EDITORIALS

What Matters in Health Disparities Education—Changing Hearts or Minds?

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All medical educators face this question when planning curricula and in the daily course of teaching: "Is it enough to give our students the cognitive tools they need to function effectively, in the form of knowledge or skills, or should we also focus on their attitudes and motivation—their affective inclination and desire to use these tools?" In other words, should we focus on students' hearts or minds? As several of the manuscripts in this Supplement illustrate, this question is particularly contentious in the context of teaching about health disparities and cultural competency, when addressing students' attitudes and motivation can be seen as an educator passing judgment[1,2].

The hearts and minds question is especially relevant when teaching interpersonal aspects of care, such as respect and empathy. Some educators prefer to teach specific skills–greet the patient when you come into the room, reflect back the emotion expressed by the patient, etc. An appealing aspect of skills-based teaching is the direct correlation between what is taught and what can be observed as outcomes. However, others believe it is important not only to teach students how to demonstrate empathy and respect, but also to foster a predisposition towards emotional engagement, or one of unconditional positive regard for others[3]. Mostow and colleagues endorse this approach in their description of a model for teaching learners how to bridge racial, ethnic, and cultural differences in the clinical encounter[4]. After finding that existing models focused mainly on behaviors rather than attitudes, they developed an approach that explicitly targets both. Interestingly, their approach to fostering empathy and positive regard for patients involves demonstrating empathy and positive regard for trainees, implying that effective approaches will engage the hearts and minds of both learners and educators.

There is an almost metaphysical aspect of the hearts and minds debate that asks if it is morally sufficient for doctors to care *for* patients, or if we must also care *about* them. Not surprisingly, ethicists have delved into this issue deeply. Common theories of ethics approach the issue very differently, with virtue-based theories emphasizing emotion and relationships[6], and principalism focusing on the cognitive processes involved in resolving dilemmas[7]. Yet most scholars, even those who strongly endorse the preeminent importance of one theory, wouldn't entirely disregard the merits of certain aspects of the others.

From a practical perspective, the hearts and minds debate is important in that it influences how we will choose to spend valuable time with students. Intuitively, it is easier to focus on teaching knowledge and skills than it is to change attitudes, and it seems more efficient to do the former than the latter. Lessons from social and cognitive psychology, however, suggest that teaching knowledge and skills alone, without attending to underlying attitudes, may in some circumstances be an ineffective approach. For instance, studies have found that our attitudes, including implicit attitudes of which we may not even be aware, can "leak" in our interactions with others[8], such that even if we display a particular behavior, patients may be able to see that our heart is not it[9]. For behaviors intended to create a connection between doctor and patient—e.g., respect, concern, empathy, understanding—the perception of disingenuousness may reduce the effectiveness of the behavior and even have deleterious effects on a patient's trust. Dissonance between attitudes and behaviors may also, over time, create resentment or burnout in a student or physician who may fatigue from acting in a way that does not reflect his or her true feelings or identity[10].

Another concern is that knowledge and skills, which reside in the cognitive circuits of our brains, are easily displaced. Cognitive load refers to the demand on the memory and processing functions of the brain at any given time. When cognitive load is high—due to competing stimuli or information overload—we may not have the processing capacity to apply knowledge and skills that we wish to, in which case our natural inclinations guide our behavior[11]. Because cognitive load is typically high in almost all real-world clinical settings, giving learners skills without attending to their underlying tendencies may not achieve the intended outcomes outside of highly controlled settings, such as observed structured clinical exams (OSCEs).

The hearts and minds debate has special implications for health disparities education. Despite the pervasiveness of inequalities in health and health care, educators often find that students perceive education intended to equip them with the knowledge and skills to reduce disparities as irrelevant to their future roles as physicians[12]. This may be in part due to the typical content and framing of this education as "cross-

cultural medicine" or "cultural competence training." In environments dominated by a biomedical view of health and health care, a focus on culture may seem, to many students, extraneous.

This Supplement is focused on health disparities education, rather than cultural competence training, because preparing students to better care for diverse populations in an effort to reduce disparities will be effective only if both their hearts and minds are engaged. Educating students about inequalities in health and health care, and about the role that we as physicians may play in causing these disparities[13], can serve to motivate students by tapping into the sense of justice and altruism that most of them bring when they choose the medical profession. By engaging their attitudes and emotions, we can better achieve the goal of influencing the way they apply their skills and approach their roles as physicians. We can also avoid the resentment they may feel if they are not motivated or do not see the relevance of learning what is being taught. Gonzales and Bussey-Jones directly address these potential barriers to health disparities education and offer valuable lessons and potential solutions generated by students themselves[14].

It is important to recognize that the distinction between hearts and minds is not always clear cut, and that, although some think of the heart as akin to emotion or attitudes and the mind as akin to knowledge or maybe even behavior, these analogies are imprecise. Attitudes are not always emotional and sometimes change as a result of gaining new knowledge, and vice versa. For instance, Teal and colleagues used an emotional experience to change cognitive patterns, "moving" their students to participate in a different type of self-talk by exposing them to their own biases through an implicit association task[2]. Conversely, as Murphy-Shigamatsu points out, new knowledge has the capacity to induce strong emotions[1].

It is also important to acknowledge that each learner has a different set of needs and personalities. Each comes with different life experiences and motivation to learn. One person may become passionately engaged in the pursuit of social justice, while others may be just as committed in principle but experience and exhibit far less emotion. Others may not be motivated by justice per se, but rather by a sense of duty in their role as a new physician, or by their sense of commitment to their own family and cultural background. The science of education is advancing to address different learning styles, but has not quite reached the stage in which we have a model for how learner-centered techniques can be applied to address the diversity of student motivation, personalities, and previous life experiences. It is for these reasons that we believe health disparities education should cast a broad net in order to meet those different needs and, ultimately, for us to move towards a more tailored educational approach that teaches to the hearts and minds of each student, wherever they may be.

As teachers we must also be mindful of our own minds and hearts. As Stephen Murphy-Shigematsu reflects, "Health disparities education is inherently difficult because it focuses on differences, which is volatile, emotional and divisive for all of us. A teacher must be prepared to deal with resistance in the form of withdrawal or defiance, seeing these as precious teaching opportunities and learning moments. I try to be mindful, listening with my heart."[1]

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