

## *Virtual Mentor*

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### IN THE LITERATURE

#### **Untangling "Social" from "Cultural" in Cross-Cultural Medical Education**

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**Green AR, Betancourt JR, Carrillo, JE. Integrating social factors into cross-cultural medical education. *Acad Med.* 2002;77(3):193-197.**

In recent years, there has been an increase in the awareness that race and ethnicity affect health outcomes. Despite best efforts to understand the correlation between socioeconomic disparities and poor health outcomes, the problems persist. Medical professionals today face the challenge of caring for patients from many cultures who have different languages, socioeconomic status, and unique ways of understanding illness and health care. Because sociocultural differences between patient and physician can lead to communication and relationship barriers, teaching physicians the concepts and skills that will help overcome these barriers should lead to improved outcomes.

In "[Integrating Social Factors into Cross-cultural Medical Education](#)",<sup>1</sup> Alexander Green, Joseph Betancourt, and J. Emilio Carrillo, describe a fundamental component of their cross-cultural curriculum for medical students and residents. Using a patient-based approach to analyze factors that correspond to negative outcomes in health, the authors advocate a "social review of systems" that emphasizes key social barriers to the delivery of effective health care.

The authors point out that, while medical education at all levels has begun to adapt to the challenges of diversity in health care, this new cross-cultural medical education pays little attention to social factors that may be the greatest barrier to successful health outcomes. Acknowledging that the usual predictors of socioeconomic status such as income and education are typically addressed, the authors charge that illiteracy, immigration experiences, religion, social stressors, and social support networks—each of which has an impact on health—are generally ignored in cultural competency courses.

The authors believe that "the brief and perfunctory social history that has become acceptable in medicine leaves physicians ill prepared to deal with the complex ways in which social factors can affect the medical encounter".<sup>2</sup> Moreover, they maintain that, by teaching doctors-in-training to view culture as the explanation for what are essentially social issues, the medical community risks inadvertently stereotyping various cultural groups as poor and undereducated. The authors believe this risk can be minimized if doctors-in-training are sensitive to the patient's social context,

know how to explore relevant social factors that cut across cultures, and use what they learn to provide better care.

To aid in the understanding of social factors, the authors have constructed a social context review along four domains (social stressors and support networks, changes in environment, life control, and literacy), each of which they think receives too little attention in traditional medical education. The authors suggest thinking of the questions and interview tools for each of the domains as a social "review of systems" similar to the traditional review of organ systems. The social context review of systems questions should be highly selective and focused specifically on issues pertinent to the individual patient. A primary goal of the social context systems review is that physicians recognize factors that can compromise treatment plans and work with patients to minimize the adverse effects of those factors. Medical care given in this way will foster trust, enhance communication, and improve outcomes.

Physicians can provide an important source of counseling and support, but the authors argue that it is usually beyond the scope of the physician's role to solve the difficult issues of social stress or lack of a support system. A critical element is the ability of the physician to recognize key problems, assess their effects on the patient's health and the medical encounter, and help the patient to develop his or her own social supports and other potential methods of dealing with medical and social issues. The authors suggest the adoption of a "biopsychosocial" approach to these issues. Doing so will prevent "medicalization of fundamentally social problems" which in turn will avoid potentially costly work-ups and treatments.

### **Questions for Discussion**

1. Can "cultural competence" be taught? Should medical schools be concerned with cross-cultural education and producing physicians who are attuned to cultural differences of patients?
2. Given the realities of medical practice, is it reasonable to ask physicians to assess patients' social context? Who might physicians rely on to assist patients in developing their social support networks? How could such services be billed and paid for?
3. Is cultural competence a necessary condition for trust between patient and physician?

### **References**

1. Green AR, Betancourt JR, Carrillo, JE. Integrating social factors into cross-cultural medical education. *Acad Med.* 2002;77(3):193-197.
2. Green, 194.

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