COMMENTARY

The globalization of cross-cultural medical education and patient-centered care

Alexander R. Green, MD, MPH

Senior Faculty, The Disparities Solutions Center
Massachusetts General Hospital – Harvard Medical School

Throughout history unfamiliar cultures have bumped up against one another, shared experiences, and even blended. This is not a new phenomenon but has reached a heightened state as the world becomes easier to navigate and more familiar. Since illness and the seeking of care are universally human experiences, medicine finds itself at the nexus of this cultural interplay. By necessity, those countries with the greatest cultural diversity have led the way in preparing young doctors to address the challenges that inherently arise in this context. Thus we see curricula on cross-cultural health care becoming integral parts of medical education in countries such as The United States, Canada, Great Britain and Australia, whether voluntarily or by regulation. In her article *Cross-cultural medical education and training* (1) Reitmanova argues that even countries with relatively small immigrant populations such as Slovakia should incorporate training on cross-cultural care into their curricula. Her three-part rationale for this is right on the mark, but I would add one additional reason – improving the quality of care for everyone.

In the United States the quality movement has pushed us to examine how we deliver health care, and to improve. An influential report called Crossing the Quality Chasm (2) proposed six "pillars of quality" that have come to define this field. In order to achieve a high level of quality, care must be: Safe, Effective, Patient-Centered, Timely, Efficient, and Equitable. Good cross-cultural education emphasizes two of these pillars – patient-centeredness and equity, not just for immigrants or minorities, but for all patients.

Dr. Reitmanova proposes an approach to cross-cultural medical education that is very similar to what we have undertaken at Harvard Medical School, where a cross-cultural care committee is continuously pushing to weave these concepts deeper into the fabric of the formal curriculum. Once, I had the opportunity to teach one of these sessions specifically for a group of visiting Japanese medical students and found that the concepts were quite unusual for them given the paucity of immigrants seen in their hospitals. When we shifted focus from immigrants to other subgroups of native Japanese – farmers, acupuncturists, the elderly – it became clear that the concepts did apply to them. Every patient has a unique perspective on health and illness – different beliefs, expectations, health behaviors, and levels of trust in medicine. The greater the difference between patient and doctor the less can be assumed about these factors and the more important it is to communicate effectively. Patient-centered, cross-cultural care teaches doctors to explore these factors and to tailor care to the needs of the individual. This can improve the quality of care provided for all patients – whether a Korean immigrant who uses herbal medicine or a Slovak native refusing surgery.

1. Reitmanova S. Cross-cultural medical education and training. Bratisl Lek Listy 2008; 109 (2): 82-87.

2. Crossing the Quality Chasm: A New Health System for the 21st Century Washington, DC: Institute of Medicine; 2001.