
Teaching Cultural Competence to Reduce Health Disparities

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As part of the Genesee County, Michigan, REACH 2010 initiative, a new course, Cultural Competence in Health Care, was developed at the University of Michigan–Flint. The objective of this course is to improve the cultural competence of future health and human service providers and to reduce persistent racial and ethnic health disparities. This article describes the course and the important role that REACH 2010 partners played in its development and implementation. Course materials, methods, and student feedback are summarized, along with lessons learned.

Keywords: *cultural competence; health disparities; community-informed instruction; higher education*

As one of Genesee County's REACH 2010 multifaceted interventions to eliminate racial disparities in infant mortality, the University of Michigan–Flint (UM–Flint) in collaboration with its community partners, developed an academic course, Cultural Competence in Health Care, to improve the quality of care provided by future health care providers. The purpose of this article is to describe this course and how the Racial and Ethnic Approaches to Community Health (REACH) 2010 partnership informed its development, implementation, and evaluation.

▶ BACKGROUND AND LITERATURE REVIEW

In 1992, W. K. Kellogg Community-Based Public Health Initiative brought together the Genesee County

Health Department, the University of Michigan (Ann Arbor and Flint campuses), and five community-based organizations from the city of Flint and surrounding areas. The purpose of this initiative, which also gave birth to community-based research principles (Schulz, Israel, Selig, & Bayer, 1998), was to strengthen the practice and teaching of public health by creating partnerships with an informed and involved public. The core of this group became known as the Broome Team and serves as a viable core network reflecting and advising on a growing number of affiliated projects within the Flint community. This existing Broome Team, which has been described elsewhere (Pestronk & Franks, 2003), was key to the development of the Genesee County REACH 2010 initiative funded by the Centers for Disease Control and Prevention (CDC) and was influential in the design of the academic course on cultural competence in health care.

It is within the context of the Broome partnership that the UM–Flint course instructor and other team members engaged in difficult and challenging meetings to discuss the impact of race, racism, and White privilege on the community's health. The discussions provided opportunities for members to express their feelings of anger, frustration, and discomfort related to racism and to begin to work to find language to communicate their feelings. These meetings gave members valuable experience to begin to engage in difficult discussions about racism and racial disparities outside of the team meeting forum. Broome Team members described positive benefits (e.g., increased mutual respect and sensitivity) and voiced that the risks of frank discussions can often outweigh expressed fears of “offending someone.”

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This dynamic and reflective partnership was the foundation for the Genesee County REACH 2010 initiative that adopted reducing institutional and individual racism as a primary strategy to eliminate racial disparities in infant mortality. As each partner organization articulated its unique contribution to eliminate racial disparities in infant mortality, UM–Flint identified teaching undergraduate and graduate students to become culturally competent as its targeted action to reduce racial health disparities.

Why Cultural Competence?

Cultural competency has become recognized as an important contributing factor in health disparities, particularly in the patient-provider interaction, affecting diagnosis, treatment, and other aspects of care delivery. This has been addressed in the Institute of Medicine (2002) report *Unequal Treatment*, the Sullivan Commission (2004) report *Missing Persons*, and by numerous authors (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Crosson, Deng, Brazeau, Boyd, & Sotto-Green, 2004; Geiger, 2001; van Ryn & Fu, 2003) and particularly cardiac care (Kaiser Family Foundation, 2002). Although the extent to which cultural competence improves health outcomes is yet to be well documented (Brach & Fraser, 2000), it is now included in varying format, length, and content in the preprofessional trainings, professional trainings, and continuing education requirements of many health and medical providers, ranging from 2 hours to 10 weeks full-time (Beach et al., 2005; Betancourt, Green, Carrillo, & Park, 2005).

The REACH 2010 partners recognized the value of addressing cultural competence despite the indirect and delayed impact of the university's proposed intervention to reduce racial disparities in infant mortality.

Nevertheless, they acknowledged the university's opportunity to affect local students during their formal education before they assumed their provider roles in the community (Institute of Medicine, 2003).

Overview of UM–Flint

UM–Flint, one of three University of Michigan campuses, is an urban, commuter campus of approximately 6,000 students. It is located in downtown Flint, within walking distance of most of the REACH 2010 partner organizations. According to the 2000 U.S. Census, 53.3% of the Flint adult population is African American, whereas less than 12% of UM–Flint students are African American. Prior to the REACH 2010 initiative, UM–Flint did not offer a course specifically focused on improving the cultural competency of its students. Although courses on race and race relations are available, none has an explicit objective of improving the competency of students to function effectively within a multiracial health and human service environment.

The course was developed and tested in one of UM–Flint's academic departments, Health Sciences & Administration (HS&A) in the School of Health Professions and Studies (SHPS). This department offers public health and allied health programs including health education, health administration, health sciences, and radiation therapy. The majority of students in these programs are from the local area with plans to gain employment and remain in the area after graduation. Although not clinicians within the baby care system, graduates often work within public or nonprofit agencies providing services for mothers, infants, and children. The long-term goal of the HS&A department is to successfully promote this course to other UM–Flint academic programs including nursing, social work, and education. This course would be relevant for other universities and colleges focused on the preparation of future health care professionals. Broader implementation could have a greater impact on the quality of health and human services and, ultimately, racial health disparities.

Role of REACH 2010 Partners

Growing out of the REACH 2010 Initiative, the voice of the community played a prominent role in the course development consistent with community-based research principles. A three-person team including a UM–Flint faculty member, the UM–Flint REACH 2010 coordinator, and the assistant director of the African Culture Education Development Center (ACEDC) developed the course objectives, topics, format, course materials (e.g.,

readings, videos, exercises, assignments), and evaluation methods. This planning process began prior to the onset of the course and continued with a weekly 3-hour debriefing throughout the semester. As the preplanning proceeded, a critical decision was made for the assistant director of the ACEDC to coteach this course. A small stipend and faculty appointment were arranged for the community instructor, who has been crucial to the success of this effort in several ways: as a direct link to the significant resources of a REACH 2010 partner with a “PhE” (“doctorate in experience”), as a conveyer of the prominence of the expertise that resides in our community, and as an African American. The community instructor brought balance and credibility to discussions about race and racism. In addition to the direct involvement of the ACEDC, the course development was informed by a REACH 2010 community consultant with academic expertise in the African American experience and the 2 1/2-day Undoing Racism Workshops conducted by the People’s Institute of New Orleans (also funded by the CDC REACH 2010 Initiative). These multiple community-based perspectives further enhanced the course’s content and relevance.

Campinha-Bacote’s (2002) model of cultural competence in health care delivery became the framework for the course content. The Campinha-Bacote model views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community). This ongoing process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire.

Beyond Campinha-Bacote’s (2002) model, several underlying assumptions and principles developed by the team and informed by the partnership guided the development of the course: (a) cultural competence and racism are linked, and one’s own racism must be addressed to move toward cultural competence; (b) racism contributes to health disparities; (c) real learning requires movement beyond one’s comfort zone; (d) a safe learning environment must be created for students to explore and discuss sensitive racial issues; and (e) opportunities for experiential learning are critical. Factors that contribute to health disparities in infant mortality are discussed along with other health conditions. All decisions made about the course format, setting, topics, and materials were based on these principles and the planning team’s assessment of the strengths and limitations of available race-related courses focusing on knowledge acquisition rather than on self-awareness and skill building.

Course Characteristics

The following definition of cultural competence guided this course:

Cultural competence comprises behaviors, attitudes, and policies that can come together on a continuum that will ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups. Cultural competency is a goal that a system, agency, program or individual continually aspires to achieve. (U.S. Department of Health and Human Services, Health Resources and Services Administration, 2002)

The overarching goal of this course is to increase students’ level of cultural competence within a health care environment through the development of awareness, knowledge, understanding, and skill to better serve diverse populations. This is accomplished through several course objectives. One of the main objectives of the course was to promote students’ self-awareness of their own racial/ethnic identity by analyzing their own role in sustaining racism and by encouraging the necessary self-reflection to make changes in their own behavior. The course emphasis on self-awareness is consistent with Campinha-Bacote’s (2002) concept of cultural awareness (e.g., one’s own unrecognized biases, prejudices, and assumptions that can lead to cultural imposition). As stated in *Unequal Treatment* (Institute of Medicine, 2002), “Healthcare providers find prejudice morally abhorrent and at odds with their professional values. But healthcare providers like other members of society may not recognize the manifestation of prejudice in their own behaviors” (p. 10).

Additional course objectives include increasing students’ understanding of cultural competence and racism, as these affect health disparities, and providing an overview of available resources about cultural competence in health care settings. To achieve these objectives, the course included a substantial number of experiential components to blend training with didactic education known to facilitate learning of topics such as racism and White privilege (Anderson, MacPhee, & Govan, 2000; Chaisson, 2004; Gillespie, 2003).

Although the course topics vary somewhat from year to year, the following have remained constant: definitions of culture, race, ethnicity, stereotypes, and cultural competence. The positive value of diversity is stressed in multiple ways through various class exercises and discussions including the unique contributions

various ethnic minority populations have made to the United States. The three levels of racism (Jones, 2000), White privilege (McIntosh, 1989), racism in the health care system, the link between racism and cultural competence, and the impact of cultural competence on racial and ethnic health disparities are also stressed. Issues of communication barriers, health literacy, and knowledge of common health behaviors of multiple racial and ethnic groups are also included.

To foster a comfortable learning environment, instructors bring snacks to each class. Four to five students sit in small groups at tables, different from a more formal classroom setting, which facilitates student sharing of their personal views. The class meets once per week for 3 hours for 15 weeks.

At the first class meeting, students are alerted to the sensitive nature of course topics and are asked to develop ground rules for the class considering the nature of anticipated course discussions. Common ground rules include listen carefully; make "I" statements; respond to the issue, not the person; be respectful; and maintain confidentiality. These help to mediate personal attacks and students' tendency to generalize about other people's experiences. Each student is entrusted with enforcement of the ground rules and is encouraged to identify infractions in a respectful manner, which reinforces learning of skills needed in interracial discussions. Instructors also comment on adherence or nonadherence to the ground rules and incorporate their observations into class discussions.

Course grades are based on class participation and the quality of personal weekly essays. Essays are graded on four factors: demonstration of understanding of major concepts in assigned readings, clarity of expression, effort expended, and instructor assessed student progress from previous weeks. Weekly essays help to maintain student involvement with course topics throughout the week between class sessions. One student wrote, "I am honestly developing this love/hate relationship with this class. I have been unable to go an entire day without giving some thought to racism and whether or not it still occurs as is portrayed in class."

The course was first offered for the winter 2002 semester and has been taught four times, once each winter semester for 4 years. Each class has approximately 30 students. The majority (more than 75%) are female, with approximately one third to one half students of color, predominately African American. Most (two thirds) are undergraduate students in radiation therapy, health education, or health care administration, with one third graduate students in health education. This class is required for all students in these programs.

Each year that the course has been offered, Beverly Tatum's (2003) book *Why Are All the Black Kids Sitting*

Together in the Cafeteria?, along with Peggy McIntosh's (1989) article "White Privilege: Unpacking the Invisible Knapsack" and Camara Jones's (2000) article "Levels of Racism: A Theoretic Framework and a Gardner's Tale," are among a long list of required assignments.

An initial focus is on students' awareness of their own racial identity facilitated by a discussion of Tatum's (2003) description of racial identity development, an in-class self-awareness exercise, and the first essay assignment, "Describe your own racial and ethnic background." As European American students often see themselves as "typical White American middle class," this focus provides the foundation for later discussions of White privilege and racial oppression. Videos have proven to be powerful in stimulating discussion and self-reflection. Videos such as *America in Black and White* (Koppel, 1999), which focuses on differential treatment of African American cardiovascular patients, enhance students' awareness and dismay of an undesirable side of some health care providers. Other videos used to help elucidate the power and pervasiveness of stereotyping include *Blue Eyed* (Strigle, Verhaag, & Verhaag, 1995), *Understanding Race* (Dougherty, 1999), and "True Colors" (Sawyer, 1991). The *Color of Fear* (Wah, 1994) is used to enable students to hear firsthand the personal pain of men of color and to begin to understand the harm of racial ignorance. This video has a powerful emotional impact on students and often creates a turning point for them, evidenced by their essays. Following this video, one student wrote,

I have concluded that there can only be one thing more painful than being the victim of discrimination. That one thing would be falling victim to discrimination and then having people tell you that your experiences and feelings are not true or valid. That is the equivalent to telling someone that they are lying.

When Billy Broke His Head (Golfus & Simpson, 1994) broadens students' understanding of cultural competence beyond race and ethnicity with its focus on disabled persons. Other videos include case studies such as the Kaiser Permanente training series (Lesser & Gerber, 2002) that addresses the appropriate use of interpreters and provides a framework for applying cultural knowledge in a health care setting.

Numerous local experts have addressed the class either as individual speakers or as part of a panel. Speakers have included a health communication specialist who is an expert on health literacy, a local African American pediatrician who is a Civil War historian born in Bermuda who chairs a community coalition on infant

TABLE 1
Frequently Assigned Essay Topics

<p>How do you describe your own race, culture, and ethnicity? What do you like most (and least) about your race, culture, and ethnicity?</p> <p>Identify Stereotypes in the Media: Where do you notice these? Who is the audience?</p> <p>Stereotypes and Racism: What is meant by racism? What's the difference between stereotypes and racism? How have you contributed to, or been impacted by the different levels of racism?</p> <p>White Privilege: What do McIntosh, Tatum, and Jones mean by "White Privilege"? How does White privilege impact Latino, American Indian, and Asian Pacific American people? How do you think White privilege has affected you?</p> <p>As a health/human service provider, discuss how you could incorporate your assigned "Multicultural Health Generalization" (http://www.med.umich.edu) in a clinical encounter with a patient/client with this ethnic background. Take into consideration the concepts and principles that we have discussed in class, and the pitfalls related to assumptions, generalizations, and stereotypes.</p> <p>Reflect on the class exercise in which you worked to integrate the knowledge from your multicultural generalization description into an interaction between you (as a health care or human service provider) and a patient/client. How would you rate yourself in doing this? Describe this experience. Discuss what challenges this posed for you.</p> <p>Reread all of your essays. Discuss your progress in this course using the Stages of Bennett's Model of Cultural Competence.</p>
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mortality, and an African American Flint police officer who is a poet and author who has experienced racial profiling by other police officers while out of uniform, exemplifying racial profiling as described in *Driving While Black* (Meeks, 2000). Students are also introduced to other local REACH 2010 interventions on infant mortality, offering opportunities for students' involvement with community agencies and exposure to available resources that focus on reducing this health disparity. These include Community Dialogue Groups, Undoing Racism Workshops, and the African Centered Healthy Eating Initiative (Pestronk & Franks, 2003).

The required weekly essays are an important course component. Although initially students do not always see the value of writing weekly essays, these provide a documentation of the progress students make throughout the semester and are a source of evaluation data. Table 1 presents examples of commonly assigned essay topics.

In addition to readings, videos, and essays, students engage in a series of interactive exercises within class. The exercises "Memory of First Difference" and "Iceberg Exercise" (Welch, 2001) are used to convey the limitations of visible characteristics of people in knowing them as individuals. To promote the value of diversity, students are provided a list of descriptors of persons applying for a job (e.g., 1 of 10 children, homeless single mother of four, multilingual, etc.) and are asked for their first thoughts about these persons from an employer perspective. Other exercises include a discussion of a multicultural quiz and various role-playing

exercises using multicultural vignettes available on the Internet (<http://www.med.umich.edu>). Students are introduced to a sampling of educational and training materials available on government, university, and professional association Web sites (e.g., <http://www.hrsa.gov/OMH/competence.htm>; <http://www.amsa.org/programs/diversitycurriculum.cfm>; <http://www.med.umich.edu/multicultural/ccp>).

Evaluation

Much attention has been paid to the evaluation of this course and student learning. Students complete an in-class pre- and posttest assessment to identify reported changes from the semester beginning to end. Results show students' increased understanding of institutional racism, White privilege, and the importance of cultural competence in health outcomes, mirroring the major issues that arose in class during the 4-year period (Table 2).

In response to the open-ended questions from the traditional end-of-semester course evaluations, many students felt that there should be fewer written assignments (less than one each week) but commented that the course should be required. Other noteworthy comments included: "I learned a lot about myself"; "The panel discussion gave me great insight on things happening in the community"; "We tackled very sensitive subjects that everyone should learn about"; "I learned material that I will use every single day"; and "The course altered my way of thinking and feeling."

TABLE 2
Major Issues That Arose in Class During 4-Year Period

Race and racism
Students' hesitancy to discuss race for fear of appearing ignorant or of being offensive
Don't know how to talk about race
Lack of personal contact with people who are different
The awareness of the intense pain and suffering that racism continues to cause
African American students benefited from hearing Caucasian students talk about race and racism
White Privilege
White students' resentment and guilt when learning about White privilege
Cultural Competence
Students with strong religious beliefs understanding that not all people wish to be treated alike
Realization of the impact of the media on their preconceived ideas and stereotypes
Realization of the insidious and unintentional force of discrimination and its impact on patient care

In the 4th year of the course, an item was added about the value of the community instructor. The student response was nearly unanimous in its praise, specifically noting the value of her “non-academic, applied/practical perspective and experience” and “the calming atmosphere she created, essential while discussing sensitive issues.” Students appreciated the “valid link to the Flint community” and “her help in promoting a better understanding of racism by sharing some of her fears and personal stories.” Other comments included, “The class would have been less effective without her,” and “The community instructor has been one of the greatest supplements to my education at UM–Flint.”

A mailed survey was sent to students 6 months after the end of the third class (summer 2004), when there were 87 alumni from the course. As indicated in Table 3, approximately 25% of the students returned the survey, with most indicating they had a better understanding of the negative role racism has on health outcomes and that they have been able to directly apply what they have learned in patient provider interactions.

The mailed survey also asked students which class activities had the greatest impact. As shown in Figure 1, students indicated that of class activities, discussion or interactive exercises and videos had the greatest impact.

The 4th year the course was taught, an additional in-class evaluative method was introduced in which students were asked to identify the most important “take-away” lesson they had learned in the class. This was a reinforcing exercise for students as they heard firsthand from all of their classmates. Identified lessons are shown in Table 4.

An additional source of evaluative data is found in the last essay assignment, which requires students to reread all of their returned essays and describe changes using Milton Bennett's (1993) model of cultural competency. Most students can identify examples marking their own development, which often reinforces their interest in continuing to move forward in becoming culturally competent.

► DISCUSSION

The Genesee County REACH 2010 Initiative has not only enabled UM–Flint to develop this course but has influenced SHPS to make diversity and cultural competence a higher priority. This is evidenced by the inclusion of “graduating culturally competent students” in SHPS’ mission statement. In 2005, the cultural competence course was adopted by SHPS, including the Nursing Department as one of a short list of approved courses to meet its new cultural diversity requirement. This will bring additional student demand from those who provide direct health care to mothers, infants, and children.

► LESSONS LEARNED

In teaching this course, the instructors have learned to be flexible and to adopt realistic expectations. Students tend to come from segregated residential communities with views of those who are different fueled by ubiquitous stereotypes. Our students lacked awareness of the continuing, pervasive fact of racism and its detrimental impact on the health of people of color and on racial health disparities. One student wrote,

TABLE 3
Summary of Student Responses to Mailed Survey About Course

<i>Percentage of Respondents Agreeing With Statement</i>	<i>Winter 2002^a</i> %	<i>Winter 2003^b</i> %	<i>Winter 2004^c</i> %
Because of this class, I feel I am more aware of how cultural differences including race can impact health care and health outcomes.	100.0	100.0	100.0
This class has made me more aware of racism in my workplace.	100.0	100.0	100.0
I better understand how racism negatively affects the health care and health outcomes of African Americans.	100.0	100.0	100.0
When I interact with patients, I am able to directly apply what I learned in the Cultural Competency class to improve patient-provider communication.	100.0	85.7	100.0
As a result of taking this class, I feel that I am more able to discuss issues related to race and racism among family members.	85.7	81.8	83.3
As a result of taking this class, I feel that I am more able to discuss issues related to race and racism in social settings.	71.5	90.0	83.3
The Cultural Competence in Health Care course helped to shape my current definition of White privilege.	71.4	63.6	100.0
As a result of taking this class, I feel that I am more able to discuss issues related to race and racism at work.	57.2	77.7	83.3
The Cultural Competence in Health Care course helped shape my current definition of racism.	42.9	90.9	100.0
As a result of the Cultural Competence in Health Care course, I now participate in activities that focus on reducing racism.	25.0	12.5	33.3

NOTE: Missing data were not included when calculating percentages.

In this course I have learned more than I thought that I could handle. I was a little upset when we watched movies in class about racism. Part of me didn't want to believe there was racism going on around me. I wanted to turn a blind eye to it and, as long as it wasn't happening to me it was ok.

Another student wrote, "Before taking this class I would have blamed a person unfairly for their deplorable condition of their health." Although all of our students demonstrated some degree of resistance including a denial of racism, almost all indicated in their essay assignments that they had moved beyond their individual comfort zones and observed that they had achieved some positive growth by the end of the semester. The instructors believe that creating a safe and comfortable environment,

coinstruction with a community partner, and careful selection and sequencing of course materials facilitated this growth. As each group of students is different, instructors need to be flexible in the presentation of new materials to enable students to move forward. Because one semester is insufficient time to change attitudes and behaviors, it is important to collaborate with like-minded community partners such as those engaged in REACH 2010 activities to identify and promote available complementary activities for students so that their learning can be reinforced and continued after the course has ended.

► CONCLUSION

Eliminating racial and ethnic health disparities in the United States is a goal that will likely elude us

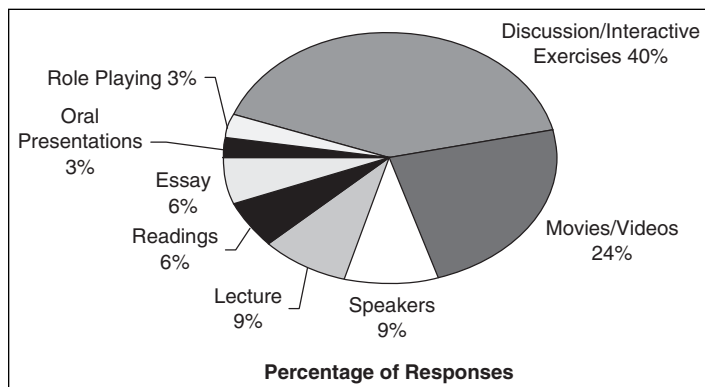


FIGURE 1 What Activities or Part of the Class Had the Greatest Impact on You?

for decades to come. Achieving this goal will require individual, organizational, institutional, and societal changes. Public universities in urban settings can begin to do their part by educating students in health and human service fields to develop awareness and skills that can help to reduce these disparities. Engaging in this endeavor requires a long-term commitment and strong community partners. Taken alone, the impact of this course in reducing racial disparities in birth outcomes is difficult to document, but universities that invite community experts into the classroom for similar courses are likely to experience more success than those that do not.

TABLE 4
What Is the Most Important Lesson Learned From This Course?

We shouldn't make assumptions.
 Words are powerful and they can hurt us.
 It is very difficult to change our behavior.
 I have an increased self-awareness of how we/I stereotype.
 White privilege is real and I understand how it affects people of color.
 I learned that there are levels of racism—personally mediated, institutionalized, internalized.
 Generalizations, stereotypes, and assumptions go beyond color.
 Our society is very segregated.
 It's always important to ask questions—in a respectful way.
 It is almost impossible to effectively help a person without learning about their culture.
 Self-awareness is important because we have a tendency to deny reality.
 We need to reconsider racism and its impact in a clinical setting.
 Individual variation within racial/ethnic groups is important.
 I feel more empowered to intervene when I notice discrimination.
 Body language can be culturally determined.
 Engaging in conversations about race and racism in the U.S. is important.
 Racism is destructive.
 Use of a “proper” interpreter is essential to provide culturally competent health care.
 Taking risks and stepping out of our comfort zones is necessary.

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