

Teaching Advocacy to Physicians in Multicultural Settings

Charles J. Schubert^{*1}, Brian Volck², Joseph Kiesler³ and Melissa D. Klein⁴

¹University of Cincinnati College of Medicine (UCCOM), Department of Pediatrics, Division of Emergency Medicine, CCHMC, Cincinnati, Ohio, USA

²UCCOM, Department of General Internal Medicine, IPJH, Cincinnati, Ohio, USA

³UCCOM, Department of Family Medicine, IPJH, The Christ Hospital, Cincinnati, Ohio, USA

⁴UCCOM, Department of Pediatrics, Division of General and Community Pediatrics, Cincinnati Children's Hospital Medical Center (CCHMC), Cincinnati, Ohio, USA

Abstract: Teaching advocacy in medical school and residency is complicated by increasing social diversity. Socioeconomic and cultural differences between advocates and patient communities demand robust communication skills. Cross-cultural communication can be enhanced with specific attitudes, knowledge and skills. Three departments within the University of Cincinnati have developed curricula to teach advocacy while working with underserved populations from a variety of cultures, encouraging learners to use advocacy to promote social change. Five such courses, emphasizing local and/or global health and combining didactic and experiential teaching methods, are described here. Special attention is given to the culture of poverty. These courses build learners' skill and confidence, and should serve as a foundation for future growth. Long term evaluation is necessary to determine if these curricular innovations result in sustainable improvements in learner competencies related to community health and child advocacy activities.

Keywords: Advocacy, communication, cultural competency, culture, global health, poverty, underserved, vulnerable populations.

INTRODUCTION

The English word, "advocacy," comes from the Latin *advocare*, meaning to call someone as a witness or advisor. Advocates and those for whom they advocate may come from very different cultural, socioeconomic or educational backgrounds. Such differences require good communication and mutual understanding between parties in an advocacy relationship. Advocacy is almost never a single event, but a process of ongoing communication, clarification of assumptions and goals, and commitment, not only to work toward a common goal, but to learn from one other. Without these, the purposes of advocacy are defeated and the relationship often degenerates into partisanship and power politics.

Traditionally, medical school and residency curricula do not specifically address how to advocate for families' cultural, social, or economic needs in spite of our increasingly diverse society. Medical students and residents often lack knowledge of the scope of these needs and existing community resources [1]. They encounter families with a variety of socioeconomic and cultural issues but may avoid asking about them due to 1) lack of time, 2) lack of awareness 3) discomfort exploring these issues, 4) lack of knowledge of available resources and 5) the perception that these social determinants are not remediable. By not recognizing or addressing many of these traditionally non-medical issues, physicians may not be able to fully assist families in a way that leads to improved health.

One of the most common settings in which these problems arise occurs when the student or resident encounters the culture of poverty. Globally 2.5 billion people live on less than 2USD per day [2]. Though the degree of poverty is not as severe in the US, the number of US families living in poverty has increased dramatically to 7.6 million in 2007, including 13.3 million children [3]. Recent research suggests that psychosocial problems related to poverty such as food insecurity, housing instability, inadequate parental education and parental substance abuse are associated with higher rates of behavioral, developmental and learning problems in children [4]. Substandard housing and homelessness have also been linked to higher rates of diarrheal illness, ear infections and health service utilization [5]. Many of these same problems affect adults and children in developing countries, though even more serious health problems also occur.

The populations of different ethnic groups are changing the cultural landscape of America with only 47% of the population predicted to identify themselves as white by 2050 [6]. This diversity across racial, ethnic and socioeconomic lines brings with it numerous challenges in meeting the medical needs of these varied populations. In addition, each of these populations has its own culture which must be understood if medical issues are to be appropriately addressed.

Medical providers require the appropriate knowledge, skills and attitudes to assess for these social and environmental risks and to engage families from a variety of economic and cultural backgrounds into a health-care partnership [7]. It has been shown that physicians believe their role should include community participation and advocacy, but to

*Address correspondence to this author at the Cincinnati Children's Hospital Medical Center, ML 2008, 3333 Burnet Avenue, Cincinnati, OH 45229-3039, USA; E-mail: chuck.schubert@cchmc.org

what level they are being prepared to assume these roles is uncertain, though perhaps changing for the better [8]. Learners in medical education need to gain an understanding about how different cultures and economic realities will impact the intended medical treatment for their patients and how to appropriately respond.

The Association of American Medical Colleges, in its Medical School Objectives Project, recommends that graduating medical students make a “commitment to provide care to patients who are unable to pay and to advocate for access to health care for members of traditionally underserved populations” [9]. Resident education guidelines in the U.S. require primary care programs to train future physicians to assess the communities health, provide culturally effective health care and learn to be an advocate for patients [10]. Knowledge and experiences with a culture or a population can lay a foundation for understanding the issues that will affect a physician’s ability to provide healthcare or other services for a specific patient or community. An increased cultural proficiency can translate into enhanced ability and comfort in working among different cultures or underserved populations. This can then allow advocacy work arising from a better understanding of the targeted population.

Other cultural issues also affect how patients view their illness and this may affect how closely the treatment regimen is followed (medical adherence). Whether or not there is a matriarch or patriarch in the family and how they interpret their family member’s illness will affect the treatment plan. In addition, competing priorities for families living in poverty may undermine the instructions of the medical provider. If rent is due or a relative has a more urgent need for the funds which would have bought the prescription, the medication may never be purchased. The urgency of the moment may supersede the therapeutic plan. Therefore, developing cultural competency among medical learners is extremely important. Because this topic spans each of the courses described below, it will be discussed separately.

DEVELOPING CULTURAL COMPETENCY

Recognizing a particular culture is simpler than defining “Culture” as an abstract, universally applicable construct. Students new to a culture typically look for observable characteristics and components, such as economy, language, religion, family structure and relationships, food, and customs rather than deducing particulars from a general theory.

Even terms such as “Hispanic Culture,” – though useful placeholders from which generalizations can be made – contain variations and exceptions. A university professor from Madrid, an undocumented farm worker from Guatemala City and a shipping clerk from the Dominican Republic may all be considered “Hispanic,” but the medical professional should attend to the particular concerns, beliefs, habits and expectations of these individuals rather than assuming broad commonalities, which are likely to be superficial.

Whatever “Culture” is, it is not synonymous with nationality, ethnicity, race or origin. Even the “Southern Culture” of Southeastern US whites is immensely complicated by class, education, and increased mobility.

Nonetheless, one can – with considerable caution – speak of cultures in a broad sense, including those defined by pov-

erty or wealth, or by education and training. In this sense, biomedicine itself is a culture, complete with its own, often bewildering, economy, language, beliefs, assumptions, habits and criteria for judging the success or failure of intervention. It is wise not to assume these are shared by persons for and with whom we advocate.

Advocates must recognize that their own assumptions can never be completely bracketed or set aside, but rather must be openly acknowledged for genuine cross-cultural communication to occur. Culture is not a problem other people have, but a name for the particular places from which we proceed. This realization is particularly important in advocacy training. Saul Alinsky, founder of the Industrial Areas Foundation and a community organizer in whose method U. S. President Barack Obama was trained, insisted that organization and advocacy were always assertions of power and must be recognized as such [11]. Whatever one thinks of Alinsky and his tactics, his observation should remind us that advocacy without understanding is power that can quickly go astray.

The cultural competency component of the Initiative for Poverty Justice and Health (IPJH) and global health programs (see below) includes didactic and participatory sessions introducing learners to an array of tools for cross-cultural communication. Using a standard taxonomy of learning, a variety of attitudes, knowledge and skills helpful in such encounters are emphasized [12].

Helpful attitudes include acceptance of cultural difference, willingness to bridge often complex and difficult barriers to communication and understanding for the welfare of the patient, recognition that not all such barriers can be successfully crossed, and a readiness to acknowledge one’s own ignorance and mistakes. While insufficient in themselves, they are necessary for all that follows.

Knowledge is usually culture-specific and often evidence- or observation-based, derived from such fields as medical anthropology, ethnobotany, linguistics and religious studies. Knowledge of specific cultural categories and practices (e.g. “fatalismo” among some Hispanics or “cupping” in some parts of Asia and Eastern Europe) may be helpful in a medical encounter, but specifics rarely generalize across cultures. A professional may know much information about the beliefs and practices among Haitian immigrants, but if her next patient is Hmong, such knowledge does her little good.

Interviewing skills and strategies generalize more readily than culture-specific information. They do not, however, operate independently of attitudes and knowledge. Such skills, building on constructive attitudes and basic information, are useful in all medical encounters, not simply those defined as “cross-cultural.” External similarities (dress, language or education) may not necessarily signify shared assumptions between patient and provider.

Identifying and clarifying assumptions is always helpful. How else, for example, can patient and provider agree on the problem, the best means of addressing it, and by what criteria the outcome is evaluated? While the issues addressed in advocacy are not identical with disease processes, only a little imagination is necessary to see how questions and ru-

brics intended for patient care might be adapted for advocacy purposes.

One such rubric was developed by Arthur Kleinman, and is sometimes referred to as “the Eight Questions” [13]. These include:

1. What do you call the problem?
2. What do you think has caused the problem?
3. Why do you think it started when it did?
4. What do you think the sickness does? How does it work?
5. How severe is the sickness? Will it have a short or long course?
6. What kind of treatment do you think the patient should receive? What are the most important results you hope to receive from this treatment?
7. What are the chief problems the sickness has caused?
8. What do you fear most about the sickness?

With judicious adaptation (using “problem” rather than “sickness” and perhaps “community,” rather than “patient”) a skilled person can use these questions to begin or further an advocacy relationship.

Elsewhere, Kleinman proposes three ways of narrating the course and significance of a disease process within a life [14]:

1. Symptoms and disability as understood within a culture’s concepts of body, health and disease. (*e.g.* “western scientific” medicine, Navajo culture, Hispanic cultures, *etc.*)
2. The specific meaning(s) a disease has within a culture. (cancer, TB, HIV, other sexually transmitted diseases, seizures, *etc.*)
3. The meaning embodied in a particular life. (How the patient narrates the illness.)

Investigating how the patient is narrating their illness will likely assist in modeling the therapeutic plan.

In addition, social determinants of health, such as unemployment, government assistance or gender disparities can have connotations that are culture-based, and a wise advocate considers and explores these with the patient and community.

Time devoted to cross-cultural communication is done not simply to streamline the tasks of medical professionals, but to avoid, prevent or alleviate common traps leading to misunderstanding, mistrust, and, at times, resentment and anger. Such pitfalls include *false universality*, the assumption that “everyone knows/feels or thinks” in certain ways when, in fact, different cultures may make radically different judgments about what is or is not a problem, what corrective means are or are not acceptable, and what the result of an advocacy effort should look like. *Cultural imperialism* assumes one’s profession, education or culture can, without consultation or clarification, correctly identify problems to be addressed and provide the means to ameliorate them. Sustained professional humility can prevent the waste of time and resources on matters a community considers unproblem-

atic. In every case, proper communication requires more than just an interpreter; it demands ongoing conversation. Similarly, *cultural colonialism* takes out of cultural context a desirable resource from another culture. Professionals dabbling in Ayurveda or Chinese herbal medicine as wellness techniques extracted from the cultural context in which they arose almost always distort these practices in ways which may offend those of the source culture, and often produce unintended, poorly understood, consequences.

The development of cultural competency is an ongoing endeavor but if pursued will reap many benefits in building the health-care partnership with the patient and community.

COURSE DESCRIPTIONS

To supplement traditional medical school and residency teaching, several courses which expose medical learners to advocacy and cultural competence were developed by three departments (Family Medicine, Internal Medicine-Pediatrics and Pediatrics) at the University of Cincinnati, College of Medicine. Each course emphasizes the importance of teaching advocacy while providing service to an under-served population and encourages learners to use advocacy as a method to promote social change. In this article, specific examples of advocacy education will be described. We will briefly introduce five such courses, followed by more thorough descriptions.

Advocacy/Injury Prevention and Surviving Poverty in Cincinnati were developed for the Cincinnati Children’s Hospital Medical Center Pediatric Residency Program. The Advocacy course was started to fulfill requirements of the Pediatric Residency Review Committee of the Accreditation Council on Graduate Medical Education (ACGME) to provide “Community and Child Advocacy Experiences” [10]. The required two week elective emphasizes advocacy for children from an injury prevention perspective. However, it has provided a framework for incorporation of the Surviving Poverty in Cincinnati curriculum which includes experiential learning experiences and supplemental didactic sessions.

The Global/Underserved Health Course is sponsored by the Christ Hospital/University of Cincinnati Family Medicine Residency Program. This two week course is taught prior to an international medical experience, and integrates local community health issues with what the learners will experience abroad. The targeted learners include medical students, nursing students, pharmacy students and resident physicians.

The Initiative for Poverty Justice and Health (IPJH) grew out of a federal faculty development grant. The rotation is designed to improve knowledge and skills in caring for underserved populations for resident learners. A Medical Student Elective in Vulnerable Populations grew out of this initiative and exposes medical students to these same issues.

The Advocacy / Injury Prevention Course teaches advocacy in a very pragmatic context, using the backdrop of injuries in the community, which are often significantly higher in low income populations. A number of didactic and experiential sessions allow the learners to understand why and how injuries occur in the community and ways to prevent them. The course begins with a focus on understanding advocacy



Fig. (1). Advocacy continuum.

and encourages each learner to develop a project addressing the prevention of a specific type of injury.

The term “advocacy” carries many meanings (as mentioned above) and occurs in many different venues. This diversity may be confusing to the individual learner. Using a paradigm to categorize the forms of advocacy, advocacy can be understood as a continuum of meanings instead of disjointed parts of a complex puzzle. Each type of advocacy fits on the continuum and thereby has a relationship with other forms of advocacy which may not have been immediately obvious. This advocacy continuum is shown in Fig. (1) above.

In learning about advocacy, learners (medical providers) are encouraged to see themselves as service providers. From this perspective, the issues and problems of individuals or communities can be more obvious. These issues often present more frequently to a medical service provider than to individuals in a community. For example, a medical provider may be the first to see children with obesity or severe asthma before the community recognizes that there is a problem. This may also occur with the increasing incidence of a specific preventable injury. Once the medical provider perceives the problem, an intervention can be developed and then placed on the advocacy continuum. For example, will the intervention be related to community education or aimed solely at the individual? Use of this continuum can encourage the service provider to consider other forms of advocacy occurring on different places on the continuum, (e.g. the need for legislative action or advocacy). Service then works as an entry point for community problem solving or policy advocacy [15].

Prior to determining the type of advocacy to be pursued, however, a process of problem assessment is performed with the learners. Learners discuss real patients they have seen and are led through a series of questions to dig deeper into the perceived issue. We first ask, “What concrete issues are you observing with this patient?” This may include socioeconomic status, body size, family make up, type of insurance, ethnicity, etc. The next step in the analysis asks: “Why are these issues occurring?” The answers may lie with cultural acceptance of certain dietary practices, or lack of a knowledge base in the parent of the patient on the particular issue. The final question has to do with determining the root causes of the observed social problem. It may be that lack of access to appropriate medication is part of the “Why” when thinking about increases in severe asthma but the root cause may lie in lack of insurance coverage for appropriate medication or pollution in a specific neighborhood. Advocacy must eventually address the root cause if a lasting solution is to be designed [16].

Some of these root causes are experienced first hand through a home visit. In this and other courses mentioned below, home visits provide an immersion experience, exposing residents to patients outside of the medical center. The

learner may accompany a nurse home visitor or a Child Protective Services case worker. Alternatively, they may conduct a home visit under the guidance of faculty personnel. These experiences allow learners to see and experience first hand some of the cultural and social issues affecting the medical care of their patients.

Teaching residents that they are a type of service provider in an at-risk or disadvantaged community is important to seeing the next step in the advocacy continuum: advancing or effecting social change. As social change is more difficult to encourage from outside a community, these “new” service providers can repeatedly see and experience the issues that surface from within the community and begin the journey down the advocacy continuum. As the service provider gains experience, insight is developed and relationships are forged with community members. Then, community problem solving can begin.

Surviving Poverty Educational Experience

The Child Health Law Partnership (Child HeLP) is a new medical-legal collaboration set in a general pediatric clinic of a large academic institution. The members of the Child HeLP team include pediatricians, lawyers, a paralegal, and social workers. The Surviving Poverty in Cincinnati series was designed to complement this program and expose pediatric interns to traditional non-medical needs.

The program combines didactic instruction and experiential learning and was incorporated into the existing Advocacy rotation. The experience includes a half day trip to Hamilton County Jobs and Family Services, where the residents receive a tour of the facility, exposure to the range of public benefit programs and the opportunity to shadow a case worker during an intake interview. The group then visits the local food bank for a tour, an introduction to community volunteer services, and the opportunity to food shop with families.

The objectives of these field trips include (1) recognition of the number of families, including children, who need assistance, (2) an introduction to the “alphabet soup” of acronyms identifying the many available programs, (3) begin to understand the time and complexity of applying for benefits, and (4) learning the location, atmosphere and services/programs available from different community resources. After this experience, the interns are given time to reflect on their experience (including their feelings and frustrations) and then share and compare observations from the agencies visited with the rest of the group.

The immersion trip is supplemented by didactic classroom experiences with educational materials created and taught collaboratively by various professionals from the Child HeLP team. The didactic series includes information pertaining to social determinants of child health (Fig. 2), budgeting difficulties on a limited income, an introduction to public benefits (Medicaid, Cash Assistance, Food Stamps,

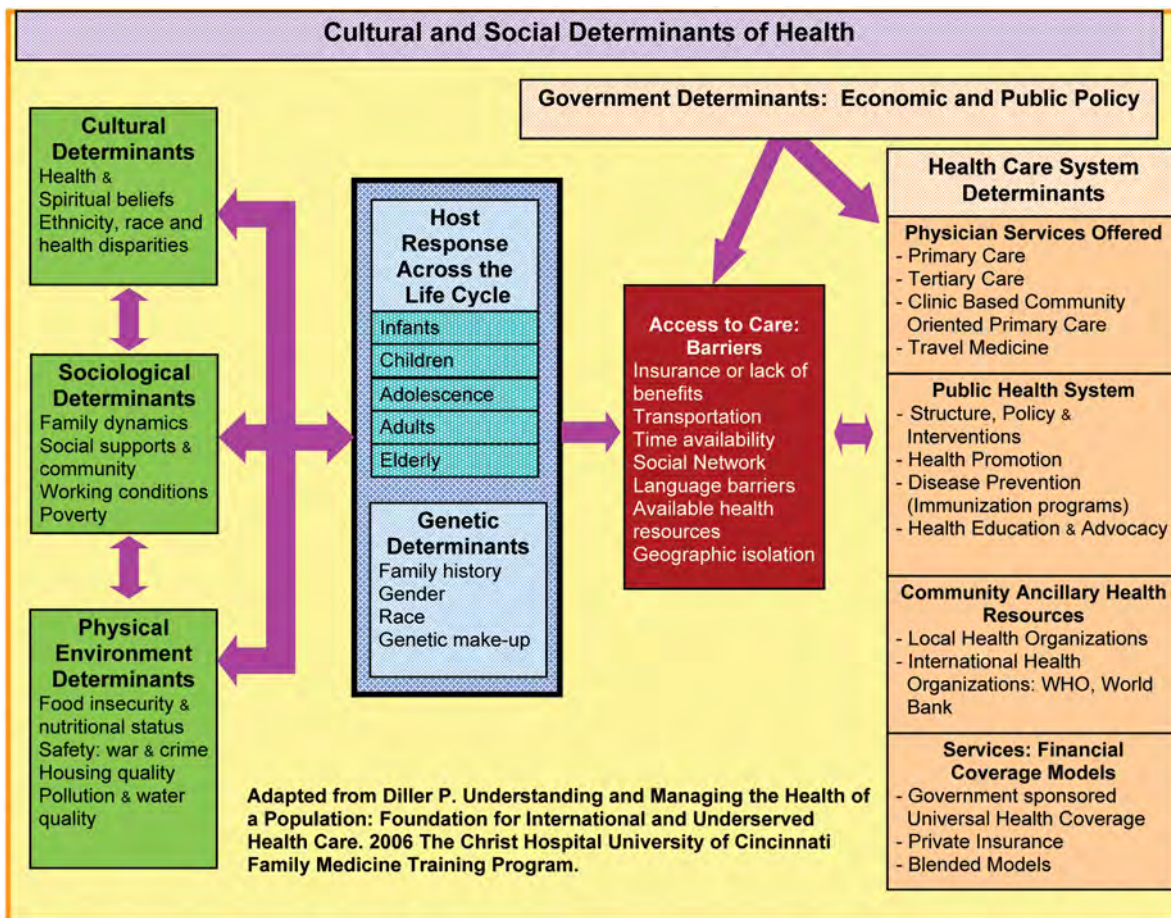


Fig. (2). Cultural and social determinants of health.

Daycare vouchers, SSI), screening for unsafe and unstable housing, and education and students rights (introduction to 504 plans, individual education plans [IEP], and differences between public and private schools).

All lectures emphasize when to refer to the social worker, Child HeLP, or other community agencies to help assist families obtain basic needs and safety. Every lecture includes an actual clinic patient case and demonstrates how the referral to the Child HeLP team improved the family's situation. For example, in the benefits lecture, interns are presented with a child with severe failure to thrive. They are challenged to ask a few questions to diagnose the patient. They learn that the mother could not afford the supplemental formula (Pediasure) that the child was previously prescribed when her food stamps and WIC (Women Infants and Children supplemental food program) were terminated, and that the Child HeLP team intervened and re-established her benefits. Subsequently, the child was able to receive his formula and gain weight.

The Surviving Poverty in Cincinnati series is a unique learning experience partly due to the unique variety of experiences and depth of instructor expertise. This educational series is being critically evaluated for usefulness, effectiveness and for improvement.

The Child HeLP team is also involved in longitudinal education of all levels of residents through their continuity clinic experience. During the first month of continuity clinic,

each intern works directly with a clinic social worker to learn how to take a social history. This process teaches the interns not only what to ask, but how to ask sensitive questions in a more empathetic and culturally competent manner. In addition, there are short informal case-based presentations, led by the Child HeLP team on a bimonthly basis. Similar to other areas of resident education, the cases are real, generated from clinic referrals, emphasizing families' legal rights and when to refer. The outcomes of the specific cases are shared to help residents realize that they can make a difference and help in the "big picture" for the improvement of their pediatric patient's overall health, safety and well being.

Global Health – Care of Underserved Populations Course

This is a one month rotation sponsored by a hospital-based Family Medicine residency program for resident physicians from numerous primary care programs and students from medical, nursing and pharmacy schools. Two weeks of didactic instruction precede a two-week medical brigade trip to Honduras, Brazil or Tanzania. The course focuses on determinants of health model, (see Fig. 2) and encourages the learners to compare and contrast their local communities with the international communities where they will provide care.

Learners are challenged throughout the course to consider how they will use their careers as health care professionals to advocate for the needs of the poor [17]. Course

topics include the Social Determinants of Health, Global Child Health, Poverty and Health, Cross Cultural Medicine, Access to Care and Community Partnerships. Experiential learning is a major component of the course, including a learning module in neighborhoods and field experiences with local social service agencies and a poverty simulation.

The Neighborhoods and Health module is a partnership with the social service agencies in, a historic, urban community in Cincinnati with one of the lowest average household incomes in the region. In the morning the learners attend a presentation on how the physical, service and social environments of a neighborhood can impact the health of its members. In the afternoon, the group travels to the neighborhood to visit a local community health center and hear from a patient panel about community assets and barriers to health. The learners then divide into teams to visit social service agencies which are serving the neighborhood: a food bank which also coordinates clothing and financial services for those in poverty; a low-income housing program; an agency that provides laundry and shower facilities for the homeless; a community action agency that advocates for issues facing low-income residents; and a jobs training program. At the end of the day, the group comes back together to discuss initial perceptions and lessons learned. At the end of the course, when the learners return from the overseas brigade, they visit the National Underground Railroad Freedom Center, which focuses on slavery and emancipation past and present, to discuss their reflections on the health of neighborhoods and communities abroad versus what the learners experienced locally. The global experience is thereby linked to the local experience, and similar cross cultural skills are often noted to serve well in both venues.

The course also offers field experiences to other community agencies. There, learners are taught key concepts – access to care, nutrition, immigrant health – in an experiential learning model. The following learning modules are included in the course: Jobs and Family Services, Women's Infants and Children Food Program, Legal Aid, Refugee Health, Homeless Van and Latino Health. Each of these modules encompasses a half day for which learners prepare with selected readings, followed by visits to the community agency to meet with key agency informants.

This course engages learners in a discussion about their role as providers caring for the poor, both locally and globally, through offering a Poverty Simulation. This simulation was purchased from the Missouri Association for Community Action [18]. Simulation participants re-enact four weeks in the lives of those in poverty. The simulation is intended to raise learner awareness of the issues those in poverty face on a daily basis: lack of affordable housing, transportation, childcare or a living wage in entry level jobs. Learners participate as families in poverty while community volunteers or social service agency representatives assume the roles of agencies the learners must engage to pay the rent, obtain child care, provide food for the family and find or keep a job. The simulation has proven a worthwhile exercise in teaching about issues of poverty, with the learners becoming engaged in the "stress" of simulated experiences that include eviction, job loss, unforeseen expenses, or a struggle to qualify for medical coverage. After the session, learners reflect on barriers, what aspect of the system they would like to see changed

and what roles they could assume in this process. This is a valuable advocacy tool encouraging the learners to envision an improved future for low income individuals and communities.

Medical Student Elective in Vulnerable Populations

The aims of this medical student elective are to 1) teach participants knowledge and skills specific to the care of poor and underserved populations internationally and in the U.S., 2) develop and sustain student interest in caring for poor and underserved populations through exposure to positive faculty role models, community experiences, and clinical opportunities in underserved care, and 3) develop leadership and advocacy skills in the care of the poor and underserved populations. Students apply at the beginning of their first year of medical school to participate in the elective. Currently, there are thirty-seven students involved in the elective who are mentored by the faculty involved with the Initiative on Poverty, Justice and Health.

The students and faculty meet monthly for a discussion of a current article, community resource or policy issue. Book discussions with student and faculty are hosted at faculty homes, based on books with a focus on caring for underserved populations. Past books have included *Not all of us are Saints* [19], *Nickel and Dimed* [20] and *Mountains Beyond Mountains* [21]. Students are also given clinical shadowing opportunities with faculty who work with underserved populations in the local community. The student elective has also started a service-learning partnership with the Center for Respite Care [22], a medical facility which provides 24 hour medical care for homeless that are too sick to be on the street or are ready to be discharged from the hospital. The students meet with the community partner to establish the partner's needs and then plan a longitudinal advocacy project with the organization based on the needs that participants at the center have defined.

Initiative for Poverty Justice and Health

This course began with a federal grant for faculty development in the area of underserved populations. Many of the faculty were already involved in advocacy issues, but the grant allowed time to develop knowledge and skills to develop educational experiences as well as to become resources in the larger academic community. An advocacy elective was developed for medical residents from Pediatrics, Family Medicine, Internal Medicine and Internal Medicine-Pediatrics. The elective utilizes a variety of venues and experiences to improve the knowledge base and skills of these learners in the advocacy and care of persons living in poverty.

The residents are exposed to didactic sessions dealing with cultural competency, public health and health policy, Latino health, international health, and the impact of poverty on the health status of individuals. Residents are placed in health centers serving low income populations and encouraged to spend extra time with a small number of patients so they can get to know and hopefully understand the patient's concerns and issues. For example, they may explore with the patient their housing issues or the ability to pay for needed medications. Neighborhood safety issues as well as the quality of schools a pediatric patient attends may be more readily

perceived as affecting the overall health of this patient, during this extended time with the patient and their family.

The residents then reflect on and share these experiences with the other learners first in an electronic dialogue on an e-learning platform (Blackboard) and then in small groups at the end of each week. Faculty participate as facilitators, but the interactive and experiential learning is generally accomplished by the learners.

The month long elective is concluded by an educational project which is presented to the larger group by each of the learners. Topics addressed in these projects have included investigations into WIC, tuberculosis control for the homeless, African immigration in the local community, access to health care for Latinos, indigent care medication programs, health literacy and others. This experience has served to ignite these learners to learn more and become more involved in addressing inequities in our society.

DISCUSSION

Teaching advocacy to physicians is an important mission which has become crucial to medical training as our society becomes increasingly diverse. Advocacy is especially important for underserved populations as they often are not able to advocate for themselves. Efforts to train physicians in this area are not new. The Ambulatory Pediatric Association approved a curriculum [23] over a decade ago and identified the importance of looking at the impact of all forces in a child's life (social, behavioral and environmental) which would impact the medical care for an individual child. This curriculum was valuable and used by some but did not have the requirements from a governing body which would have encouraged broader implementation. In addition, this curriculum was aimed at a specific group of learners (pediatric residents) and therefore may not have been generalizable to other learners such as medical students. This paucity of resources led the students of one medical school (University of Michigan) to develop their own curriculum.

These students developed a longitudinal set of courses and experiences which were incorporated into the standard curriculum throughout the four years of medical school [1]. This approach is clearly advantageous in building the knowledge, skills and attitudes necessary to become competent in dealing with issues of poverty and their impact on medical care. The Cincinnati courses and programs in advocacy also build learner skills over time and should serve as a foundation for future growth in this area. There was concern among the leaders of the Michigan course about its sustainability, as it is student led. This concern was partly addressed by securing faculty support across different departments. This interdisciplinary approach is similar to the structure in Cincinnati which has proven valuable in maintaining our own courses.

Other institutions have also realized the importance of teaching residents the impact of poverty and culture on medical care. The pediatric interns at Boston Medical Center participate in the poverty simulation, mentioned above, during their intern orientation [24].

Beyond the focus of the impact of poverty on healthcare is the impact of culture. Teaching and equipping medical learners with tools to understand this cultural impact on healthcare will hopefully make them more effective and sen-

sitive physicians. However, as there are many different cultures, most of which are not static, there is a need for ongoing self-education especially when a new culture is encountered. The broad based approach developed in Cincinnati through the courses described gives our learners a foundation of knowledge skills and attitudes on which to incorporate new cultural experiences in the provision of healthcare.

Whether or not any these courses make a difference in the competencies of medical providers or the care provided to underserved populations needs more rigorous evaluation. Kaczorowski *et al.* demonstrated an improvement in competencies related to community health and child advocacy activities when evaluating a block rotation which was incorporated into a pediatric residency program [25]. More evaluations of this type are required to advance understanding in this field and to develop more effective ways to teach advocacy in multicultural and underserved settings.

CONCLUSION

This article describes several courses designed to teach medical learners to advocate for patients from multicultural populations, including the culture of poverty. The authors recognized that traditional medical student and residency curricula did not address these topics. A number of different learning experiences, combining both experiential and didactic teaching methods, were created to expose medical learners to the issues that exist in underserved populations, both locally and globally, who represent a variety of cultures. Building cultural competency was one of the foundational requirements in providing medical care to these populations and is emphasized in a variety of ways in each of these courses. It is hoped that the course development in Cincinnati can be a model to other institutions and thereby prove to be effective and reproducible.

REFERENCES

- [1] Doran KA, Kirley K, Bamosky AR, Williams JC, Cheng JE. Developing a novel poverty in healthcare curriculum for medical students at the University of Michigan Medical School. *Acad Med* 2008; 83: 5-13.
- [2] Chen S, Ravallion M. How have the world's poorest fared since the early 1980's? *World Bank Policy Res Work Paper* 3341, June 2004.
- [3] DeNavas-Walt C, Proctor BD, Smith JC. Income, Poverty, and Health Insurance Coverage in the United States: 2007. *US Census Bureau Curr Popul Rep* 2008; pp. 45-60.
- [4] Garg A, Butz A, Dworkin P, Lewis R, Thompson R, Serwint J. Improving the management of family psychosocial problems at low-income children's well child care visits: The WE CARE Project. *Pediatrics* 2007; 120: 547-58.
- [5] Wood DL, Valdez RB, Hayashi T, Shen A. Health of homeless and housed poor children. *Pediatrics* 1990; 86: 858-66
- [6] Passel JS, Cohn D. *US Population Projections: 2005-2050*. Pew Research Center Social and Demographic Trends 2008 Feb 11 [cited 2009 Mar 1]; Available from: <http://pewhispanic.org/files/reports/85.pdf>
- [7] McGravey AR, Bithoney WG, Nethersole S, Carrillo JM. Serving the underserved: residency training issues. *Ambul Child Health* 1996; 1: 244-9.
- [8] Gruen RL, Campbell EG, Blumenthal D. Public roles of US physicians: community participation, political involvement, and collective advocacy. *JAMA* 2006; 296: 2467-75.
- [9] AAMC Medical Schools Outcome Project. Report I. Learning Objectives for Medical Student Education. *Guidelines for Medical Schools*. [Online]. pp 9; 1998 Jan [cited 2009 Mar 1]; Available from: <http://www.aamc.org/meded/msop/>
- [10] Accreditation Council for Graduate Medication Education, Residency Review Committee Program Requirements. [Online]. *Pediat-*

- rics 2007 July pp 23 [cited 2009 Mar 1]; Available from: http://www.acgme.org/acWebsite/navPages/nav_comRRC.asp
- [11] Lizza, R. The agitator: Barack Obama's unlikely political education. *The New Republic* 2007 March 19; 22.
- [12] Betancourt J. Cross-cultural medical education: conceptual approaches and frameworks for evaluation. *Acad Med* 2003; 78: 560-9.
- [13] Fadiman A. *The spirit catches you and you fall down: a hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Straus and Giroux 1997; pp. 260-1.
- [14] Kleinman A. *The illness narratives: suffering, healing and the human condition*. New York: Basic Books 1988.
- [15] Hausner S. The Critical Link Between Service and Advocacy in Visions of Service. In: Sagawa S, Halperin S, Eds. *The Future of the National and Community Service Act*. Washington, DC: American Youth Policy Center 1993; p. 31.
- [16] Adapted from: Hope A, Timmel S. *Training for Transformation*. Gweru Zimbabwe: Mambo Press 1989; pp. 55-64.
- [17] McCally M, Haines A, Fein O, Addington W, Lawrence RS, Cassel CK. Poverty and ill health: physicians can, and should make a difference. *Ann Intern Med* 1998; 129: 726-33.
- [18] Missouri Association for Community Action [Online]. [cited 2009 Mar 1]. Available from: <http://www.communityaction.org/>
- [19] Hilfiker D. *Not All of Us Are Saints: A doctor's journey with the poor*. New York: Ballantine Books 1994.
- [20] Ehrenreich B. *Nickel and Dimed: On (not) getting by in America*. New York: Henry Holt and Company 2001.
- [21] Kidder T. *Mountains Beyond Mountains: The quest of Paul Farmer, a man who would cure the world*. New York: Random House 2003.
- [22] The Center for Respite Care [homepage on the internet]. [cited 2009 Mar 1]; Available from: www.homelessrespice.org
- [23] Bithoney WG, McGravey AR, Nethersole S, McCarthy P, Palfrey J. Serving the underserved: a residency educational curriculum. *Ambul Pediatr Assoc* 1993.
- [24] Boston Combined Residency Program in Pediatrics. Author Correspondance. [cited 2009 Feb 26].
- [25] Kaczorowski J, Aligne CA, Halterman JS, Allan MJ, Aten MJ, Shipley LJ. A block rotation in community health and child advocacy: improved competency of pediatric residency graduates. *Ambul Pediatr* 2004; 4: 283-88.

Received: February 10, 2009

Revised: May 21, 2009

Accepted: May 30, 2009

© Schubert *et al.*; Licensee *Bentham Open*

This is an open access article licensed under the terms of the Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>) which permits unrestricted, non-commercial use, distribution and reproduction in any medium, provided the work is properly cited.