INTRODUCTION

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“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

Martin Luther King, Jr.

Disparities in health and health care across a range of populations and conditions are well described.¹ Yet, many physicians remain unaware of their existence.² To address this lack of awareness, accrediting bodies have established requirements for medical schools and residencies to teach medical students and residents physicians about various aspects of disparities in health and health care.^{3,4} The Association of American Medical Colleges' (AAMC) report “Cultural Competency Education” states that students should understand “demographic influences on health care quality and effectiveness, such as racial and ethnic disparities in the diagnosis and treatment of diseases” as well as “any personal biases in their approach to health care delivery.”⁵ Additionally, as part of their physician licensure requirements, New Jersey and California^{6,7} require documentation of cultural competency training in continuing medical education. Other states are debating such requirements, including Arizona, Colorado, Florida, Georgia, Kentucky, New Mexico, New York, Ohio and Washington.⁸ In New Jersey, this training must include strategies to recognize and respond to health care disparities as well as the impact of stereotyping on medical decision making.⁶

There is a limited understanding, however, of the best methods of teaching about health disparities. To date, health disparities education has had limited acceptance and implementation in medical schools and residency training programs. This reluctance is due, in part, to uncertainty about what should be taught in such a curriculum, how it should be taught and whether health disparities' training has a significant impact on learners and patients.⁹ The California Endowment funded this supplement to help highlight innovations and progress in the evolution of health disparities education in order to enhance the scope and quality of medical education on this topic.

While much of the health disparities literature focuses on disparities experienced by racial and ethnic populations compared to whites, the full spectrum of health care-related disparities includes those related to gender, language, socioeconomic status and other social characteristics of patients. The manuscripts in this supplement reflect the broad nature of health disparities education. The articles by Wakeman and Rich highlight the US prison population as one of most vulnerable to experiencing disparities. Diamond and Jacobs outline how limited English proficiency (LEP) contributes to disparities and recommend best strategies for clinicians to use when caring for patients with LEP. Bereksnyei et al. elaborate on these strategies when the ideal situation of having trained medical interpreters is unavailable; their linguistic competency curriculum can provide measurable and enduring skills to students.

This issue opens with a comparison of cultural diversity teaching methods and curriculum across the US, UK and Canada. The article by Dogra et al. emphasizes the inconsistency in terminology when discussing issues related to cultural competence, cultural awareness and cultural sensitivity. The lack of language precision continues to be an issue throughout the medical education literature. It is one reason why this supplement focuses on health care disparities education as a separate topic—and not under the guise of cultural competency. It has become increasingly clear that the definitions and approaches to cultural competency in this country, as well as in others, are varied and diverse. While there is general agreement on the meaning and overall impact of health care disparities, an accepted standard nomenclature remains elusive but would be useful in solidifying this arena.

The supplement then moves to the areas of curriculum and approaches to teaching. The articles by Glick et al., Cene et al., Mostow et al. and Sheu et al. focus on novel curricular tools to teach about health care disparities both in undergraduate and graduate medical education. Current educators will find these educational innovations to be ideal tools to use in various settings. Cohen et al. shed light on the use of interdisciplinary educational forums (medical-legal) as a means of combating potential causes of disparities and train providers. The article by Chokshi provides practical advice regarding how to use a social determinants framework when teaching in this area.

The role of the provider as a source of and solution to health disparities is highlighted in the article by Burgess et al., who caution us to be wary of the “stereotype” as a possible threat to the patient-physician and physician-trainee interaction. These scholars suggest that such threats can materialize as implicit biases on the part of patients and physicians, and thus may contribute to disparities. They recommend that we actively

confront these issues in our educational initiatives. As a cautionary tale, Thompson et al. note that medical students may perceive their teachers' cultural competency as either the same or worse than their own. If learners believe that their educators have nothing to offer, it is unclear how effective any educational efforts can be if we fail to ascertain and leverage the learner's knowledge and interest in the area. As pointed out by Gonzalez and Bussey-Jones, students who express an interest in disparities may serve as key allies in developing positive attitudes among the entire student body. Teal et al. and Lie et al. suggest the use of reflective exercises with medical students to highlight potential biases in the patient-physician encounter or at least provide interest and exposure to culturally relevant issues. Perhaps it will be a consequence of the urging of Tilburt that we consider incorporating students' worldviews in the reflective scenarios posited by Teal et al.

Although the manuscripts in the Supplement describe numerous innovative curricula and educational approaches to health disparities education, few provide strong evidence for their effectiveness. The manuscript by Wilkerson et al. demonstrates a potentially usefully patient-centered care scale for use with standardized patients that may allow us to measure our trainees' application of the materials learned in a health disparities curriculum. Vela et al. documented the impact of a health disparities education program at the University of Chicago on enrollment of under-represented minority students.

There is a need for scientifically rigorous evaluation of programs so that the most effective educational interventions are perpetuated. Clearly, the ultimate goal of all medical education is learner expertise that results in high quality, equitable patient care. We must, however, resist the urge to mandate documentation of changes in practice and, more distally, the reduction or elimination of disparities as a result of disparities educational interventions. Disparities education should not be held to a higher standard than other medical curricula. Much of medical school coursework (e.g., physiology, genetics) has not been subjected to rigorous studies of their influence on provider behaviors and patient outcomes. Even as findings from a recent paper by Sequist et al.⁹ suggest that in isolation, short-term cultural competency interventions may not improve patient outcomes, education about disparities should be included simply because we recognize its meaning and importance in medical education. Research, then, should be viewed as a means to evaluate the most effective ways to teach rather than prove its value.

As with medical curricula more broadly, there are rewards and challenges to teaching about health disparities and solutions. The reflection by Greene discusses the rewards provided to educators when focusing their curriculum in the area of disparities. Murphy-Shigematsu discusses the challenges of teaching in this area. In a multi-institution study, Carter-Pokras et al. note common barriers and challenges when partaking in curricular innovation and dissemination. Despite the barriers, this group continues to participate in cultural competency and health disparities education. However, not much is known about those educators who work diligently in the area of health disparities and receive little support from their institutions or superiors. The career trajectory for these educators remains speculative as the

available support required for health disparities education is uncharted territory. Finally, as we look at the work of Price-Haywood et al., we are made aware of the knowledge and skill deficits of practicing physicians as related to issues of health care disparities. The next step naturally is to provide current practitioners with improved educational interventions and enhanced skills in the area of disparities.

This supplement is simply one contribution to the expanding field of health disparities education. Much remains to be done. The SGIM Disparities Task Force and its Subcommittee on Disparities Education are committed to providing generalists with the most up-to-date educational tools available (see Ross et al.) and challenging others to provide rigorous and innovative research to improve our understanding and enhance our ability to educate learners. While the focus of this Supplement is centered on education, it is clear that addressing disparities requires more than education alone. Multilevel, multisystem interventions on a host of social factors, along with the proximate medical education curricular innovations described in this special issue, will be required to address disparities in ways that improve equitable care to our patients.

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