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Introduction

Cultural competency efforts have shifted from being a recommended area of focus in undergraduate and graduate medical education to becoming an integral part of the curriculum. Citing a definition from the National Center for Cultural Competence, the Association of American Medical Colleges (AAMC) defines the term cultural competence as follows:

*Cultural and linguistic competence is a set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations. “Culture” refers to integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups. “Competence” implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, practices, and needs presented by patients and their communities.*

The John A. Burns School of Medicine’s (JABSOM) mission and vision position the school to be at the forefront of educational and research initiatives that integrate cultural competency. JABSOM’s mission statement reads as follows: *as part of the fabric of Hawaii, is a diverse learning community committed to excellence and leadership in: educating current and future healthcare professionals and leaders; delivering high-quality healthcare; conducting research and translating discoveries into practice; establishing community partnerships and fostering multidisciplinary collaboration; pursuing alliances unique to Hawaii and the Asia-Pacific region; acting with forethought regarding right relationships, respect, and moral action. Pono.*

JABSOM’s vision statement is *Maika`i Loa: Attain Lasting Optimal Health for All (ALOHA).*

There is no lack of cultural competency efforts throughout the school; however, in Fall 2007, preliminary inquiries with various departments, programs, and individuals revealed that documentation of cultural competency efforts were not readily available or easily obtainable from a “centralized” source. Moreover, there was a sense that “someone” was working on “something,” but specifics often could not be provided. In an attempt to increase communication and collaboration among the various JABSOM departments, programs, and individuals, we initiated this project in Spring 2008 to summarize JABSOM’s cultural “competency” initiatives/programs into a resource guide for everyone’s use. This is our fifth update.

Initially, an additional purpose of this project was to assist JABSOM with its preparation for the Liaison Committee on Medical Education (LCME) accreditation. Our medical school is required to provide a summary of our collective efforts in cultural competency as part of our national accreditation process. The results of our data collection served as the basis for some of the responses to LCME questions related to cultural competency.

Once again, we wanted to provide the departments/programs that had contributed to the past

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guides the opportunity to update their sections. In addition, we invited new departments/programs to participate in this year’s summary of cultural competency initiatives, including the School of Nursing. A list of questions regarding perceptions and concerns regarding cultural competency efforts and a summary grid were sent via e-mail. Those who opted to participate could either complete the attachments, responding by e-mail, or through a face-to-face or phone interview. We received a total 18 responses, including a collective response from course directors responsible for centralized Office of Medical Education courses.

This guide should be viewed as a work in progress. As cultural competency efforts are refined, and new initiatives added, we intend to update the guide on an annual or more frequent basis as needed to reflect these changes.

We would like to thank those departments, programs, and individuals who took the time to respond to our survey. They not only provided us with wonderful insight into their cultural competency initiatives, but also shared helpful information, such as evaluation and assessment tools, that may be of interest and use to others.

We have done our best to reflect the information in as accurate a manner as possible. Any questions, concerns, or suggestions regarding this guide should be directed to: Maria B.J. Chun at mariachu@hawaii.edu or (808) 586-2925.

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Overview/Summary

In general, each department that provided a response had at least one type of cultural competency initiative or effort. The initiatives or efforts included guest lecturers and/or presentations, educational sessions, formal courses, internships/externships, teaching strategies, research endeavors and collaborations within JABSOM and with departments outside of the medical school, and partnerships with community groups. Increased collaboration and communication among the JABSOM departments would contribute to a more cohesive and integrated effort. Some of the respondents commented on the lack of funding and staffing as barriers to the development, implementation, and maintenance of cultural competency efforts. Other factors that may limit departments from the optimal development of cultural competency initiatives include minimal teaching resources outside of the classroom and competing agendas/curricular times between cultural and didactic courses.

Cultural competency efforts were found in the curriculum for both medical students (e.g., Department of Native Hawaiian Health, Office of Medical Education) and residents (e.g., Departments of Psychiatry, Family Medicine and Community Health, Geriatric Medicine, Surgery). Although faculty development in the area of cultural competency appeared to be rather limited in the past, the Office of Medical Education and Department of Native Hawaiian Health have expanded their existing initiatives to include faculty. Another area in need of improvement is evaluation of cultural competency efforts to assess efficacy. Beyond course evaluations, few programs conducted formal evaluations of their cultural competency efforts. Currently, only four departments reported utilizing a standardized tool (Communication Sciences and Disorders, Family Medicine and Community Health, Native Hawaiian Health, and Surgery).

A number of departments, such as Native Hawaiian Health, Psychiatry, Complementary and Alternative Medicine, Family Medicine and Community Health, and Communication Sciences and Disorders, have heavily integrated cultural competency into their departments’ missions. Their educational, training, and research programs start with the understanding of the importance of cultural competence, or as some prefer, “cultural humility.” Several departments found the term cultural “competence” to be a little misleading because they feel no individual can be truly “competent” in understanding any culture. However, we opted to use this term since it is the “official” term of reference for the accrediting bodies, such as the LCME.

Other departments also appreciate the importance of culture and have begun to develop various initiatives. The Department of Surgery has continued its efforts to study cultural competency in surgical residency and is currently conducting its third pre-posttest of a cultural standardized patient exam that was the result of collaboration with the Department of Family Medicine and Community Health.

Following is a list of departments and/or programs that participated in the survey and shared their cultural competency efforts with us. We have provided contact persons and information. When available, we have also included table summaries and sample evaluation tools.
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Cultural Competence Initiative(s):
The Office of Medical Education is tasked with supporting the implementation and evaluation of the medical student educational experience, primarily in the first and second years of study (known as the pre-clinical years). The office oversees a number of centralized courses that focus on exposing medical students to working with diverse populations. The office also collaborates with the Department of Native Hawaiian Health on a number of its cultural competency initiatives.
Below is a list of courses and related contact information:

**Course(s):** MD1 MDED 581 Community Health  
MD2 MDED 582 Community Health  
MD3 MDED 583 Community Health  
MD4 MDED 584 Community Health  

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Comprising the Community Health Program, these community health courses provide field experiences for students by placing them in community settings to work with healthcare professionals as they serve patients. The program consists of a number of community organizations, each of which has a site coordinator who is responsible for developing the curriculum. Therefore, students have a variety of exposure to cultural sensitivity issues. The Area Health Education Centers (AHEC at the Kalihi Palama Center), for example, have activities that incorporate cultural components into their curriculum.

To provide exposure to cultural issues affecting health to the entire class a *Cultural Sensitivity Colloquium* was implemented. This colloquium was organized by Dr. Martina Kamaka, M.D. and the Department of Native Hawaiian Health. The objectives of this event are:

1) understanding the importance of culturally competent care in medicine and medical education;  
2) exploring our own values and biases;  
3) understanding the culture of Western Medicine and its impact on medical care; and  
4) addressing the health disparities of Native Hawaiians.

Dr. Kamaka also provides two cultural competency workshops for first year students in MD1 and MD4. Although Kokua Kalihi Valley Health Center is not part of the Community Health Program, Dr. Bradley Chun, M.D., an internist and an assistant clinical professor in the UHM Department of Medicine, teaches clinical skills to first year students.
**Course(s):** Clinical Skills Series: MDED 571-577

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The Clinical Skills Series instructs students on medical interviewing and physical exam skills pertinent to the basic physical exam. Cultural sensitivity is part and parcel to the interpersonal, communication, and physical examination skills taught in the Clinical Skills Courses in the first two years at JABSOM. Students are taught that illness is the manifestation of disease process in a unique individual. Cultural sensitivity comprises understanding the patient’s response to his/her illness in terms of cultural identity, personal beliefs. Practice, diagnostic, and treatment plans are adapted accordingly.

In addition, students are instructed to understand the impact illness has on a patient in the setting of family, educational and religious background, economic circumstances, and insurance realities. Avoidance of stereotypes is emphasized.

See Appendix A for details of how cultural sensitivity is integrated into the curriculum.
**Course(s):** MDED 566 Topics in Health and Illness

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In the Third Year Colloquia Series there is no specific session on cultural competency. However, there are several scenarios from the Ethics Session, which include several cultural situations. Small group discussions are held; students then decide on a course of action. Pre and post votes of what they would do in each situation (using an audience response system) are completed. Finally, a panel of individuals (an ethicist/physician, nurse, pastor, and ED physician) discusses the approach from their perspective. Students’ post-votes are then collected and recorded.

**Course(s):** PBL MD1 (MDED 551)

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This course includes lectures and panel discussions, such as Native Hawaiian Health issues and homelessness. With regard to PBL case content, issues related to Native Hawaiian Health, homelessness in Hawaii (especially Micronesian peoples), health literacy, ageism and effective communication with the healthy elderly, and effective communication with adolescents are covered.
**Course(s):** PBL MD2 (MDED 552)

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MDED 552 has attempted to incorporate a “human touch” to all its PBL cases by providing information about characters/patients such as age, ethnicity, marital status, interests, hobbies, concerns, and joys. Additionally, much of the cases contain dialogue so that students can get a sense of actual conversations that take place between healthcare workers and patients. These curricular changes are supportive of cultural competency efforts but were more driven by principles of PBL case design than by a specific “cultural competency initiative.” There is no specific evaluation data focusing on the cultural competence aspects of our curriculum.

See Appendix B for additional details.

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**Course(s):** PBL MD3 (MDED 553)

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The course consists of lectures and panels, such as living with HIV, which includes discussions about various lifestyles. With regard to PBL case content, communicating through an interpreter, living with HIV infections, and Vietnamese attitudes towards health are covered.
In addition to the aforementioned courses, we also make an attempt to evaluate an aspect of cultural competency in our fourth year students during their Clinical Skills Assessment course (MDED 541). In the standardized patient exam, we ask our patients to rate student performance using a patient perception scale. One of the questions we ask is: Rate the student's skill at “Respecting your beliefs and ideas.” These types of questions are added to the evaluation with cultural competencyspecifically in mind.
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Culture Competence Initiative(s):
The Office of Global Health/Medicine (OGH/M) in the Dean’s Office, in collaboration with the clinical departments, oversees reciprocal student exchanges between JABSOM’s 4th year students and medical students from Asia in their 6th year of medical school. A goal of the program is to foster mutual understanding and competence in the cultures, primarily associated with health care, of the peoples of the Pacific and Asia. Each year, a total of approximately 50 to 60 students participate in the program. OGH/M supports the efforts of departments with regard to student placement overseas, including aspects related to culture and health.

Dr. Walter K. Patrick offers courses in Global Health and Medicine and Disaster Management and Crisis Communication, which have significant components and emphasis on culture and health. In addition to teaching courses, Dr. Patrick provides consultation to faculty and students planning overseas project or field studies.
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Cultural Competence Initiative(s):
The Hawaii and Pacific Basin Area Health Education Center (AHEC) is a federally funded program whose purpose is to improve the health of the underserved through increasing the number of qualified healthcare providers. The AHEC provides many accredited educational programs and professional support for health care professionals that practice in underserved communities, which will help to enhance the diversity and quality of Hawaii healthcare as well as improve the cultural competency of providers.

This program mainly focuses on four areas:
1. Health education and recruitment to health professionals for students across the state from kindergarten through college;
2. Educating health professions, students in rural and underserved areas, often in interdisciplinary teams;
3. Recruitment, retention, and continuing education of practicing health professionals in medically underserved areas; and
4. Providing community based and community driven health education in over a dozen community learning centers across the state.

The Hawaii Pacific Basin Area Health Education Center (HPB AHEC) has nine centers across the Pacific; five in Hawaii and four in the US Affiliated Pacific Islands (Palau, CNMI and YAP and American Samoa).

Every year, the HPB AHEC provides training opportunities for health professions students to work in rural and
underserved communities across the Pacific. These rural traineeships are excellent learning opportunities for students to gain valuable cultural competency skills. This year, Kendra Dilcher, a second year JABSOM student wrote about her HPB AHEC experience training in American Samoa in the Hawai’i Journal of Medicine and Public Health (April 2012, Volume 71, No. 4, Supplement 1). Below is an excerpt from her article highlighting the importance cultural competency in the provision of healthcare:

*It has also long been a Samoan cultural custom to center family gatherings around food. However, “Samoan culture has taken on a Western flavor and the food that is offered generally consists of kegs of high fat beef [known locally as pisupol]. Food served is supplemented with salty side orders, white rice, soda and dessert, and each person served on 1 or 2 large aluminum foil trays.” Asking patients about their views on how this affects their weight, some responded by saying that they “know the foods are no good but can’t stop eating them because they taste good.” They did not have fast foods, frozen, or canned foods when they were younger. They ate foods from their land, not wasting things or having as many leftovers, because there weren’t ways to save the food. Today, people can package foods into containers and store them in refrigerators, allowing them to have constant access to leftover unhealthy foods.*
COMMUNICATION SCIENCES AND DISORDERS

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Culture Competence Initiative(s):
The Department of Communication Sciences and Disorders (CSD) is one of the few U.S. interdisciplinary programs that prepare students in a multilingual and multicultural environment. This program provides a Bachelor of Science degree in speech language pathology and audiology as well as a Master of Science degree in speech pathology. Previously known as the Division of Speech Pathology and Audiology, the department’s mission has the following goals:

1. Develop a multicultural focus through didactic and clinical experiences;
2. Educate and train students to meet the needs of individuals with communication disorders in Hawaii and the Pacific Basin;
3. Provide a program that integrates academic, clinic, and research experiences;
4. Provide students with exposure to clients with a variety of communication disorders and differences across a variety of severity, age groups, and socioeconomic backgrounds;
5. Nurture ethical behavior in academic, clinical, and research activities;
6. Promote students’ critical thinking skills and commitment to life-long learning; and
7. Establish students’ participation in professional and community volunteer activities fostered by membership in National Student Speech Language Hearing Association (NSSLHA) and faculty role models

These initiatives are incorporated throughout the curriculum, such as a cultural ethics course, ethnography, and medical interviewing. In addition, there is a weekly symposium, which discusses the importance of cultural values with relation to language development. For instance, a Japanese American student would collaborate with a student from Japan to present their attitudes towards how they were raised in different cultures and how this affects language. The CSD believes that although speech pathologists are designed to treat physical anomalies, cultural competency is still crucial to providing optimal patient care.

The department had shared a checklist that it has used to evaluate its students (Appendix C).
COMPLEMENTARY AND ALTERNATIVE MEDICINE

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Cultural Competence Initiative(s):

For the Department of Complementary and Alternative Medicine, cultural “competency” is an integral part of its mission. The department has a Wellness Center in the Auxiliary Services Building on the Kaka'ako Campus where they practice. Their services include: acupuncture, Oriental medicine, family practice, lifestyle medicine, holistic pediatrics, massage, music therapy, weight training, and endurance training. The department also has a radio talk show on KIPO where faculty, such as Dr. Terry Shintani, M.D., J.D., discusses various health issues with the public.

The department also has a number of research initiatives. Dr. Amy Brown is involved with studying the utilization of poi in the diet of end stage cancer patients. Dr. Shintani continues to research the “Hawaii Diet,” which is a “culturally appropriate, macrobiotic diet.” Additionally,
the department is collaborating with the Department of Cell and Molecular Biology on a grant to study complementary and alternative medicine. The proposal is comprised of four translational projects, which include research on how bamboo shoots, bitter melon, cruciferous vegetables impact diet and weight. The department also has collaborated with the Matsunaga Peace Center on skill-building.

In addition to the above, the department oversees the Master’s and Ph.D. programs in translational research, which include two courses on cultural competence at the doctoral level:

1. BIOM 647 *Cultural Competence in Biomedical Research I*, which is the introductory course in the application of cultural awareness to biomedical research in the Clinical Research curriculum; and
2. BIOM 650 *Cultural Competence in Biomedical Research II*, which builds on the introductory course and assists students with planning and implementing an ethnically and culturally appropriate clinical research project.

The Department of Complementary and Alternative Medicine feels that the term “cultural humility” better captures what it is trying to teach and promote (i.e. it is impossible for anyone to become “competent” in another’s culture). Cultural humility promotes sensitivity and use of different strategies when dealing with diverse groups.
FAMILY MEDICINE AND COMMUNITY HEALTH

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Cultural Sensitivity Initiative(s):
The Department of Family Medicine and Community Health has developed a formal, cross-cultural curriculum for residents. Once every three months, the residents participate in lectures/discussions/workshops regarding the following:

1. Introduction to cross-cultural issues during intern orientation, including a three day Native Hawaiian immersion experience;
2. Experiential exercises to enhance residents’ self-awareness, insight and empathy,
3. Introduction to ethnographic research as a key means toward understanding culture;
4. Patient-centered cross-cultural sensitivity for eliciting patients’ explanatory models of illness;
5. Ethnomedicines (e.g., Chinese, Japanese, Native Hawaiian, Micronesian, Filipino);
6. Cosmopolitan biomedicine as an ethnomedicine;
7. Moral and ethical considerations of cross-cultural health issues;
8. Complementary and alternative medicine;
9. Interactive case workshops (utilizing residents’ patients);

The department also has developed evaluation methods to assess its cultural sensitivity initiatives:
1. Weekly half-day of precepting by the cross-cultural curriculum director and other cross-cultural faculty to ensure that the cross-cultural skills are being utilized effectively in the clinic (outpatient setting);
2. Observation of inpatient rounds each block by the cross-cultural curriculum director to ensure that cross-cultural skills are being utilized effectively in the hospital;
3. Resident attendance and participation of residents at didactics and workshops;
4. Self-awareness assessments with faculty feedback;
5. Pre- and post-workshop written assessments of knowledge gained, as appropriate to the particular topic and workshop format;
6. A series of “standardized patient” exercises including Micronesian, Samoan, and Native Hawaiian patients, videotaped with and observed by faculty advisors of each resident. These include working with interpreters, end-of-life decision making, delivering bad news, and working with cultural beliefs and practices that may limit the patient’s acceptance of medical advice.

A sample of the department’s evaluation tools can be found in Appendix D.

The department also works closely with the Department of Native Hawaiian Health. Dr. Maskarinec is a member of its Cultural Competency Curriculum Development Committee. The department also participates in its Cultural Immersion Weekend for intern orientation and invites speakers from the Department of Native Hawaiian Health to conduct presentations to its residents and faculty.
GERIATRIC MEDICINE

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Cultural Competence Initiative(s):
The Department of Geriatric Medicine’s goal is to develop knowledge, attitudes, and skills that enable effective delivery of care in diverse cross-cultural settings with improved outcomes. Ethnogeriatric cultural competency is taught to all levels of learners, including medical students, residents, fellows, practicing physicians, and allied health students and faculty. Several innovative curricula have been developed.

Publications:
- Patricia Blanchette, M.D. Professor, was editor of the API section of an online course on cultural competence and co-authored several of the sections – the Stanford Ethnogeriatrics website - http://www.stanford.edu/group/ethnoger/

- Patricia Blanchette, M.D. Professor, also co-edited, authored, and co-authored some of the chapters of Cultural Issues in End-of-Life Decision-Making, 1999, Sage Publications.

- Marianne Tanabe, Associate Clinical Professor, authored a chapter on Japanese Americans in Doorway Thoughts Cross Cultural Health Care for Older Americans, 2008, published by Jones
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HOSPITAL AND EXTERNAL BUSINESS AFFAIRS

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Culture Competence Initiative(s):
Although the Office of Hospital and External Business Affairs (OHEBA) is not directly involved with organizing cultural initiatives for students, our office strongly believes that being culturally sensitive to patients via superior communication and understanding cultural differences is key to establishing a good practice and lowering malpractice risk. Our office is responsible for patient safety and risk management for the JABSOM and serves as an administrative liaison with various hospitals, clinics, and other affiliates of JABSOM, such as the school’s faculty practice plan -- UCERA (University Clinical, Education and Research Associates). Our office hosts patient safety educational programs two times per year in conjunction with our professional liability carrier, wherein we routinely emphasize the importance of communication and sensitivity, taking into consideration cultural differences between provider and patient, from a legal standpoint.

We presented in 2011 on Cultural Differences & Professional Liability Implications with Vicky Rollins of The Doctors Company and Mr. Roeca. We highlighted how traditional patient safety concerns are magnified by cultural differences and demonstrated the legal consequences through case scenarios. In 2013, we would like to draw upon prior themes, but emphasize the informed consent process, in conjunction with other subject matter experts in the industry.
MEDICAL TECHNOLOGY

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Culture Competence Initiative(s):
The Department of Medical Technology does not have any specific cultural competency initiatives or programs. However, as guest speakers are invited to address the topic, cultural competency is informally introduced in the Clinical Laboratory Management course, which is offered during the first semester of the program. In addition, it is mandatory for all undergraduate students to complete the University's General Education Requirements that include 2 courses (6 credits) in Global and Multicultural Perspectives as part of their Foundations Requirements. We recently began an international student exchange with a University in Japan.
**MEDICINE**

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**Website Link:** [http://uhimrp.org/](http://uhimrp.org/)

**Culture Competence Initiative(s):**

The Department of Medicine has a session on cultural competence for the Transitional Residents given by Glenn Rediger, M.D. Dr. Rediger utilizes a PowerPoint presentation called “The Keys to Cultural Competence.” He also uses a video of a medical encounter with a non-English speaking patient and an interpreter, which serves as the starting point for a discussion on the use of interpreters. In his session, Dr. Rediger also engages the residents in an exercise called “Cultural Pursuit,” in which each participant receives a 3x5 card with a vignette, and speculates what is happening in the encounter. The vignettes are based on true encounters in Hawaii, many of which from Dr. Neal Palafox’s book, *Crossing-Cultural Caring: A Handbook for Health Care Professionals in Hawaii* (1980), and from other physicians’ experiences.

A Department of Medicine Grand Rounds presentation was given by Lee Buenconsejo-Lum, M.D., on March 30, 2010 titled, “Leveraging resources for cancer control in the USAPI working together to reduce health disparities.” Cultural competency was a major emphasis of presentation.

A Department of Medicine Grand Rounds presentation on the Basic Health Hawaii insurance
plan was given on October 26, 2010. This was a panel discussion explaining the details and implications of the insurance plan targeted to citizens of the Compact of Free Association nations living in Hawaii that was implemented in July 2010.

Other presentations included:

<table>
<thead>
<tr>
<th>Date</th>
<th>GRTitle</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/29/2011</td>
<td>Bridging the Generational Gap Between Teachers and Learners</td>
<td>Kasuya, Richard</td>
</tr>
<tr>
<td>2/21/2012</td>
<td>Federally Qualified Health Centers: Past, Present, and Role in Health Care Reform</td>
<td>Rediger, Glenn</td>
</tr>
<tr>
<td>3/27/2012</td>
<td>Disease In Japan: Unique Cases, Culture, and Pathology</td>
<td>Deshpande, Gautam</td>
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<tr>
<th>Date</th>
<th>Topic</th>
<th>Speaker</th>
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<tbody>
<tr>
<td>7/26/2011</td>
<td>Generational Differences in GME</td>
<td>Kasuya, Richard</td>
</tr>
<tr>
<td>8/23/2011</td>
<td>End of Life Issues</td>
<td>Roytman, Marina</td>
</tr>
<tr>
<td>2/21/2012</td>
<td>Federally Qualified Health Centers: Past, Present, and Role in Health Care Reform</td>
<td>Rediger, Glenn</td>
</tr>
<tr>
<td>2/28/2012</td>
<td>Cultural Competency</td>
<td>Chun, Bradley, Kamaka, Martina, Chun, Maria, Rediger, Glenn</td>
</tr>
<tr>
<td>3/27/2012</td>
<td>Medical Education in Japan</td>
<td>Deshpande, Gautam</td>
</tr>
<tr>
<td>4/24/2012</td>
<td>What's in a Name: Part 1 -- Pacific (Japan, Marshalese?)</td>
<td>Kealiikuaaina, Kahoko</td>
</tr>
<tr>
<td>5/15/2012</td>
<td>Depression &amp; Stressors in Native Hawaiians</td>
<td>Kaholokula, Joseph Keawe'aimoku</td>
</tr>
</tbody>
</table>
NATIVE HAWAIIAN HEALTH

Contact Person(s) and Information:

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Cultural Competence Initiative(s):

The Department of Native Hawaiian Health is involved with a number of cultural competency initiatives for medical students. For first year medical students, it developed an “Introduction to Hawaiian Health” lecture, a series of four-hour workshops, “The interaction of Culture and Health,” a Native Hawaiian (NH) cultural standardized patient encounter and a year-long elective focusing on Native Hawaiian health and traditional healing. In addition, it offers a Cultural Immersion Weekend, which is a 2.5 day experience in Waianae. The curricular content is designed to employ a variety of teaching modalities such as lectures, small group discussions, role playing, experiential learning and standardized patient encounters. Traditional healers and cultural consultants are invited lecturers and cultural resources within the community are utilized. Topics are wide ranging and include: NH history, NH health disparities, social justice, cultural trauma, culture of medicine, self-awareness, patient-physician interaction and traditional healing practices.

Other initiatives include fourth year elective rotations in Native Hawaiian communities, an immersion weekend for family medicine residents and a quarterly lecture series on Native Hawaiian health for the family medicine residency. The C3 team has also recently organized two faculty cultural immersions. New efforts include developing a cultural standardized patient case for second year students.
The Department has a Cultural Competency Curriculum Committee (C3) which spearheads many of these initiatives. Members of the committee include community members, faculty from the Departments of Native Hawaiian Health and Family Medicine as well as the School of Social Work. In addition to the Office of Medical Education, the Department of Native Hawaiian Health has collaborated with the Departments of Family Medicine and Community Health, Surgery, and the School of Social Work on some of the C3 initiatives. For more details on the department’s cultural competence initiatives, please see the following table.
<table>
<thead>
<tr>
<th>Initiative/Programm</th>
<th>Description</th>
<th>Target Population/Group (Medical student? Resident? Faculty?)</th>
<th>Method(s) Used to Evaluate the Initiative or Program</th>
<th>Name of Contact Person(s) – phone number, e-mail address</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction to Hawaiian Health</td>
<td>One hour lecture during orientation month to introduce students to basics of Hawaiian health, with a review of the historical record.</td>
<td>1st year medical students</td>
<td>Post course evaluation</td>
<td>Martina Kamaka, MD 692-1014 <a href="mailto:martina@hawaii.edu">martina@hawaii.edu</a></td>
<td>Lecture is designed to complement workshops (see below).</td>
</tr>
<tr>
<td>Workshop on Culture and Health (OME colloquia)</td>
<td>Three 4-hr. workshops focusing on health disparities, cultural competency, social justice, cultural trauma, doctor-patient relationship and communication, self-discovery exercises and traditional healing.</td>
<td>1st year medical students</td>
<td>Post course evaluation Assessment tool used with standardized patients</td>
<td>Same as above</td>
<td>Time in the second workshop is shared with rural health.</td>
</tr>
<tr>
<td>Cultural Immersion Weekend</td>
<td>2.5 day experience in Waianae featuring visit to WCCHC, Kaala Farms, Makua Valley, Pokai Bay Navigational Heiau. Time is also spent in small group discussions and traditional food prep.</td>
<td>1st year medical students Family Practice Interns</td>
<td>Pre and post test Post course evaluation</td>
<td>Same as above</td>
<td></td>
</tr>
<tr>
<td>Initiative/Program</td>
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<tr>
<td>NH health lecture series for FP residency</td>
<td>Quarterly lecture series focusing on NH health. Series includes field trips.</td>
<td>FP residents and faculty</td>
<td>None</td>
<td>Same as above</td>
<td>Developing a case for second year students for next school year</td>
</tr>
<tr>
<td>Standardized Patient Exercise</td>
<td>NH culturally based standardized patient scenario</td>
<td>First year medical students</td>
<td>Post course evaluation JABSOM Cultural Standardized Patient Assessment Tool (CSPAT)</td>
<td>Same as above</td>
<td></td>
</tr>
<tr>
<td>Native Hawaiian Health Elective, Past, Present and Future</td>
<td>First year elective (community health selective) Class meets weekly focusing on traditional healing and NH holistic concepts around health. Features field trips and service learning projects related to NH health.</td>
<td>First year medical students</td>
<td>Post course evaluation</td>
<td>Martina Kamaka, MD 587-8572 <a href="mailto:martinak@hawaii.edu">martinak@hawaii.edu</a> and Vanessa Wong, MD 692-1032 <a href="mailto:wongvanz@hawaii.edu">wongvanz@hawaii.edu</a></td>
<td>This is a revised course. Prior courses had a research methodologies component</td>
</tr>
<tr>
<td>Native Hawaiian Health 4th year elective</td>
<td>Elective rotation featuring clinical time in a community serving large NH population. Students also shadow a traditional healer.</td>
<td>4th year medical students (JABSOM, US, and international)</td>
<td>Post course evaluation</td>
<td>Dee-Ann Carpenter, MD 587-8558 <a href="mailto:deannce@hawaii.edu">deannce@hawaii.edu</a></td>
<td></td>
</tr>
<tr>
<td>Problem Based Learning Cases</td>
<td>Revision of a PBL case allowing for introduction of cultural issues and topics</td>
<td>1st year medical students</td>
<td>Post course evaluation</td>
<td>Martina Kamaka, MD Richard Kasuya, MD Office of Medical Education</td>
<td>Collaborative effort across departments</td>
</tr>
</tbody>
</table>
OBSTETRICS, GYNECOLOGY, AND WOMEN’S HEALTH

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Cultural Competence Initiative(s):
The Department of Obstetrics and Gynecology reports some structured training regarding cultural competence for medical students in the third year clerkship. Students are exposed to clinical situations involving interactions with different “cultures” on a daily basis while on the floors and clinics.

There are also several initiatives for residents. For example, each year the Kokuwa Kalihi Valley Comprehensive Family Services presents their “Working with Interpreters” workshop. Funded by the Office of Minority Health, the workshop provides information on effective communication and cultural/linguistic competency. Additionally, the resident education series on professionalism includes a lecture on “Health Literacy,” which is defined as, “The degree
to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

Resident evaluation tools such as the 360 evaluation and patient surveys are intended to reveal competency in the general area of professionalism and in the specific area of cultural competency and sensitivity.
PEDIATRICS

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Email: kennethn@kapiolani.org

Assistant: Lee Ann Tokuda.
Phone: (808) 983-8988

Website Link: http://www.uhp pediatrics.org

Cultural Competence Initiative(s):
The Department of Pediatrics does not have a separate program or course in cultural competency, but it is integrated into the general teaching programs for students and residents.
PSYCHIATRY

Contact Person(s) and Information:

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Susana Helm, Ph.D.
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Website Link: http://www2.jabsom.hawaii.edu/dop

Cultural Competence Initiative(s):
Culture is an integral part of the Department of Psychiatry and is an overarching theme for virtually all the work done by faculty and staff, from education & training to research to clinical services to the myriad of community & university endeavors cross-cutting each of these areas of scholarship. The department has several cultural competence initiatives, which span cultural diversity including ethnocultural identification, age, and rural health disparities.

The new People and Cultures of Hawai‘i: The Evolution of Culture and Ethnicity is available on the UH Press website (http://www.uhpress.hawaii.edu/p-7700-9780824835804.aspx). The editors of the book are the recent past Department Chair (Dr. Andrade) as the lead editor, and the Department Chair Emeritus (Dr. John McDermott, Jr.), who served as the senior editor of the first textbook when he was Department Chair. The revision of People and Cultures of Hawaii
(1980) has been a project of selected department faculty and reflects what has changed since the
first publication and discusses how ethnic aspects affect cultural identity, and present the research
and advancements that the department’s scholars and researchers have been involved in during
the past 28 years.

Education and Training
During all four years of psychiatry residency, as well as in the child and adolescent psychiatry,
geriatric psychiatry, and addictions psychiatry fellowship programs, a case conference format is
utilized and the fundamentals of culture are integrated into the discussion. Advanced seminars in
general psychiatry present the nuances of culture and how it impacts diagnoses. In addition to
formal lectures, teaching occurs with “real” cases. Residents are taught to formulate cases
culturally.

Cultural psychiatry is introduced in the resident training starting from the first year. Cultural
psychiatry refers to the description, definition, and assessment and management of all psychiatric
conditions, inasmuch as they reflect and are subjected to the patterning influence of cultural
factors. Culture permeates clinical and non-clinical events in all diseases; it is not just a
consideration for ethnic minorities, those from non-Western nations, or “the other”. The course
starts with an introduction to cultural psychiatry in the didactic setting, then continues with
periodic case conference with an emphasis on the cultural aspects of the clinical scenario. People
and Cultures of Hawaii (2011) is used as the main text for the course.

Resident training is provided in the areas of Child and Adolescent Psychiatry and Geriatric
Psychiatry. A cultural integration program for adolescents (ages 12 to 18) at the Family
Treatment Center, Queen’s Medical Center (residential/in-patient) has provided preliminary
evidence that integrating culture into treatment contributes to greater engagement,
meaningfulness, resilience and wellness for Native Hawaiian youth with severe mental illness. In
addition, it assists clinicians in assessing treatment response and can potentially improve
outcomes. For the geriatric psychiatry fellowship, residents participate in a lecture on culture
and aging. Residents also have informal opportunities for individual supervision regarding
geriatric mental health and cultural issues.
Commencing Fall 2010, Dr. William Haning is providing a brief lecture series on military culture to assist psychiatry residents/fellows assigned to Tripler Army Medical Center psychiatry inpatient and to the Veteran’s Administration outpatient services.

Research
The Department’s work with culture and ethnicity also involve research and training in its Asian/Pacific Islander Youth Violence Center (Earl Hishinuma, PhD, Principal Investigator), and National Center on Indigenous Hawaiian Behavioral Health (Deborah Goebert, DrPH, Director). Researcher- and Clinician-Educators are involved in these two centers from the Department, as well as other JABSOM departments (e.g., Pediatrics), and the University of Hawaii’s Departments of Psychology, Sociology, Social Work, Political Science, Women’s Studies, and Urban Planning.

Community-Based Participatory Research is increasingly emphasized in the Department of Psychiatry as a way to improve clinical practice, prevention, and intervention. For example, researchers are developing evidence-based youth substance use prevention with Native Hawaiian youth and communities.

Recent scholarly publications highlighting cultural diversity include:


**Clinical Services**

The Department of Psychiatry has initiated a Rural Health Collaboration, which focuses on improving mental health care access to rural areas of our state. Our primary mode of service delivery is through telepsychiatry, including direct patient care and consultation with rural health care providers and systems of care. Education and training is provided to residents and fellows, and is supported by research and evaluation endeavors. Areas of specialization include Child and Adolescent Psychiatry as well as Adult Psychiatry. Rural mental health disparities exist, and to a certain extent reflect ethnocultural health disparities.
Surgery

Contact Person(s) and Information:

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Danny M. Takanishi, Jr., M.D., FACS
Professor and Program Director
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Phone: (808) 586-2920

Website Link: http://www.cchc-conference.com

Cultural Competence Initiative(s):

The UHM Department of Surgery has developed several cultural competency initiatives over the past five years. These include research projects, curriculum development, and cultural training. Below is a description of some of these initiatives.

Research projects

The department’s primary cultural competency research project involves the refinement of a reliable and valid tool – the Cross-Cultural Care (CCC) Survey (Weissman and Betancourt, 2003) that was designed to measure the preparedness of residents to deliver high-quality care to
diverse patient populations. With permission from the survey’s developers, the first phase of our study was comprised of the administration of the survey to our general surgery residents; this allowed us to obtain a baseline assessment to identify existing gaps. For comparative purposes, we also collected and analyzed data from other residency programs within JABSOM (Family Medicine, Psychiatry, Internal Medicine and OB/GYN). We also conducted a qualitative needs assessment via interviews with our faculty to obtain their views on cultural competency and its potential role in our curriculum. The results of these efforts have been published in peer-reviewed journal publications.

We continue to refine the survey and attempt to expand its use to practicing physicians, psychologists, and allied health professionals. In addition to taking the lead on development of the JABSOM Cultural Competency Resource Guide, which will be in its 5th edition, our department also initiated the formation of the JABSOM Cross-Cultural Health Care Research Collaborative. Past and current representation included the UHM Departments of Surgery, Family Medicine and Community Health, Native Hawaiian Health, Public Health Studies, Geriatric Medicine, Internal Medicine, and Psychiatry, along with participation from undergraduate, graduate, and medical students. The collaborative meets quarterly to discuss departmental and interdepartmental projects related to cross-cultural healthcare.

Curriculum development
Partnering with the UHM Department of Family Medicine and Community Health (DFMCH), we developed a cultural standardized patient exam. The scenario focuses on the issue of informed consent -- an elderly Samoan male with uncontrolled diabetes has injured his foot and must have his leg amputated or face certain death. We piloted the exam in April 2009 with our then-Associate Program Director, and conducted a pretest with our PGY-1s in September 2009 and a follow up in February-March 2010. We utilized the CCC Survey and the OSLE Competencies Tools developed by the family medicine department to assess the residents’ performance. We are currently in the process of conducting our fourth pretest (Fall 2012) and post-test (Spring 2013). A description of our protocol and the results of our work was published in the Journal of Surgical Education, 69, 650-658.

We have been attempting to determine whether our training efforts adequately prepare and
provide our residents with the requisite skills for effectively dealing with diverse patient populations. We have been assisting the UHM Department of Native Hawaiian Health (DNHH) with their cultural standardized patient exams, which are administered to all first-year medical students. One of the goals of the project is the development and utilization of a reliable, valid, and standardized assessment tool. In conjunction with DNHH (Martina Kamaka, M.D., head of the Cultural Competency Curriculum Committee) and DFMCH (Gregory Maskarinec, Ph.D., Director of Research), we have applied for a Stemmler Grant, which would allow us to refine our existing tool and develop a standardized measure that can be used for both undergraduate and graduate medical education training programs at JABSOM.

With regard to premed/undergraduate students, we have developed a cultural competency in health professions course (HON 491) for the UHM Honors Program, which has been taught each Fall semester since 2009. A second course on developing cross-cultural healthcare resources will be offered in Spring 2013.

Training
The Department is the lead coordinator of JABSOM’s Cross-Cultural Health Care Conference: Collaborative and Multidisciplinary Interventions. The inaugural conference was held on February 11-12, 2010 and was supported by the American College of Surgeons – Hawaii Chapter; Society for Community Research and Action – Western Region; and the UHM Departments of Surgery and Psychology, and the Office of Public Health Studies. The second conference took place on October 7-8, 2011, with over 15 collaborating organizations. Now a biennial event, our third conference is scheduled for February 8-9, 2013 at the Ala Moana Hotel. We have utilized the CCC Survey and the Health Beliefs and Attitudes Survey or HBAS (Crosson, 2004), which attempts to measure physicians’ attitudes towards cultural competency in practice, as pre and post test measures to assess the efficacy of the conference sessions. We administered the CCC Survey at the first conference and the HBAS at our second. For our third conference, we are developing online versions of the survey (permission has been obtained by the developers), with the assistance of the JABSOM Biostatistical Core.
Other

One of our department’s faculty members, Maria Chun was selected as a Diversity Delegate for the 2011 American Psychological Association’s State Leadership Conference. She had subsequently been elected as the Chair of the Hawaii Psychological Association’s Diversity Committee for 2012-2014.

Finally, the recipients of our UHM Department of Surgery’s Culturally Competent Care Award for general surgery residents who exemplify excellence in cross-cultural health care were Chayanin Musikasinthorn, M.D (2011) and Richard Moore, M.D. (2012).
TELEHEALTH RESEARCH INSTITUTE

Contact Person(s) and Information:

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Culture Competence Initiative(s):
The Telehealth Research Institute is an activity of the JABSOM Dean’s office. The Institute operates the SimTiki Simulation Center and conducts research and educational activities in several technology focused areas encompassing telemedicine, simulation-based healthcare education, and information technology. An extensive portfolio of international education initiatives comprises about 40% of the SimTiki Educational activities. A specific focus area for the educational training programs and research initiatives is what is termed “localization” of curriculum transfer. This effort includes consideration of cross-cultural factors which influence and guide curriculum sharing across international boundaries.

Effective curriculum transfer/sharing strategies are studied as we deliver educational programs and evolve existing curriculum for international participants. The efforts in this area include curriculum transfer in both directions; US to International, and International to US. Considerations of differences in language, clinical practice patterns, professional culture - especially healthcare system provider vertical relationships (nurse-physician, student-mentor, etc.), and educational systems and expectations are key to the cross-cultural transfer of curriculum; we call this process “Localization”. Examples of our current activities include development and delivery of a hybrid Japanese enabled Fundamental Critical Care Support (FCCS) course. This course is a two day standardized program of the Society of Critical Care
Medicine, and has been localized through the translation of written the course textbook presentation slides, and examinations. In addition to translation we have incorporated instructors from Japan who can accurately integrate culturally appropriate content into the core curriculum at skills stations and during interactive discussion groups. A similar effort has been initiated through collaboration with Okayama University, to transfer a successful standardized Japanese curriculum, Immediate Stroke Life Support (ISLS) to a localized English language/American version. This process has involved consideration multiple core cultural competency factors.

In addition to International cultural competency the SimTiki simulation center has a broad variety of course which are focused on vertical cross-cultural competency within the US health care system. Initiatives in this discipline have been termed interprofessional or interdisciplinary initiatives, and are largely focused on communications and teamwork building. This is an area which is not traditionally considered in the cross-cultural competency rubric, yet encompasses many of the core elements in the AAMC definition of cultural competence.

Our initiatives in Telehealth include leadership of the HRSA funded Pacific Basin Telehealth Resource Center (www.pbtrc.org). Dr. Deborah Birkmire-Peters of TRI is the PBTRC director. The Centers mission includes enabling telehealth through “Empowering cultural diversity and creating a synergistic telehealth community.”
TROPICAL MEDICINE, MEDICAL MICROBIOLOGY AND PHARMACOLOGY

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Cultural Competence Initiative(s):
The faculty of the Department of Tropical Medicine, Medical Microbiology and Pharmacology are committed to incorporating concepts of cultural competency into its academic courses and research. The Department has many projects that assimilate microbiology, entomology, advanced biomedical technology and social sciences to investigate the dynamics of an infectious organism in a community. Dengue, for example, currently does not have effective chemotherapies for treatment or a vaccine for prevention. Therefore modifying human behavior to reduce contact with mosquitos is an important component of prevention and control measures. Modifying human behavior requires an intimate knowledge of the cultural aspects of a community (e.g., water storage, waste disposal, ability to understand disease transmission, cultural myths, and traditional prevention methods). Although changing long held habits and behaviors are difficulty, the Department is dedicated to finding preventive and control measures taking these cultural
characteristics into account. Members of the Department are part of the Global Infectious Disease program funded by the National Institutes of Health. This program trains young students and scientists from African and Asia to conduct both applied and basic research in areas of infectious disease control and prevention that are applicable in their home countries. Allowing these students to contemplate combining scientific concepts with the customs and traditions of their native country is essential for designing new culturally appropriate disease control programs.
COLLABORATORS

SCHOOL OF NURSING

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The School of Nursing and Dental Hygiene (SONDH) has a number of programs and initiatives that integrate culture. They include, but are not limited to, the following:

IKE AO PONO PROGRAM. With Nalani Minton, B.S., M.A., M.A., as the Program Director, the purpose of the program is to provide academic, cultural and social support to Native Hawaiian and Pacific Islander students in the SONDH.

E ALA PONO. Overseen by Dr. Kristine Qureshi, DNSc, RN, who is the Program Director, the purpose of the program is to provide academic, cultural and social support to a selected group of Native Hawaiian masters students, who, upon graduation commit to seek employment in area of Hawaii that serves largely Native Hawaiian population and strive to improve health of Native Hawaiian children and their families.
Regarding educational initiatives, SONDH’s graduate program (master’s level) coursework includes the Advanced Public Health Nursing Program, which requires courses that focus specifically on culture: 1. Health and Healing Practices of Native Hawaiian and Pacific Island People, and 2. Community Based participatory Research. These courses are usually taught by Dr. Alice Tse, Ph.D., APRN.

With regard to service/community engagement, both Drs. Qureshi and Tse are members of and represent the State of Hawaii at the American Pacific Nursing Leaders Council. They have extensive interaction with nurses from the US Affiliated Pacific Islands (USAPI). SONDH also engages in cultural research projects. Drs. Qureshi and Tse are CoPIs on an NIH U13 Community Partnership grant that focuses on building capacity for Community Based Participatory Research (CBPR) among nurses in the USAPI.
APPENDIX A

Cultural Sensitivity for MDED 571-577, Clinical Skills Training
(Prepared by John Melish, M.D.)

In all first- and second-year courses involving clinical skills, cultural sensitivity is taught by:

History taking:
- Respect for all patients no matter what their economic, social, or ethnic status.
- Use of open-ended non-judgmental questions.
- Attention to use of language understandable to patients of various educational and cultural backgrounds.
- The non-judgmental inclusion of over-the-counter and alternative medications and treatments when medication histories are obtained.
- The use of competent translators when language barriers interfere with data gathering or treatment planning.
- Attention to the Patient Profile, an expansion of the “social history,” which focuses on:
  - The typical day
  - Educational level
  - Work situation and demands
  - Family support
  - Insurance status
  - Location
  - Place of origin
  - Diet – related to ethnic background and personal preference
  - Exercise
  - Patient attitude and behavior in regard to current and previous health problems
  - Habits – alcohol, smoking, illicit drugs

Physical Examination:
- Attention of student to asking permission to perform aspects of the history and PE, after explaining the purpose of these activities
- Appropriate draping and chaperoning to preserve individual patient dignity and privacy.
- Reporting to patients in lay terms findings from physical examination

Diagnosis and Treatment:
- The importance of patient assent and participation in the development of diagnostic testing
  development of treatment plans – especially those requiring behavior changes: assessing willingness to change.
- Understanding the importance of the patient’s family and work environment in patient
  treatment and care planning.
- Are treatment plans economically feasible for the patient?
- Teaching students that medical adherence problems reside in large part in areas requiring cultural sensitivity.
- Teaching students to be aware of body language indicating understanding and emotion.
These principles are taught in the context of
- Lectures on Patient Data Gathering
- Laboratories in Basic Physical Examination where students examine each other, learn appropriate draping, and give assent in participating in this activity
- Laboratories in Extended Physical Examination skills where students examine each other, learn appropriate draping, and give assent in participating in this activity
- Clinical Skills Preceptorships – where students are observed practicing Cultural Sensitivity Skills as they interview and exam real patients with clinical faculty

These lessons and experiences in “cultural sensitivity” in the clinical skills teaching program prepare students for their clinical clerkships, medical residences, and future medical practice in our unique environment and also other environments to which they will have to adapt if they practice elsewhere.
APPENDIX B

PBL Case Content Related to Cultural Competency
(Prepared by Damon Sakai, M.D.)

The following content learning opportunities have been placed in our PBL cases that may have some relationship to cultural competency:

- Depression after myocardial infarction
- Anxiety, depression, and social isolation’s effect mortality after a myocardial infarction
- Important health issues for Jehovah’s Witnesses
- Discussing blood transfusions with a Jehovah’s Witness
- Spirituality in medicine
- Prayer in medical care
- Feelings of depression in nursing homes
- Social stigma associated with TB
- How do patients with TB react to their diagnosis
- Adjusting to the death of a spouse
- Helping families deal with grief or bereavement
- Delivering bad news
- Discussing living wills or futile care with patients
- Responding to a patient who asks for physician-assisted suicide
- Patients reaction to news of a life-threatening or terminal illness
- Patient reactions to chronic disease
- The epidemiology of alcoholism
- A poor economy’s affect the health of a population
- Trends in obesity and inactivity
- Ethnic differences in response to hypertensive therapy
- African-Americans and the risk of hypertension and the complications of hypertension
- Important health issues of Samoans
- Illnesses are prevalent in the nursing home population
APPENDIX C

Checklist Utilized by Department of Communication Sciences and Disorders (provided by Dorothy Craven, Ph.D.)
Personal Reflection

This tool was developed to heighten your awareness of how you view clients from culturally and linguistically diverse (CLD) populations. There is no answer key; however, it will be important for you to review those responses which you rated “5” and “4”, even “3”. While several sources were consulted in the development of this checklists, the following documents inspired its design. Goode, T. O. (1989, revised 2002). Promoting cultural and linguistic competence self-assessment checklist for personnel Providing services and supports in early intervention/childhood settings.

Ratings:
- I Strongly Agree
- I Agree
- Neutral
- I Disagree
- 5 Strongly Disagree

I understand how culture can impact child-rearing practices in:
- ___ Discipline
- ___ Toileting
- ___ Self-help skills
- ___ Dressing
- ___ Feeding
- ___ Expectations or the future

I understand the impact of culture on life activities, such as:
- ___ Family roles
- ___ Gender roles
- ___ Customs or superstitions
- ___ Perception or time
- ___ Views of disabilities

I understand my clients’ cultural norms may influence communication in many ways, including:
- ___ Eye contact
- ___ Use of gestures
- ___ Turn-taking
- ___ Asking and responding to questions
- ___ Interrupting
- ___ Interpersonal space
- ___ Comfort with silence
- ___ Topics of conversation
- ___ Greetings
- ___ Use of humor

I treat all of my clients with respect for their culture, even though it may be different from my own.

I do not impose my beliefs and value systems onto my clients, their family members or friends.

I believe that it is acceptable to speak a language other than English.

I accept my clients’ decisions as to the degree to which they choose to acculturate into the dominant culture.

I have no problems accepting and providing services to clients who are GBLT (Gay, Lesbian, Bisexual, or Transgendered).

I am driven to respond to others’ insensitive comments or behaviors.

I do not partake in insensitive comments or behaviors.

I am aware that the roles family members play may differ between by culture.

I recognize family members and other designees as decision makers or services and support.

I respect non-traditional family structures (e.g. divorced parents, same gender parents, grandparents as caretakers, etc).

I understand the difference between a communication disability and a communication difference.

I understand that most people who have limited English skills and/or accents:
- ___ Have the same intellectual capacity as anyone else
- ___ May be very capable of communicating clearly and effectively in their native language
Service Delivery

This tool was developed to heighten your awareness of how you view clients from culturally and linguistically diverse (CLO) populations. There is no right answer. It will be important for you to review those responses which you rated a -3: or even a -2. Examining those areas may improve your service delivery to your clients.

Ratings:
[ ] Things that I always do
[ ] Things that I sometimes do
[ ] Things that I rarely do

___ I include the client and their family as partners in determining outcomes for treatment.
___ I recognize differences in narrative styles and pragmatic behaviors that vary across cultures.
___ I take the time to learn about acceptable behaviors and customs that are prevalent in my clients' cultures.
___ I consider my clients' beliefs in both traditional and alternative medicines when prescribing a treatment regimen.
___ I respect my clients' decision to seek alternative treatments from a holistic practitioner.
___ I am aware of the possibility that individuals from my clients' racial/ethnic background may have a higher incidence of specific disorders/diseases (sickle cell anemia, diabetes, hypertension, cardiovascular disease) which may lead to neurological complications with implications for communication.
___ I am aware of the possibility that individuals from my clients' racial/ethnic background may be prone to middle ear and upper respiratory infections which may impact hearing and the development of communication skills.
___ I understand that some individuals may have different reading levels in English or their native language.
___ I provide written information for clients to take home in their preferred language.
___ I seek assistance from bilingual co-workers and individuals in related professions who are bilingual who can help interpret, as needed.
___ I have trained my interpreters using clearly defined roles and responsibilities to assist me in providing services to linguistically diverse populations.
___ I ask questions about the clients' language history.
___ I ask the clients' family members and friends about the clients' exposure to English.
___ I use assessment tools and materials (e.g., language batteries, articulation assessments, PB word lists, spondee word lists) that are not biased against culturally and linguistically diverse (CLD) populations.
___ I consider the cultural and linguistic background of my clients when selecting treatment materials (e.g., pictures, books/workbooks, flashcards, videos, music, food, etc.) so that they are relevant to the client.

I consider the cultural/linguistic background of my clients and their families when planning:
___ Appointments
___ Community outings
___ Holiday celebrations
___ Meals, snacks

I allow for alternative methods of sharing experiences and communication to support the "oral tradition" that is prevalent in some cultures, such as:
___ Story telling
___ Use of props

I allow for alternatives to written communication, which may be preferred, such as:
___ Word of mouth
___ Modeling the recommendations

When communicating with clients whose native language is NOT English, I use:
___ Key words in their language
___ Visual aids
___ Gestures/physical prompts
___ Interpreters/Translators
# Appendix D

Checklist Utilized by Department of Family Medicine and Community Health (provided by Gregory Maskarinec, Ph.D. and Lee Buenconsejo-Lum, M.D.)

University of Hawai'i FPRP OSLE Core Competencies Evaluation by Patient / Interpreters

**Resident:** _________ **SP #** ___ **Date:** _______

*Circle descriptions that best reflect the resident’s performance during your patient encounter, then give the doctor a final ‘score’ for each category below*

<table>
<thead>
<tr>
<th>Below Expectations (1-2)</th>
<th>Meets Expectations (3-4)</th>
<th>Exceed Expectations (5)</th>
<th>Numerical rating (1-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Interviews and examines patient poorly; fumbles or hesitates during the exam</td>
<td>- Attempts to examine at least one patient problem in-depth</td>
<td>- Able to examine at least two patient problems in-depth, according to highest priority</td>
<td></td>
</tr>
<tr>
<td>- Misses key cues to examine patient problems more in-depth</td>
<td>- USUALLY respectful of patient preferences</td>
<td>- Is highly respectful of patient preference</td>
<td></td>
</tr>
<tr>
<td>- Disregards patient preference</td>
<td>- Generally friendly and warm</td>
<td>- Is warm and friendly, creates as relaxed an atmosphere as possible</td>
<td></td>
</tr>
<tr>
<td>- Cold/unfeeling/indifferent toward patient</td>
<td>- Maintains patient modesty and comfort</td>
<td>- ASKS PERMISSION first and explains what s/he is going to do before/during exam</td>
<td></td>
</tr>
<tr>
<td>- Ignores sensitive areas of history-taking or physical exam</td>
<td>- Explains what s/he is going to do before/during exam</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Doesn’t explain/give much warning before conducting PE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medical Knowledge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Appears to have poor understanding of complex problems</td>
<td>- Appears to adequately understand complex problems</td>
<td>- Appears to have a comprehensive understanding of complex problems</td>
<td></td>
</tr>
<tr>
<td><strong>Practice-Based Learning and Improvement</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Ignores feedback</td>
<td>- Intermittently seeks feedback</td>
<td>- Eagerly accepts feedback</td>
<td></td>
</tr>
<tr>
<td><strong>Interpersonal and Communication Skills</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Has poor relationships with patient/family</td>
<td>- Acknowledges patient concerns sometimes, picks up a few “cues”</td>
<td>- Acknowledges patient’s concerns, picks up MOST non-verbal or verbal cues</td>
<td></td>
</tr>
<tr>
<td>- Negates or puts down patient concerns</td>
<td>- Sometimes listens to patient, sometime interrupts</td>
<td>- Interacts with patient at the same level, no “talking down” to patient</td>
<td></td>
</tr>
<tr>
<td>- Misses MOST patient cues</td>
<td>- Asks questions of the patient to help clarify the doctor’s understanding of the problem</td>
<td>- Listens carefully to patients and answers their questions, asks patient if the doctor understands the problem correctly</td>
<td></td>
</tr>
<tr>
<td>- “Talks down to patient”</td>
<td>- Intermittently educates, counsels patients</td>
<td>- Hardly interrupts unless the patient is rambling</td>
<td></td>
</tr>
<tr>
<td>- Does not listen to patient, answer their questions or ask for patient understanding</td>
<td>- Sometimes encourages the patient to ask questions</td>
<td>- Educates and counsels patients, using language they understand, encourages patient to ask questions</td>
<td></td>
</tr>
<tr>
<td>- Interrupts patient often</td>
<td>- Discusses options and plans for further management</td>
<td>- Discusses options and plans for further management</td>
<td></td>
</tr>
<tr>
<td>- Avoids educating or counseling patient</td>
<td>- Uses non-medical</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Speaks in medical jargon most of the time, with little attempt to ensure the patient understands</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Does NOT discuss options and plans for further management</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>- Does NOT negotiate final plan with patient/family i.e. just tells the patient what they are supposed to do without checking to see if the patient</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>agrees or has questions</strong></td>
<td><strong>jargon sometimes</strong></td>
<td><strong>Negotiates</strong> final plan with patient/family</td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------</td>
<td>---------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>• Said a lot of “oops” or “sorry” or communicated in a way that did not promote themselves as a knowledgeable or trustworthy physician</td>
<td>• Communicated in a manner so that the patient feels somewhat comfortable/trusting of this physician</td>
<td>• Communicated in a manner such that the patient could open up and trust this physician’s knowledge and actions.</td>
<td></td>
</tr>
</tbody>
</table>

**PROFESSIONALISM**

<table>
<thead>
<tr>
<th>Not respectful</th>
<th>Usually respectful</th>
<th>Consistently respectful</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not compassionate</td>
<td>Usually compassionate</td>
<td>Very compassionate</td>
</tr>
<tr>
<td>Does not recognize limits of his/her knowledge or skills</td>
<td>Tries to considerate of others</td>
<td>Considers needs of others (patients, colleagues)</td>
</tr>
</tbody>
</table>

**SYSTEM-BASED PRACTICE**

<table>
<thead>
<tr>
<th>No attempt to look for resources, drug formularies</th>
<th>Realizes need to look for resources, prescribe according to insurance formularies (or lowest cost medications)</th>
<th>Identifies and proposes to give patient resources at the end of the first visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>No attempt to balance cost and resources with quality patient care</td>
<td></td>
<td>Prescribes medications according to insurance formularies</td>
</tr>
</tbody>
</table>

Would you return to this physician for your care? ____ Yes ____ No (If NO, you must explain below)

**DID THE RESIDENT DO THE FOLLOWING? (CHECK OFF THE THINGS THAT THE RESIDENT DID)**

**Pre-session with the Interpreter (untrained)**

- Introduce yourself to the interpreter and the client
- State that you need the interpreter to interpret everything that is said
  - Avoid summarization
  - Avoid making diagnoses/treatment recommendations
  - Avoid judgments or opinions
- Encourage the interpreter to ask clarification questions

**During the Interview**

- Speak directly to the patient, using appropriate body language
- Speak slowly and in short sentences
- Ask One question at a time
- Avoid using slang, metaphors and medical terminology
- Maintain control of the interview
  - If the interpreter volunteers an opinion or answers for the patient, remind him to interpret only what the patient says.
  - If a side conversation occurs or you believe that information was omitted, guide the interpreter back to facilitating communication.
  - Ask what was said in any side discussions/conversations.
- Check for understanding
  - Allow the interpreter and patient time for questions and clarifications
- Ask the patient to repeat instructions
  - Lack of linguistic or conceptual equivalence

**COMMENTS (MUST BE COMPLETED IF ANY "BELOW EXPECTATIONS" OR RATINGS BELOW 3 ARE NOTED):**

---

Standardized Patient or Interpreter

Real Name and Signature

Date
OTHER RESOURCES

(Courtesy of Virginia Tanji, Director, JABSOM Health Sciences Library – http://hslib.jabsom.hawaii.edu/)

JABSOM library resources on culture and cultural competence:


To find books on culture:
2. In the search box enter the term: Cultural Characteristics
3. Narrow the search to "as a phrase" within "Subject"
4. Limit the Location to "UHM School of Medicine: All Collections", which also includes the UHM electronic location.

If further assistance is needed, you may contact Virginia Tanji at tanji@hawaii.edu.