Original Research

Cultural Competence Education for Practicing Physicians: Lessons in Cultural Humility, Nonjudgmental Behaviors, and Health Beliefs Elicitation

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Introduction: *Although numerous studies have examined cultural competence training, debate still exists about efficacious approaches to this training. Furthermore, little focus has been placed on training and evaluating practicing physicians.*

Methods: *A skills-based course on culturally competent diabetes care was developed and subsequently tested in a controlled trial of primary physicians caring for patients enrolled in one state's Medicaid program. We hypothesized that physicians completing the course would show higher levels of self-reported cultural competence as measured by a Cultural Competence Assessment Tool (CCAT) than those in the control group. Differences in CCAT subscale scores were also compared.*

Results: *Ninety physicians completed the study, with 41 in the control and 49 in the intervention group. Most were female (66%), with an average age of 44, and 12 years in practice. There were no significant differences on total CCAT score (212.7 ± 26.7 for control versus 217.2 ± 28.6 for intervention, p = .444) or subscales measuring cultural knowledge. There were significant positive differences on the subscales measuring physicians' nonjudgmental attitudes/behaviors (subscale score 2.38 ± 0.46 for control versus 2.69 ± 0.52 for intervention, p = .004) and future likelihood of eliciting patients' beliefs about diabetes and treatment preferences (3.11 ± 0.53 for control versus 3.37 ± 0.45 for intervention, p = .014). There was, however, a significant negative difference on the subscale measuring cultural self-awareness (3.48 ± 0.36 for control versus 3.26 ± 0.48 for intervention, p = .018).*

Discussion: *A predominantly skills-based approach to training physicians did not change aggregate measures of cultural competence, but did affect key attitudes and behaviors, which may better reflect the goals of cultural competence training.*

Key Words: *cultural competency; diabetes mellitus, type 2; patient-physician relations; continuing medical education*

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Introduction

Among the most troubling trends in health disparities is that diabetes care indicators continue to worsen for minority populations.[1] African Americans, American Indians, and Hispanics/Latinos have higher rates of diabetes, diabetes complications, and mortality than White, non-Hispanics.[2–5] The prevalence of diabetes among Mexican Americans is 1.7 times higher,[3] and US Latinos also have higher rates of renal disease and retinopathy.[4] African Americans have 2 to 4 times higher rates of renal disease, blindness, and amputations.[4] Adequate control of blood glucose can prevent

diabetes complications,[6] but environmental, socioeconomic, and provider- and patient-related barriers can make this difficult to achieve.

Optimizing the efficacy of the provider-patient relationship is a crucial component in mitigating diabetes health disparities. Good patient-provider communication positively affects patient and physician satisfaction, patient adherence to therapy, and health outcomes.[7–9] Schillinger et al demonstrated that a patient-centered approach to diabetes care improved medication adherence and glycemic control.[10] Recently, Fernandez et al. found that in a population of patients attending safety net clinics, patient trust in health care providers, an important aspect of culturally competent care, was associated with better glycemic control.[11]

In designing cultural competence curricula, a key decision is which teaching approach should be used. The US Institute of Medicine's (IOM's) landmark report, "Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care," described three main approaches to teaching cultural competence: Multicultural/Categorical, Cultural Sensitivity/Awareness, and Cross-Cultural.[12]

The Multicultural/Categorical approach stresses the acquisition of specific cultural knowledge about patients. Students, especially those lacking familiarity with particular cultural groups, often want this kind of knowledge.[13] One frequent drawback to this approach, however, is the inadvertent reinforcement of stereotypes about the health beliefs or behaviors of entire racial or ethnic groups, which can minimize within-group differences.[14]

The Cultural Sensitivity/Awareness approach aims to increase students' awareness of their own cultural backgrounds and other cultures via self-reflection,[12] the use of videos featuring cultural vignettes,[15] and other techniques such as shared narratives.[16] The goals of this approach are to change student attitudes and broaden their perspectives on culture.

The Cross-Cultural or "skills-based" approach focuses on the doctor-patient interaction and teaches the skills that allow providers to uncover and explore their patients' own sense of culture and their explanatory models of disease, and create a treatment plan that includes input from the patient.[12] This approach avoids stereotyping since the patient becomes the source from whom additional cultural knowledge is acquired.[14]

Cultural competence training is recommended as a key element for improving the quality of medical care and reducing health disparities.[12] In response to this recommendation, cultural competence education is now included in US medical school curricula to fulfill accreditation requirements,[17,18] and is required for licensure in 5 states, with legislation pending in 5 additional states.[19,20]

Two reviews of cultural competence training studies published from 1980 to 2003 concluded that a majority of curricular content was geared to teaching about specific ethnic groups and general concepts of cross-cultural medicine (ie, the Categorical approach).[21,22] The majority of the cultural competence training programs included in earlier reviews were designed for medical students and residents, with few studies focusing on physicians in practice. For medical students and residents, there is good evidence that cultural competence training improves knowledge, attitudes, and skills. However, teaching approaches, study quality, and assessment methods varied greatly among the studies reviewed, leading to inconclusive meta-analysis results on which approaches work best for teaching cultural competence.[21,22]

Although in the past decade there has been an increase in continuing medical education (CME) cultural competence training programs, few studies have evaluated the efficacy of these programs, and among those that have, the results are inconclusive.[20,23–27] A review by Lie et al focused on studies examining the effect of cultural competence training on patient outcomes and found several shortcomings in the literature that limited their interpretation of results, including a lack of information about prior provider training, provider demographics, and curricula utilized.[23] They also found that the lack of control groups further limited the quality of studies. They noted that while they found a trend in the direction of a positive effect on patient outcomes, controlled studies with detailed program descriptions were still needed.[23]

Previous research performed by our group demonstrated that a skills-based course on cultural competence and diabetes care, delivered via the Internet, was effective in increasing the self-reported cultural competence of family medicine residents.[28] In the present study, a revised version of that course with expanded cultural competence and diabetes content was tested in a controlled trial on a statewide sample of practicing physicians who cared for patients enrolled in a state Medicaid program.

This report addresses important gaps in the knowledge of cultural competence teaching and assessment by describing in detail the course design and development process, and also by focusing solely on practicing physicians. We tested the hypothesis that physicians completing the course would report higher levels of cultural competence as measured by our Cultural Competence Assessment Tool (CCAT)[28] than those in the control group. Finally, we examined changes in CCAT subscales and explored implications of our findings for further cultural competence training and assessment.

Methods

Course Content Development

Experts in anthropology, cultural competence, medicine, and ethnic minority health care (see Acknowledgments) helped refine the previous online CME course, "Delivering Culturally Effective Care for Patients With Type 2

Diabetes,"[28] which featured a skill-based approach to cultural competence drawing from the theoretical frameworks of Kleinman,[29] Berlin, and Fowkes.[30]

The course authors designed a predominantly skills-based model based on the IOM's Cross-Cultural approach because it could be used with patients of any racial, ethnic, or cultural background as well as avoiding the risk of stereotyping associated with categorical approaches. Although culturally and ethnically specific information was an essential component of the training (all "virtual patients" in the online case studies were categorized along racial/ethnic lines in keeping with the goal of training to mitigate minority health disparities), participants were encouraged to define culture broadly, cautioned against overgeneralization and ethnic stereotyping, and instructed in the importance of using the skills-based model to assess individual patients in the clinical encounter.[31]

Defining culture broadly also allows consideration of perhaps the most important factor in the clinical encounter: "the culture of medicine."[32] The biomedical model—the "culture" that directs physician behaviors—is not necessarily shared nor understood by patients. Recognition of the culture of medicine and effectively communicating the biomedical model to patients were key aspects of our expanded cultural competence approach.

The skills-based model developed by the investigators was called Ask, Share, Compare, and Negotiate (ASCN or "askin").[28] In this model, providers are trained to (1) *ask* in a nonjudgmental fashion about patients' views of the cause of their disease and its treatment, (2) *share* the biomedical view, (3) *compare* the patients' and providers' views of illness/disease, and (4) *negotiate* a treatment plan.

The authors also wanted the course to be an interactive, case-based experience to engage physicians in the patient care process.[33] A total of 5 case-based modules consistent with currently recommended best practices were designed.[34] These modules presented "virtual patients" from 5 different ethnic and cultural backgrounds that either had or were at risk for type 2 diabetes. The first module presented Ms. Gonzales, a 65-year-old Mexican American woman with poorly controlled diabetes; provided information on health disparities; gave in-depth definitions and histories of the terms *race, ethnicity,* and *culture;* and introduced the ASCN model. The 4 other case modules depicted a Hmong man with fatigue, an African American woman with diabetes and heart disease, a European American man with metabolic syndrome, and a recently immigrated Pakistani woman with diabetes complications. TABLE 1 lists each module with the key teaching points.

Successful completion of each module required a combination of cultural skills and knowledge about diabetes management issues (see FIGURES 1 and 2). The cases were designed to be interactive; users had a range of actions they could take as the case progressed and a limited amount of "time" for each virtual "office visit." The future direction of the case was determined by the user's choices. Participants received immediate feedback on their choices and their virtual office "visit time" (ie, minutes spent on each encounter) on-screen, and again at the end of each module using an internal scoring system of "essential points." FIGURE 1 displays an example of this feedback. In this example, feedback is provided so the user can make a better selection. The user must make a different selection in order to progress in the case. The feedback also provides a link so that the user can review the Ask, Share, Compare, Negotiate (ASCN) model that was introduced in the first case module (Ms. Gonzales).

FIGURES 1 and 2 display visit time and essential points information. "Essential points" earned and virtual case-time elapsed are shown in the upper right-hand corner of both figures. One essential point was awarded each time participants correctly used the ASCN model in the patient encounter. Participants could not progress through the case without gathering sufficient essential teaching points from their care of the patient. In the event of inappropriate selections, they were asked to reattempt the question. Thus, they could not rapidly scroll through to the end without engaging and correctly processing the material.

The completed course, "Delivering Culturally Competent Care: Managing Type 2 Diabetes in Diverse Populations," provided up to 9 hours of education (dependent on how many modules were completed) and was posted online on a password-protected Web site.

Study Participants and Recruitment

In 2008, a study invitation letter was sent out to primary care physicians participating in Arizona's Medicaid program. After initial screening and collection of demographic information, physicians were alternatively allocated such that every other respondent was consecutively assigned to the intervention or control group, with overrecruitment to the intervention group in anticipation of a 20% noncompletion rate. Based on our previous study with family medicine residents,[28] it was determined that a sample size of 45 participants per group would provide 80% power to detect a change on the outcome measure, consistent with a moderate effect size.

Outcome Measure

Development and testing of the CCAT has been previously described elsewhere.[28] The original CCAT consisted of 68 items within 6 subscales: (1) Cultural Self-Awareness, (2) Nonjudgmental Thinking, (3) Cultural Knowledge, (4) Nonverbal Communication, (5) Empowerment, and (6) Explanatory Model Elicitation. The Explanatory Model

TABLE 1. Case Module Information

Patients	Description	Key Cultural Competence Teaching Points	Key Diabetes Teaching Points
Virginia Gonzales	A 65-year-old Mexican American woman with poorly controlled diabetes	• Introduction to the Ask, Share, Compare, Negotiate (ASCN) model • Health disparities • Definitions of race, ethnicity, and culture	• Barriers to diabetes care • Standards of care for patients with diabetes • Diabetic retinopathy • Preventing diabetes nephropathy • Diabetes epidemiology in Latino populations
Nhia Tou Xiong	A 67-year-old Hmong man with fatigue	• Practice with ASCN model • General information on greetings • Hmong refugees in the U.S. • Family-based decision making • Diagnosing depression in cross-cultural settings • Nonverbal communication • Health literacy • Hmong health beliefs	• Diagnosing type 2 diabetes • Monofilament testing • Hemoglobinopathies and hemoglobin A_{1c} testing • Oral diabetes medications • Depression and diabetes
Pamela Johnson	A 60-year-old African American woman with diabetes and chest pain	• Practice with the ASCN model • Health literacy and the culture of medicine • The health beliefs model • Distrust of the medical system • Cultural sensitivity • Health disparities in cardiac care • Motivational interviewing	• Diabetic retinopathy • Diabetic neuropathy • Evaluation of chest pain • Aspirin use in diabetes • Statin use in diabetes • Hypertension in diabetes • Insulin and oral diabetes medications • Diabetes in African American patients
James Roberts	A 70-year-old European American man with hypertension	• Practice with the ASCN model • Motivational interviewing • The cross-cultural office visit • Exploring "White/European American" culture • Understanding medicine as a culture • Definitions of race, ethnicity, and culture	• Lifestyle management of hypertension • Management of hypertension with medications • Diagnosing obesity • Definitions of overweight and obesity in adults and children • Diagnosing alcohol misuse • Adult preventive services • Screening for diabetes type 2 • Metabolic syndrome • Treatment of pre-diabetes

(Continued)

TABLE 1. Continued

Patients	Description	Key Cultural Competence Teaching Points	Key Diabetes Teaching Points
Samidha Khan	A 52-year-old Pakistani woman with diabetes who recently immigrated to the United States	• Practice with the ASCN model • General information on greetings • Modesty in Islam • Nonverbal communication • Working with interpreters • Culturally and Linguistically Appropriate Services (CLAS) standards • Questions to elicit patients' explanatory model of disease • The health beliefs model • Health beliefs and Islam	• Oral diabetes medications • Preventing diabetic nephropathy • Type 2 diabetes in Muslim communities • Diabetes combination therapy • Side effects of diabetes medications • Treatment options for diabetic neuropathy

FIGURE 1. Screen shot from "Delivering Culturally Competent Care: Managing Type 2 Diabetes in Diverse Populations." Source: University of Arizona College Medicine OCME; used with permission.

FIGURE 2. Screen shot demonstrating diabetes content from "Delivering Culturally Competent Care: Managing Type 2 Diabetes in Diverse Populations." Source: University of Arizona College Medicine OCME; used with permission.

Elicitation subscale included 2 sets of items, one aimed at physicians' current behaviors (Elicitation Today) and the other at behaviors they would perform in the future (Elicitation Future). The Cultural Knowledge, Nonverbal Communication, and Empowerment subscales included items specific to 3 racial and ethnic cultural groups (Black/African American, Hispanic/Latino, and White/European American). The modified CCAT was expanded to include items pertaining to American Indian and Asian racial groups, yielding a total of 81 items.

Study Design

The study utilized a controlled, posttest-only design. Based on the previous study with family medicine residents that demonstrated a potential pretest sensitization effect[28] and consistent with educational research methodology,[35] a pretest was not utilized in order to mitigate pretest sensitization effects.[36] The intervention group had 1 month to complete the introductory case (Ms. Gonzales) and at least 2 of the 4 additional modules. The control group received no training. After one month, both control and intervention group participants completed the CCAT. Those in the intervention group received $300 to complete the modules; the control group received $200. The study protocol was approved by the University of Arizona's Human Subjects Protection Program.

Statistical Analysis

The study's primary hypothesis was that physicians who had taken the online course would have higher CCAT scores than a control group of physicians who had not taken the course. The primary study endpoint was the difference in total CCAT score between control and intervention groups. Total CCAT scores were obtained by summing individual Likert-scale items (ranging from 1 to 4). Items in the Nonjudgmental subscale were reverse-coded before inclusion in the total CCAT

calculation. A weighted total CCAT mean score, consisting of equally weighted subscales, was also calculated by adding mean scores for each subscale and dividing by the total number of subscales.

Mean subscale scores were secondary endpoints and were obtained by summing the Likert-scale items and dividing by the total number of items in that subscale. Independent sample t-tests were used to compare total CCAT, total CCAT mean score, and subscale scores between each group. Chi-square and independent sample t-tests were used to compare categorical and continuous data for the intervention and control groups.

Results

Demographics

Of the 117 physicians who responded to the study invitation letter, 4 were ineligible and 3 did not complete the screening procedures. Of the remaining 110 physicians, 51 were assigned to the control group and 59 to the intervention group. A total of 90 physicians completed the study: 41 in the control group and 49 in the intervention group. All intervention group physicians completed the required minimum of three modules. TABLE 2 displays demographic characteristics for study participants. There were significantly more DOs in the control group versus intervention ($p = .014$). There were no other significant demographic differences between the groups for any of the variables identified in TABLE 2.

CCAT Scores

The modified CCAT showed good internal reliability, with Cronbach's alpha ranging from 0.77–0.93 ($n = 90$) on all subscales, 0.89–0.93 on the 3 modified subscales ($n = 90$), and an overall alpha of 0.94. There were no significant differences between the two groups on total CCAT score (212.7 ± 26.7 for the control group versus 217.2 ± 28.6 for the intervention group, $p = .444$), or mean CCAT score (2.70 ± 0.29 for control versus 2.79 ± 0.30 for intervention, $p = .154$).

Analysis of the CCAT subscales (TABLE 3) showed that the CME program was associated with significant changes in 3 subscales. Specifically the reverse-coded scores for the Nonjudgmental subscale were higher in the intervention group (2.69) than the control group (2.38, $p = .004$), indicating less endorsement of judgmental attitudes/behaviors. This difference represents a medium effect size with Cohen's $d = 0.63$. Providers who took the course also were more likely to indicate that they would elicit patients' explanatory models in the future (3.11 for control versus 3.37 intervention, $p = .014$, $d = 0.53$). An unexpected finding was that Self-Awareness scores were significantly lower in

TABLE 2. Demographics/Characteristics for Control and Intervention Groups, $N = 90$

	Control, $N = 41$	Intervention, $N = 49$
Gender		
Female/Male	61.0% (25)/39.0% (16)	69.4% (34)/30.6% (15)
Mean Age	43 (range, 31–62)	46 (range, 30–78)
Mean Years	10 (range, 1–32)	13 (range, 1–37)
Since Residency		
Race/Ethnicity		
White, non-Hispanic	73.2% (30)	61.2% (30)
Asian	12.2% (5)	20.4% (10)
Other	7.3% (3)	0.0% (0)
Hispanic/Latino	0.0% (0)	6.1% (3)
African American	2.4% (1)	10.2% (5)
American Indian	4.9% (2)	2.0% (1)
Degree		
MD	75.6% (31)	93.9% (46)
DO	24.4% (10)	6.1% (3)
Specialty		
Family Medicine	56.1% (23)	38.8% (19)
Internal Medicine	43.9% (18)	59.2% (29)
General Practice	0.0% (0)	2.0% (1)
Prior Cultural Competence Training		
<1 hour	24.4% (10)	30.6% (15)
1–3 hours	29.3% (12)	18.4% (9)
4–6 hours	22.0% (9)	22.4% (11)
7–10 hours	4.9% (2)	6.1% (3)
> 10 hours	19.5% (8)	20.4% (10)
Patient Panels Race/Ethnicity (mean %)		
White, non-Hispanic	40.3%	44.4%
African American	6.0%	5.4%
Hispanic/Latino	21.5%	23.6%
Asian	3.7%	2.8%
American Indian	25.5%	23.0%
Other	3.0%	1.0%
Patients With Diabetes Seen per Week (mean %)		
1–10	0.0% (0)	2.0% (1)
11–30	9.8% (4)	12.2% (6)
31–50	43.9% (18)	32.7% (16)
>50	46.3% (19)	53.1% (26)

TABLE 3. Cultural Competence Assessment Tool (CCAT) Total and Subscale Scores by Group

Subscale	Control Group Mean Score	Intervention Group Mean Score	p value
Cultural Self-Awareness	3.48 ± 0.36	3.26 ± 0.48	.018
Nonjudgmental	2.38 ± 0.46	2.69 ± 0.52	.004
Cultural Knowledge	2.38 ± 0.40	2.37 ± 0.47	.875
Nonverbal Communication	2.45 ± 0.53	2.57 ± 0.57	.296
Empowerment	2.60 ± 0.66	2.78 ± 0.66	.209
Explanatory Model Elicitation	2.92 ± 0.48	3.08 ± 0.44	.098
Elicitation Today	2.73 ± 0.51	2.80 ± 0.56	.573
Elicitation Future	3.11 ± 0.53	3.37 ± 0.45	.014
Total CCAT	212.7 ± 26.7	217.2 ± 28.6	.444

the intervention group (3.26 for the intervention group versus 3.48 for control, $p = .018$, $d = 0.52$). Scores for the Cultural Knowledge, Nonverbal Communication and Empowerment subscales were not significantly different. There were no significant differences in total CCAT score, mean CCAT score, or subscale scores based on MD or DO degree or any other demographic variable listed in TABLE 2.

To test whether modification to the CCAT contributed to these findings, the additional items were removed and the above analyses were repeated. Reliabilities for the subscales were similar, and there was no difference in the pattern of significant scores.

Discussion

Contrary to the *a priori* hypothesis, there was no significant difference in cultural competence between control and intervention groups as measured by total CCAT score. This result conflicts with our previous study of a similar program in a group of resident physicians.[28]

We were puzzled by the unexpected *lower* level of self-awareness in the intervention group (eg, a lowered ability to "describe my own beliefs about health and illness to a person from a different background than mine"). A possible explanation is that the course led to an increased appreciation of within-group variability in the participants themselves and thus greater "cultural humility," which Tervalon and Murray-Garcia propose as a more suitable goal for multicultural medical education.[37]

Understanding these findings may lead to a better knowledge of what behaviors best represent cultural competence

in practicing physicians and how to reliably assess and teach desired behaviors. The case modules used the skills-based ASCN model.[28] Gathering information about the patients' view of their diabetes in a nonjudgmental fashion was the primary focus of this model and was emphasized in each case. Participants were encouraged to avoid coming to premature, judgmental conclusions regarding patients' adherence to therapy without asking about patients' views and preferences in regard to treatment. This participatory decision making is an integral component of culturally competent and patient-centered care,[38] and, as hoped, participants in the intervention group reported that they would ask about their patients' explanatory model of illness and exhibited less endorsement of judgmental attitudes/behaviors than those not taking the course.

However, exposure to the diverse case mix in the course, and messages in each case regarding the diversity *within* racially and ethnically defined groups, as well as a broadened definition of *culture* (including the *culture of medicine*), may have led participants to question previous ideas regarding their own racial, ethnic, and cultural identity. This, in turn, may have resulted in an appropriate lowering of confidence in their abilities to assess a patient's culture without input from the actual patient. Similarly, lack of differences in the Cultural Knowledge, Nonverbal Communication, and Empowerment subscales may be explained by a greater awareness of within-group variability resulting from the course. This was a major emphasis of the course, but ultimately the CCAT was still based predominantly on racial and ethnic groupings—which has been noted as a complicated issue in comparing cultural competence assessment instruments.[31] Rather than increasing specific knowledge, it is possible that the course promoted an increased sense of "cultural humility" by encouraging continuous self-evaluation and self-critique regarding the shifting and fluid aspects of cultural identity, and by placing less emphasis on memorizing culturally-specific traits.[37] Inherent in the concept of cultural humility is respect for patients and an awareness of the power dynamics influencing the patient-physician relationship.[37] This awareness challenges the standard biomedical model of objectivity in the clinical encounter and may lead physicians to being more "humble" in acknowledging that they know less about cultural and ethnic groups than they had assumed.

There are several limitations to our study. Our physicians may not have been typical in that they were taking care of patients on Medicaid and had many years in clinical practices caring for diverse patient groups. The study included only primary care physicians, most of whom had many hours of previous cultural competence training. The sample size was relatively small, thus limiting the power to detect differences between subgroups. However, we did see changes consistent with moderate effect sizes for intervention and control groups. A further limitation is that the actual time spent on

Lessons for Practice

- The Ask, Share, Compare, Negotiate (ASCN or "askin") model trains physicians to (1) *ask* in a nonjudgmental fashion about the patient's views of the cause of their disease and its treatment, (2) *share* the biomedical model, (3) *compare* the patient's and provider's views of illness/disease, and (4) *negotiate* a treatment plan.

- This skills-based approach helps physicians to avoid coming to premature, judgmental conclusions regarding patients' adherence to therapy without asking about patients' views and preferences in regard to treatment.

- This model may also foster an increased sense of cultural humility.

the course was not captured; thus, we do not know the influence of time on participants' scores or other variables. Finally, the posttest-only design, while avoiding the pretest sensitization effect, made it impossible to know if baseline differences may have accounted for the similarity of scores between the 2 groups. In future studies, the degree of pretest sensitization could be assessed by utilizing a Solomon 4 group design, which, in addition to posttest-only control/intervention groups, also includes pretest/posttest control and intervention groups.[35]

Conclusions

The results of this study bring us back to a central, unresolved issue in cultural competence training, namely, what is cultural competence and how do we teach it? A recent review of cultural competence CME offerings called on programs to offer greater self-reflection, critical thinking, and cultural humility.[20] Our results support this recommendation by pointing to nonjudgmental behaviors and the elicitation of patients' explanatory models as key areas for training programs to target. Cultural self-awareness and knowledge remain challenging to teach and assess. Rather than just increasing specific cultural knowledge about targeted ethnic groups, increases in cultural humility and curiosity may also be the desired outcomes. More research and assessment tools aligned to these outcomes are needed. While the reduction of health disparities remains rooted in teaching about the cultural components of ethnicity, a skills-based approach holds the potential to improve the patient-physician relationship through an increased awareness of the cultural backgrounds that both patient and provider bring to the clinical encounter. The skills-based model provides physicians with the flexibility to treat patients from any cultural, ethnic, or racial background with humility, self-awareness, and the ability to forge the therapeutic alliances that are a cornerstone of ongoing patient-centered care and a key component in the elimination of health disparities.

Acknowledgments

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