RESOLUTION 205 - 2011

Subject:    Requiring Diversity Competency Training in Medical School and Residency Programs

Introduced by:  Kiruba Vembu, Katherine Oyster, Jennifer Lippitt, Zach Shaheen, and Albert Chow

Referred to:  Quality and Clinical Outcomes

Whereas, Studies show that culturally appropriate communication between patients and their caregivers can influence health outcomes;¹ and

Whereas, In states such as New Jersey, cultural competency training is required;² and

Whereas, Safety concerns affect decisions about sexual identity disclosure, residency, and career paths for physicians in training;³ and

Whereas, It has been demonstrated in the allied health field that proper education of practitioners promotes a therapeutic environment that better serves the lesbian, gay, bisexual, transgender, and questioning (LGBTQ) patient population;⁴ therefore, be it

RESOLVED, That the Wisconsin Medical Society supports the requirement of training that ensures competency in working with and caring for diverse populations, including communities that differ in race, ethnicity, culture, age, sex, gender, gender identity, sexual orientation, religious affiliation, socioeconomic status and disability; and be it further

RESOLVED, That this required competency training would encompass the following:

- Providing definitions of the terms cultural competency, in race, ethnicity, culture, sex, gender, gender identity, sexual orientation, disability, and provide tools to develop a critical understanding of one’s own privileges and prejudices
- Identifying and understanding of the ways in which traditions and beliefs of diverse patient populations affect the nature of professional relationships and patient care
- Developing an understanding of the extent to which stereotypes can affect medical decision-making
- Identifying strategies for recognizing patterns of health care disparities as well as barriers to quality health care, and providing clinically relevant strategies to combat them
- Enhancing cross-cultural clinical skills, including history-taking, problem solving and promoting patient compliance; and be it further

RESOLVED, That the Wisconsin Medical Society representatives introduce and support these measures immediately for discussion at the 2011 AMA Annual meeting.

Fiscal note: Within current budget.

References:


**Relevant Policies**

**Society:**

UNS-001

**Report of the Task Force on Urban Medicine:** The Wisconsin Medical Society supports the report of the Urban Medicine Task Force and favors the following recommendations: With regards to:

1. *Reimbursement/Paperwork Issues.* The Wisconsin Medical Society believes that:
   a. Intake forms, prior authorization forms and referral forms used by the HMOs should become uniform among the HMOs. The information contained on these forms should be made part of the telecommunication system.
   b. Regarding reimbursement for care provided to pregnant women, there should be a change in the billing rules whereby the physician gets an extension to the billing time when prenatal care has been provided, rather than the present 60-day limit. The physician who provides prenatal care to a patient, but may not provide services throughout the pregnancy, should get reimbursed for the care given. The HMOs should notify the physician when a patient has been dropped from MA or has been switched to another HMO.
   c. Health Professional Shortage Areas (HPSA) should be publicized and physicians should be educated about the higher reimbursement rates when seeing patients who live in a HPSA.
   d. Physicians practicing in the inner city should have money available on a short-term low interest basis to be used when necessary. Longer-term low interest loans should be available to expand/open a practice. In particular, the Wisconsin Medical Society should pursue the possibility of expanding the Wisconsin Health and Educational Facilities Authority (WHEFA) program to include physicians and physician clinics in underserved areas.

2. *Patient Access.* The Wisconsin Medical Society believes:
   a. There should be patient access to culturally and geographically appropriate physicians.
   b. New incentives should be provided to encourage physicians to work in the inner city, such as low interest loans.
   c. The Healthy Start program should be supported and expanded and access to the program should be improved.
   d. Communities should be encouraged to establish free clinics to provide health care for the working poor and for those who are temporarily uninsured. Retired physicians could staff these clinics.

3. *Continuity of Care.* The Wisconsin Medical Society believes the Bureau of Health Care Financing and the HMOs should be asked to address the issue of continuity of care at their HMO Forum meetings, particularly in providing HMO care throughout a woman’s pregnancy and coverage for the newborn at the time of delivery and during the first six months of life. Ongoing seminars/provider forums should be held by the Bureau of Health Care Financing for physicians to inform them of aspects of the MA HMO system.

4. *Education, and the Lack of Patient Education.* The Wisconsin Medical Society believes patient advocate should be available at all the HMOs to answer questions from patients and to work pro-actively to educate patients on their rights and responsibilities.

5. *Collaboration, and the Lack of Cooperation Between Private Physicians and Community Based Clinics.* The Wisconsin Medical Society believes that private physicians should have access for their HMO patients to non-physician services provided through the community-based clinics. An assessment survey should be done to determine the services available at such community clinics.
**SCH-005**  
**School-Based Clinics:** The Wisconsin Medical Society endorses the development of programs, including those located in schools, to provide comprehensive health care services where the health care needs of the population are not being met. Efforts should be made to have the support of parents and communities, and school-based or school-linked clinics should be established with careful attention to proper staffing and physician supervision of services, appropriate hours of operation and effective follow-up care of patients. “Comprehensive primary health care” refers to a package of services that is culturally and socially age-appropriate, family-centered, linked to community resources and that provides the full range of primary health care services, especially those that address the major causes of adolescent morbidity and death. These services include the assessment of

- Nutritional status
- Fitness
- Oral health
- Sexuality
- Risk-taking behavior
- Perinatal status
- Alcohol, tobacco, and other substance use
- Other issues related to growth and development

Services with a preventative and education focus are basic to primary health care and are often provided by public health nurses, school nurses and nurse practitioners, as well as physicians.

**PHY-012**  
**Medicine and Culture:** The Wisconsin Medical Society encourages physicians to undertake reasonable efforts to provide culturally and linguistically appropriate services as needed in their practices.

**ETH-024**  
**Physician Sensitivity to Patients’ Religious and Cultural Beliefs in Medical Practice:** The Wisconsin Medical Society (Society) believes that physicians should maintain respect for their patients’ beliefs. Therefore, the Society:

- Encourages clinicians to inquire about the religious or cultural orientation and beliefs of the patients so they may consider these in the treatment of their patients.
- Urges that all interactions with patients should be handled with recognition of the patient’s vulnerability to the attitudes of the physician and respect for the patient’s autonomy.
- Supports the position that medical recommendations that concern a patient’s beliefs should be made in a context of empathic respect for the value and meaning of those beliefs.

The Society also believes that physicians should not impose their own religious, anti-religious or ideological systems of beliefs on their patients, nor substitute such beliefs or ritual for accepted diagnostic concepts or therapeutic practice.

**MCH-025**  
**HIV and Pregnancy:** The Wisconsin Medical Society believes

- That all pregnant women should be provided with culturally, linguistically, educationally and age-appropriate information regarding HIV risk factors and prevention.
- That the physician is the proper conduit for this information.
- That all pregnant women should be offered and encouraged to accept voluntary HIV antibody testing early in pregnancy so that important interventions for the woman’s health and that of her infant can be offered in the most timely and effective manner.

**AMA:**  
**H-295.878**  
**Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) Health Issues in Medical Education**
Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, and Transgender communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBT health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10)

H-295.897
Enhancing the Cultural Competence of Physicians
The AMA will:
(1) continue to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their lifespan and encourage them to include the topic of culturally effective health care in their curricula;
(2) continue research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys and focus groups at regularly scheduled meetings;
(3) form an expert national advisory panel (including representation from the AMA Minority Affairs Consortium and International Medical Graduate Section) to consult on all areas related to enhancing the cultural competence of physicians, including developing a list of resources on cultural competencies for physicians and maintaining it and related resources in an electronic database;
(4) assist physicians in obtaining information about and/or training in culturally effective health care through development of an annotated resource database on the AMA home page, with information also available through postal distribution on diskette and/or CD-ROM; and
(5) seek external funding to develop a five-year program for promoting cultural competence in and through the education of physicians, including a critical review and comprehensive plan for action, in collaboration with the AMA Consortium on Minority Affairs and the medical associations that participate in the consortium (National Medical Association, National Hispanic Medical Association, and Association of American Indian Physicians,) the American Medical Women’s Association, the American Public Health Association, the American Academy of Pediatrics, and other appropriate groups. The goal of the program would be to restructure the continuum of medical education and staff and faculty development programs to deliberately emphasize cultural competence as part of professional practice. (CME Rep. 5, A-98; Reaffirmed: Res. 221, A-07)

H-295.874
Educating Medical Students for Cultural Competence: What do we know?
Our AMA:
(1) Supports efforts designed to integrate cultural competence training across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care.
(2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students’ appropriate learning experiences to assure their cultural competence.
(3) Supports medical schools in their efforts to evaluate the effectiveness of their cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students’ cultural competence.
(4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of cultural competence in the undergraduate medical school curriculum.
(5) Recommends studying the integration of cultural competence training in graduate and continuing medical education and publicizing successful models. (CME Rep. 11, A-06)