught and experienced by trainees and students. For example, what does the absence of a racially diverse faculty, research and otherwise, teach implicitly about the institution's value for equity, and about "us" and "them"? Researchers and researched? Clinicians and clinical material? And what is taught to trainees in the seemingly "tacked on" presence of a few multicultural sessions a year, perhaps at the end of the day, with no evaluative or attendance requirement?

Are institutional policies consistent with the principles of equity and respect taught in formal multicultural sessions? For example, one of us (J.M.G.) helped develop a vibrant multicultural initiative, emphasizing the elimination of racial inequalities in clinical services. During one of the conferences, an intern physician noted that African American patients seemed more agitated and angry when they finally made it into the ER to see a physician. A senior resident pointed out to this intern the institutional policy that—given the same severity of illness—privately insured patients are called into the ER ahead of those with public insurance. In this community, that policy often meant that similarly ill white patients were seen ahead of African American patients. Could this be part of some African Americans' frustrated, angry dispositions when they were finally allowed to see a physician?

Imagine the morally injurious and professionally frustrating position in which this policy must put interns, residents, attending physicians, and other ER staff. Ethicists and medical educators who emphasize professionalism characteristics believe such moral dilemmas and educational contradictions may explain the demonstrated increases in cynicism documented as trainees near the ends of their programs.^{17,19,20}

If we are honest and passionate about resolving these institutionally created dilemmas, the conceptual diagram of one's institutional curriculum regarding

multicultural and equity issues may provide a useful and accessible starting point for identification of such dilemmas and their impacts on the education, mental health, and ongoing development of all physicians.

In the next illustration of area (D), we ask what it "teaches" a trainee to hear one's supervising resident or attending denigrate a patient or colleague and have no one senior to that trainee offer a challenge to this dysfunctional status quo. A Mexican American physician explained the injury of just such an experience²⁹:

While completing the first clinical rotation of medical school, I encountered a venerated faculty member making disparaging comments about a Mexican woman's cultural healing practice during teaching rounds. . . . Whether these insensitive remarks were made in ignorance or with full knowledge of these practices, the gratuitous and cynical pronouncement of this woman's "stupidity" defined a true culture clash and clearly suggested that one of the cultures was primitive and inferior to the other. . . . Remarkably, not one member of the large medical team took exception to the authoritative words of this master clinician-educator. It was a powerful lesson for students being newly indoctrinated into the culture of medicine.²⁹

Finally, area (D) may engender the most resistance by institutional stakeholders. There may be objections to a newly perceived presence of "the cultural police," imposed "political correctness," or varied definitions of "medical student mistreatment." For example, a training program began a multicultural initiative that included not just cultural information, but a transformative component that sought to effect deep personal change in physicians and physician trainees, and cross-disciplinary alliances in the goal of delivering equitable health care to the surrounding diverse population.^{9,12,30,31} On one occasion, a resident and a social worker independently approached multicultural program staff, including author J.M.G., to express concerns about the treatment of an African American patient and his family. Several members of the treatment team believed the mother of the patient was belligerent, pushy, and inappropriate in her attempts to secure and understand the best medical care for her ill son. It was the poignant and shared opinion of the social worker and the resident

physician that the same behavior in a white parent would have been depicted as the appropriately concerned behavior of an articulate and sophisticated patient advocate. A multicultural program official notified the senior attending physician on the ward service of the team members' concerns. The reporting of these concerns for discussion to the entire treatment team, broached by the clinical fellow in charge that day, was as follows: "Okay, you guys, who ratted on us to Multicultural?"

Most of us would agree that we should not be treating families or patients differently on the basis of their race or perceived economic or educational status. It is not clear whether this was happening on this inpatient ward, but the concerns, reluctantly and courageously shared on separate occasions by treatment team members who had not conferred with one another, at least give a reason to consider the possibility in a constructive, nondefensive, reflective dialogue.

In fact, one of tenets of the training program in question was that we are all on a journey—unlearning racism—that we all have internalized racist stereotypes as members of this country. Shame and guilt are not helpful, but let's move on, as humble, lifelong learners, to a constructive recreation of ourselves and our collective and individual clinical approaches, in the name of the highest standard of patient care for each person we are privileged to serve. That is what the written and spoken curriculum of this program sought to promote.⁹

And it wasn't that this multicultural initiative failed. It wasn't even that one of these perspectives on the mother's behavior was correct and the other incorrect. The point in our sharing this true story is to illustrate how much learning happens outside of and even in contradiction to formal educational activities and controlled, idealistic case analyses. To ignore this reality and leave these realms of teaching and role modeling untouched by our initiatives is to cause frustration and confusion that is detrimental to the very value we would want this topic to assume.^{12,17,19,20}

Stories such as these keep us from labeling this part of a medical school's multicultural curriculum as "hidden." It may not be written anywhere, but it is

definitely an easily identifiable and frequently experienced dimension of the institutional curriculum.

Those familiar with the LCME and Accreditation Council for Graduate Medical Education (ACGME) standards of professionalism will recognize the newly mandated duty, for which medical educators will be held accountable, to at least have a plan in place to transform students' experiences from the (D) region of our diagram to the (F) region. Note that this model suggests that removing recalcitrant faculty from direct contact with students and trainees (from area [D] to area [B]) might be an effective short- or long-term strategy to positively influence the institutional curriculum.

Good things learned but not taught

Area (E) represents things learned, consistent with the program's ideals, even though program planners did not formally teach them. Students and trainees may have been enabled or convinced of the importance of the topic matter just by the very existence of the formal multicultural curriculum. For example, it may not have been the plan or ability of program planners to teach Spanish, but the new validity of the topic and its connection to excellent patient care may have led a student to seek out and set up an immersion experience in a Latin American country over the summer. Besides explicitly publicizing an institution's current or planned multicultural offerings, medical educators might influence the size of area (E) by paying close attention to what is prioritized in their admission criteria. That is, perhaps the intrinsic motivation or demonstrated commitment to issues of social justice and the medically underserved can predict the individual who will go on to seek out or create educational activities and opportunities for himself or others, consistent with the tenets of the institution's multicultural program.

Area (E) can also be a place of frustration, if institutional policies do not support the formal lessons that have been internalized by trainees. During a multicultural training session,^{30,31} a middle-aged Puerto Rican community member described the childhood experience of interpreting for his mother at her doctor's appointment. The burden of responsibility was so great and the experience so traumatizing, he testified, that he had stuttered in English ever since.

An intern, recalling that formal multicultural curriculum session, also testified, "I think of that story *every time* that situation comes up, and it changes what I do." She had clearly internalized the formally presented message into her professional identity so that it changed her clinical behavior: she did not use family members to interpret for patients. Fortunately for this intern, she trained at a hospital that had an exemplary, multidimensional, 24-hour interpreter service that did not leave her in area (E) of the diagram in her goal of providing the highest-quality care to all patients. Yet, what cynicism and resentment of the formal multicultural curriculum and its teachers might have resulted, had the institutional curriculum in action been inconsistent with the curriculum on paper and the curriculum from the student's experience? Rather, operating in area (F), the program's explicitly communicated multicultural tenet, and the intern's internalizing of that tenet as valuable and essential to excellent patient care, were supported and reinforced by the institution's policies and priorities.

Things not taught, not intended, but nonetheless experienced by students

Lastly, area (G) represents the part of the institutional curriculum not formally taught, not intended, but nonetheless experienced by students. This includes the unspoken reward system, including what other medical students or residents pass on about how trainees will actually be evaluated or rewarded, despite what is rhetorically spoken by program planners. Maudsley¹⁸ points out this "fundamental distinction between what students are taught and what they learn." He goes on to write, "The vast majority of important informal interactions are student conversations where no faculty are present."^{18(p433)} In the end, students may believe that however well or poorly they learn cross-cultural interviewing skills, the most important thing to get them into a desired residency program is how well they score on paper exams, or how consistent their relational style is to that of senior residents or attendings, dysfunctional or not.

Optimizing the Institutional Curriculum

The most recent LCME standards could not be more clear about the importance

of identifying and remedying any element of the institutional curriculum that contradicts formal learning objectives and attempts to teach professionalism in medicine:

In addition to defining the attributes of professionalism expected of the academic community, the school and its faculty, staff, students, and residents should regularly assess the learning environment to identify positive and negative influences on the maintenance of professional standards and conduct, and develop appropriate strategies to enhance the positive and mitigate the negative influences.¹

Both the LCME (mandating guidelines for medical schools granting the MD degree) and the ACGME (mandating guidelines for graduate medical programs) include multicultural principles in what they expect graduates to learn from their training programs. Medical educators, administrators, and institutional equity-makers also recently received invaluable assistance and validation from the LCME standards in tackling these issues head-on with recalcitrant faculty role models, with due process:

Such [professionalism] attributes should also be promulgated *among the faculty and staff* associated with the school, with suitable *mechanisms available to identify and promptly correct* recurring violations of professional standards.¹ [our emphases]

However, we suggest that one of the easier, albeit most unpleasant, things to do may be to identify the faculty member or resident whose behavior is so consistently egregious that it screams to be demonized among us as unethical or culturally disrespectful. The more challenging task is to comprehensively "diagnose" and remedy the entire institutional curriculum, to transform the full "moral community"¹⁶ in which this undesirable behavior went previously unchecked by supervisors and peers, perhaps even as this person was rewarded with serial professional advancements.

Learning communities as organizational structures have an ongoing, developmental nature to them. Perhaps the most difficult task is to commit the institutional energy and resources to an ongoing process of organizational critique and recreation, hopefully consistent with the stated institutional mission of excellent, culturally respectful care for all patients.

The recently burgeoning literature on teaching and modeling professionalism in medical training provides useful case studies and perspectives that overlap and augment the literature concerning multiculturalism in medicine. In particular, the seminal articles by Hafferty¹⁶ and Hafferty and Franks¹⁷ on the “hidden curriculum” of medical training are especially instructive. Dovetailing the notion of the institutional curriculum in regard to multiculturalism and equity, Hafferty and Franks¹⁷(p869) write of the entire medical school experience:

What students learn about the core values of medicine and medical work takes place not so much in the content of formal lectures but rather between the blackboard and the pen, not so much at the bedside (medicine’s preeminent metaphor) but via its more insidious and evil twin, “the corridor.” It is time medicine started claiming ownership of both realms.¹⁷(p869)

“Claiming ownership” of the hidden curriculum seems to be the exact strategy detailed in the case studies of the Mayo Clinic’s “Professionalism Covenant”²² and the University of Texas Medical Branch, Galveston’s “Project Professionalism.”²³ Through employee and teaching faculty awards, faculty academies, staff grants to improve patient care, supervisors’ tool kits, and orientation and development programs that “acculturate and assimilate new employees” to the desired culture of professionalism, to name just a few institutional innovations, leaders seem to be taking hold of that institutional or “hidden” curricula and manipulating, infusing, and transforming those institutional curricula to be consistent with excellent patient care and medical training. Lest we worry that, for instance, Mayo Clinic employees resent this institutional leadership as undesired social manipulation, Mayo presents some of their evaluation of this institutionalization of the Professionalism Covenant: More than 90% of Mayo physicians and nurses say they are proud to work there and that they would refer their relatives there for medical care. The attrition rate is half the national rate for academic physicians and five times lower than the national average for nurses.²²

The literature concerning specifically the *institutional* aspects of multicultural education is less voluminous, but it is highly instructive.^{6,9–15} It includes

exploration, intervention, and evaluation of the institutional context of multicultural education from critical anthropologic perspectives,^{10,14} health care management perspectives,¹³ training competencies that include institutional advocacy skills,^{6,9} and the constructive development of physician trainees’ racial identities, specifically considering the supportive or obstructive natures of institutional resources, policies, and role models.^{9,12}

The purpose of our discussion was not to provide an exhaustive detailing of the organizational strategies that transform institutional environments. Rather, we sought to present a usable, relatively simple conceptual model for how educators might begin to identify the elements and potential impacts of their perhaps previously undiagnosed institutional curricula.

Conclusion

The conceptual model we have detailed here, adapted from Coles and Grant,²⁴ can assist medical educators in identifying those dimensions of the institutional curriculum that may enhance or obstruct trainees’ optimal learning and behavior change regarding issues of multiculturalism in medicine. It is also through such a model that medical educators can think consciously about their existing institutional curriculum and how one might reclaim what is maximally consistent with the best of multicultural tenets and equitable health care.

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References

- Liaison Committee on Medical Education. Accreditation Standards. Available at: (<http://www.lcme.org/standard.htm#learningenvironment>). Accessed March 18, 2008.
- Accreditation Council on Graduate Medical Education. Common Program Requirements: General Competencies. Available at: (<http://www.acgme.org/outcome/comp/GeneralCompetenciesStandards21307.pdf>). Accessed March 14, 2008.
- Culturally effective pediatric care: Education and training issues. American Academy of Pediatrics Committee on Pediatric Workforce. *Pediatrics*. 1999;103:167–170.
- Smedley BD, Stith AY, Nelson AR, eds. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academy Press; 2003.
- Kripalani S, Bussey-Jones J, Katz M, Genao I. A prescription for cultural competence in medical education. *J Gen Intern Med*. 2006; 21:1116–1120.
- Sue DW, Carter RT, Casas JM, et al. *Multicultural Counseling Competencies: Individual and Organizational Development*. Thousand Oaks, Calif: Sage Publications; 1998.
- Betancourt JR, Green AR, Carrillo JE. Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Rep*. 2003;118:293–302.
- Loudon R, Anderson P, Gill P, Greenfield S. Educating medical students for work in culturally diverse societies. *JAMA*. 1999;282: 875–880.
- Tervalon M, Murray-García J. Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in medical education. *J Health Care Poor Underserved*. 1998;9:117–125.
- Wear D. Insurgent multiculturalism: Rethinking how and why we teach culture in medical education. *Acad Med*. 2003;78:549–554.
- Kumagai A, White C, Ross P, Purkiss J, O’Neal C, Steiger J. Use of interactive theater for faculty development in multicultural medical education. *Med Teach*. 2007;29:335–340.
- Murray-García J, Harrell S, Garcia J, Gizzi E, Simms-Mackey P. Self-reflection in multicultural education: Be careful what you ask for. *Acad Med*. 2005;80:694–701.
- Dreachslin JL, Weech-Maldonado R, Dansky KH. Racial and ethnic diversity and organizational behavior: A focused research agenda for health services management. *Soc Sci Med*. 2004;59:961–971.
- Taylor J. Confronting “culture” in medicine’s “culture of no culture.” *Acad Med*. 2003;78: 555–559.
- Betancourt JR. Eliminating racial and ethnic disparities in health care: What is the role of academic medicine? *Acad Med*. 2006;81:788–792.
- Hafferty F. Beyond curriculum reform: Confronting medicine’s hidden curriculum. *Acad Med*. 1998;73:403–407.
- Hafferty F, Franks R. The hidden curriculum, ethics teaching, and the structure of medical education. *Acad Med*. 1994;69:861–871.
- Maudsley R. Role models and the learning environment: Essential elements in effective medical education. *Acad Med*. 2001;76:432–434.
- Inui T. *A Flag In The Wind: Educating for Professionalism in Medicine*. Washington, DC: Association of American Medical Colleges; 2003.
- Satterwhite R, Satterwhite W, Enarson C. An ethical paradox: The effect of unethical conduct on medical students’ values. *J Med Ethics*. 2000;26:462–465.
- Wear D. On white coats and professional development: The formal and the hidden curricula. *Ann Intern Med*. 1998;129: 734–737.
- Viggiano T, Pawlina W, Lindor K, Olsen K, Cortese D. Putting the needs of the patient first: Mayo Clinic’s core value, institutional

- culture, and professionalism covenant. *Acad Med.* 2007;82:1089–1093.
- 23 Smith K, Saavedra R, Raeke J, O'Donnell A. The journey to creating a campus-wide culture of professionalism. *Acad Med.* 2007;82:1015–1021.
- 24 Coles CR, Grant JG. Curriculum evaluation in medical and health-care education. *Med Educ.* 1985;19:405–422.
- 25 Kim D. The link between individual and organizational learning. *Sloan Manage Rev.* Fall 1993:37–50.
- 26 Welch M. Enhancing awareness of diversity and cultural competence: A workshop series for department chairs and course directors. *Acad Med.* 1997;72:461–462.
- 27 Moreno N, Tharp T. An interdisciplinary national program developed at Baylor to make science exciting for all K–5 students. *Acad Med.* 1999;74:345–347.
- 28 Murray-García J, García J. From enrichment to equity: Comments on diversifying the K–12 medical school pipeline. *J Natl Med Assoc.* 2002;94:721–731.
- 29 García J, Murray-García J. Culture clash. *Arch Intern Med.* 1999;159:1373–1374.
- 30 Tervalon M, Epstein K, Murray-García J. Children's Hospital Oakland Multicultural Curriculum Program Portable Curriculum. Oakland, Calif: Oakland Children's Hospital; 2002.
- 31 Tervalon M, Murray-García J, Tunstall C. Lessons Learned From the Multicultural Curriculum Program at Children's Hospital Oakland: Phase One. Oakland, Calif: Oakland Children's Hospital; 2002.

Teaching and Learning Moments

Doctors and Divination

Near the end of my internship, Mr. P. was admitted for a pulmonary embolism. He was a dignified man, with dark silvering hair, wire-rimmed glasses, and a pile of books and journals at his bedside. When I returned later that afternoon, his wife and son were there. The son looked vaguely familiar, and he confirmed that we had met in medical school, where he was still finishing. Less than a month ago, the patient's low-back pain and leg numbness had led to x-rays, then a CT. A biopsy confirmed metastatic lung cancer. He felt quite well. In his hospital room, he smiled, laughed, and joked with family and friends. For me, though, Mr. P. had the haunted look of a man who did not yet know how little time he had left.

My patient's pulmonary embolism was found by CT, and he was eager to know what else the scan showed. With the patient's consent, his son reviewed the scan with me. The cancer was widely metastatic, taking up nearly a third of one lung and producing lesions in multiple bones. I watched my colleague's eyes as he scanned his father's report, and saw him pause. At that moment I wondered if I would have known what to say if I had spent less time memorizing biochemical pathways and

more time studying divination. How does a fortune-teller deliver bad news?

After rotating on the medical oncology service, assisting at lung resections as a medical student, and losing my stepfather to metastatic lung cancer, my vision of Mr. P.'s future was darkened by the outcomes I had seen. But I held back that guilty knowledge. How much detail should one give about events not yet certain, no matter how likely?

We went into his father's room, and I told his parents what we knew. Yes, we could see the cancer on the scan. Of course there were options for treatment. No one asked me how long he had. That was fine with me, because I didn't want to answer. I struggled with supporting their hope and tempering it with reality.

Two weeks later, he was back.

Now Mr. P. had bleeding from damage to his intestines from radiation. He was still dignified, but pale and washed out. His wife and son looked to me as if they had aged a year in the two weeks he was home. We had to strike a careful balance between managing his pulmonary embolism and his gastrointestinal bleeding. I sat up all night at his bedside with his nurse,

pouring in blood products to match his losses and reversing his anticoagulation because the bleeding wouldn't stop.

In the morning his son came to find me. "He has a facial," he said anxiously. "Can you come check, but don't scare my parents?" I went into the room with a smile and shook the patient's hand. While Mr. P.'s grip was strong, his returned smile drooped on one side. His son was right. There was little anyone could do to stop the relentless progression of his cancer.

A week later, my patient was rushed to intensive care in the middle of the night. When his wife woke their son, at first he was afraid. Then his growing knowledge and experience kicked in, and he rushed to the hospital in part to make sure his father was not put through futile efforts at resuscitation. The least we could do, he said, was let him go gracefully. His son's gift to his father, his growing medical knowledge and insight, was also a burden as he balanced what to say, when to say it, and when to just be there.

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