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Effectively teaching cultural competence in healthcare education

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BOSTON UNIVERSITY
SCHOOL OF MEDICINE

Thesis

**EFFECTIVELY TEACHING CULTURAL COMPETENCE
IN HEALTHCARE EDUCATION**

by

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B.S., College of William & Mary, 2019

Submitted in partial fulfillment of the
requirements for the degree of
Master of Science

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DEDICATION

I would like to dedicate this work to my family, friends, and mentors.

ACKNOWLEDGMENTS

First, I would like to thank my First Reader, David Flynn, for his outstanding mentorship during the research collection, data analysis and proof-reading stages of this project. I am also grateful for his continued encouragement throughout this process.

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EFFECTIVELY TEACHING CULTURAL COMPETENCE IN HEALTHCARE

EDUCATION

SHELBY FEREBEE

ABSTRACT

Introduction: According to current census projections, by the year 2050 racial and ethnic minority groups will make up over half of the United States population. With the rise of a more multicultural and diverse population, there has been growing concern with regards to the health disparities and how healthcare professionals can increase positive healthcare outcomes. In an effort to contend with the growing population, the subsequent disparities that will be faced by a more diverse population, and the difficulties many healthcare practitioner's will encounter while communicating and working with this population group, many healthcare educators have turned their attention to training and educating the next generation of healthcare providers on the practice of cultural competence. For many institutions, however, there is still uncertainty over the most effective means for teaching cultural competence throughout the healthcare curriculum.

Data collected from a 2017-2020 study conducted at Boston University in the M.S. in Oral Health Sciences Program, a credential enhancing program for pre dental students with the aim of providing students with admission into an accredited dental institution, evaluates an effective mechanism for training healthcare professionals in cultural competence skills. This study hypothesizes that one effective and powerful tool for teaching the next generation of health professionals to be culturally competent

providers is through role-playing, case-based, simulated exercises which emphasize the importance of the provider patient relationship, holistic approaches to healthcare, and compassion when working with patients.

Methods: A course session was created in an *Evidence Based Dentistry Course* within the M.S. in Oral Health Sciences Program. From 2017-2019 the course session was composed of three parts: a role-playing enactment of two patient case-based encounters, a real-time class group discussion following both patient encounters, and a PowerPoint presentation emphasizing the key take-away points from the role-playing exercise. At the conclusion of the session, students were asked to participate in a post-session survey regarding the student's feelings about the session. In 2020, due to the COVID-19 pandemic, a switch in course session modality in the *Evidence Based Dentistry* course to an online format, prompted a change in the session format. In 2020, students were asked to read both patient encounters on their own, reflect, discuss, and comment on the learning platform Blackboard Learn discussion board on their takeaways from the case, and participate in PowerPoint presentation presented by facilitators. At the conclusion of the 2020 session, students were asked to complete a post-session survey on the effectiveness of the session. In addition to qualitative data obtained from the post-session surveys, in 2020, student discussion board posts were coded and analyzed qualitatively using the coding software NVivo 12 to determine whether students understood the important takeaways from the discussion board portion of the session.

Results: According to results from the course session implemented from 2017-2019, overall, the role-playing exercise significantly improved participants understanding of

key components of cultural competence. From 2017-2019 students were strongly able to identify the importance of communication in patient encounters, were able to understand the strategies such as communication and compassion in patient encounters, were better able to identify the importance of building a trusting patient -physician relationship, and most importantly, students were able to recognize their own cultural biases when treating patients. Results from 2020, revealed that even with a change in course modality and format to a discussion board format, students were still able to understand the key take-aways of cultural competence from the session.

Discussion: This study reveals that students were able to understand cultural competence after completion of both iterations of the course session from 2017-2019 & 2020 and that this session can be an effective method for training the next generation of healthcare professionals the practice of cultural competence. While this study provides insight into the future of cultural competence training, it is important to recognize that more studies must be conducted to provide additional answers to several questions about the most effective mechanism for teaching cultural competence, what to teach in cultural competence education, and when to begin training students the practice of cultural competence.

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LIST OF ABBREVIATIONS

AAMC	Association of American Medical Colleges
BU	Boston University
CODA	Commission on Dental Accreditation
D-TAACT	Dental Tool for Assessing Cultural Competence Training
PICO	Patient, Intervention, Comparative, Outcome

INTRODUCTION

According to census data and analysis from the previous decade, it is projected that by the year 2050 racial and ethnic minority groups will make up approximately 58% of the United States population (Albino et al., 2012). With the rise of a more multicultural society, there has been a growing concern over how to address the health disparities that plague racial and ethnic minority populations and how healthcare professionals can increase positive healthcare outcomes among this population.

Healthcare practitioners are faced with the difficult challenge of understanding patients more holistically while also communicating with them effectively to improve a patient's health outcomes. Furthermore, healthcare professionals are responsible for creating positive outcomes in patient satisfaction, adherence to therapy and health improvement (*Constantinou et al., 2018*). Continuing evidence suggests that many racial and ethnic minority groups are not satisfied with the current state of healthcare. Much of this dissatisfaction can be attributed to implicit bias on the part of physicians and current challenges faced by practitioners who feel underprepared to work with minority groups because of differences in language, financial status, and healthcare practice (*Constantinou et al., 2018; DallaPiazza et al., 2018*).

In an effort to contend with health disparities and the challenges faced by practitioners working with a more diverse population, health care educators have begun to emphasize the importance of educating the current and future healthcare workforce on the practice of cultural competence. The Commission on Dental Accreditation (CODA),

the accrediting body responsible for all North American dental universities, mandates that all dental school graduates be:

“Competent in managing a diverse patient population and have the diverse interpersonal and communication skills to function successfully in a multicultural work environment (Behar-Horenstein et al., 2017).”

Medical school accreditation bodies have also instituted similar mandates, which emphasize the importance of producing a culturally competent workforce.

While there is consensus among healthcare professionals, that the future healthcare workforce must be culturally competent, there is currently no consensus on how cultural competence training should be incorporated into medical curricula in practice (Kripalani et al., 2006). Therefore, variability exists in the design and implementation of cultural competence in healthcare. With this variability, it has become difficult to come to an agreement on the most effective mechanisms for educating the next generation of healthcare practitioners the practice of cultural competence.

This research project seeks to explore effective mechanisms for teaching cultural competence in healthcare curriculum. This study hypothesizes that early educational exposure to cultural competence through role playing case studies which emphasize the importance of provider-patient interactions, holistic patient care, and recognition of the importance of patient history and socioeconomic factors can serve as the most effective mechanisms for teaching the future healthcare workforce the practice of cultural competence. Utilizing

student self-reported survey data conducted between 2017-2020 from a Boston University course in the Master of Science in Oral Health Sciences program, in which a role-playing case study was used to teach cultural competence, this paper will attempt to support the finding that role-playing case studies are an effective means for educating future dental professionals on the practice of cultural competence.

LITERATURE REVIEW / BACKGROUND

The History of Cultural Competence

The term cultural competence is not a new phenomenon, it first emerged in the 1960's at the peak of the Civil Rights Movement. During this period, there was a rising interest in combating the failures of the healthcare system, and most systems at the time, in order to provide adequate services to ethnic-minority groups and low-income populations (Chin, 2000). At this time, the term cultural sensitivity predominated in discussions around providing healthcare services to members of ethnic minority groups, especially given the prevailing language and cultural barriers faced by immigrants and the racial and economic barriers faced by people of color (Chin, 2000). Cultural sensitivity centers around a knowledge and understanding of cultural differences and how they can impact quality of care.

It wasn't until the mid-1980's when a shift from cultural sensitivity to a more skill-based focus of cultural competence emerged. This emergence can be credited to the publication of a monograph entitled *Toward a Culturally Competent System of Care* which defined cultural competence as not only an awareness of cultural and ethnic differences, but as a skill-based set of behaviors, attitudes, and policies that could enable a system of healthcare agencies to provide effective care in the wake of cross-cultural situations and differences (Betancourt, 2006; Jernigan et al., 2016). With this communication and skills centered approach to what was previously cultural sensitivity, cultural competence attempted to provide a script for healthcare professionals to use when treating a diverse patient population. The script would require the healthcare

professional to tailor patient consultations to what the physician perceived to be the cultural identifications of the patient (Manzi et al., 2020). In simplified terms, cultural competence would be based on the cultural stereotypes perceived by the physician. Additionally, because of its skill based and scripted nature, cultural competence would be a concept that could be instantly achievable by healthcare and pre-health care professionals (Wiley, 2018).

Due to concern that healthcare professionals would rely on preconceived stereotypes in patient consultation and care, in the 1990's, medical educators began to adjust the definition of cultural competence to include ways which promoted continued learning, physician self-awareness, and clinical safe spaces for physicians and patients to discuss the patients' cultural beliefs and identifications (Manzi et al., 2020). This currently accepted model and definition of cultural competence in pre-health professional education and among healthcare institutions, recognizes the need for continued learning and grants healthcare professionals and pre-health professional students the ability to practice culturally appropriate communication and care to patients' who are racially or ethnically different from themselves without culturally preconceived stereotypes (Wiley, 2018). Finally, in the 2000's, cultural competence and cultural humility became the topic of discussion for educating the future healthcare workforce. Cultural humility promotes a dialogue between the physician and patient which allows the patient to define their own identity. A physician with cultural humility places each patient as a unique individual who exists within a cultural context. Additionally, cultural humility encourages and acknowledges the individuality and unique socio-cultural environment of the patient

(Manzi et al., 2020). In Figure 1, a timeline of events in the emergence of the term cultural competence is depicted.

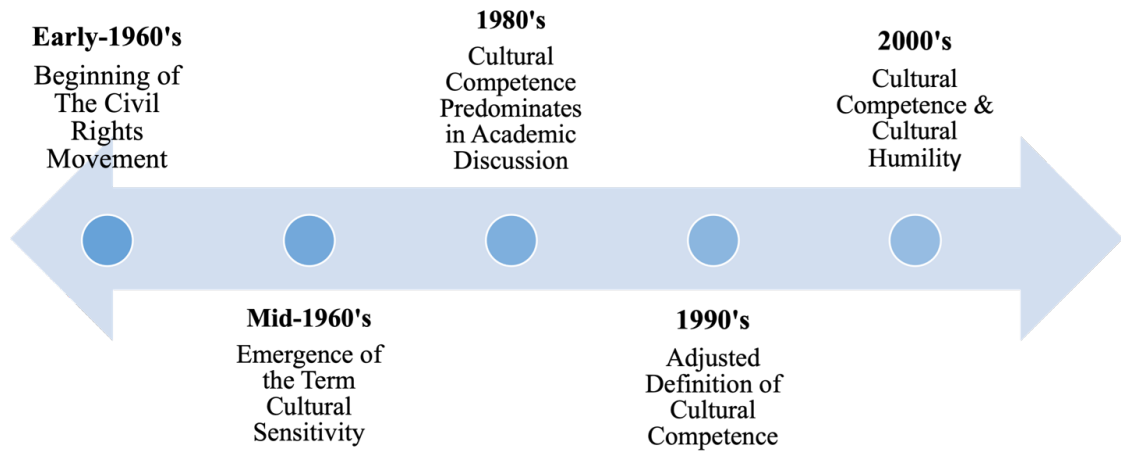


Figure 1. Timeline of Events of the Term Cultural Competence. This figure represents a timeline in the events leading to the currently accepted definitions of cultural competence. Figure information compiled from Chin (2000).

Cultural Competence in Healthcare

Existing literature on the practice of cultural competence in healthcare is extensive. Much of the current literature focuses on the importance of advancing the cultural competence skills of current and future healthcare professionals in order to combat many of the health disparities that affect racial and ethnic minority groups (Behar-Horenstein et al., 2017). In the United States, health disparities are profound. Those most affected by these health disparities include racial and ethnic minority groups who are more susceptible to inequity in care due to race, ethnicity, socioeconomic status, gender identity, age, educational attainment, and geographic locations with limited access to healthcare (Behar-Horenstein et al., 2017). According to the Office of Minority Health

and Health Disparities at the Centers for Disease Control and Prevention, there is compelling evidence that race and ethnicity correlate with increasing health disparity among the U.S. population, and that these disparities will only worsen as the population continues to diversify (Lukes, 2020). Table 1., depicts the expected rise in racial and ethnic minority groups by the year 2050. Current studies agree that physician training in cultural competence may reduce provider bias, improve patient-provider communication, and increase ethnic and minority group access to high quality care and thus provide one solution to eliminate racial/ethnic disparities in healthcare (Betancourt, 2006; Jernigan et al., 2016). Despite the consensus that cultural competency training is needed, for many healthcare institutions responsible for educating the future healthcare workforce on current and future health inequities, it is still unclear what efforts should be used to produce culturally competent providers (Albino et al., 2012).

Table 1. The Rise of Racial/Ethnic Minority Groups in the U.S. By the Year 2050. This table depicts the expected percentage change of racial and ethnic populations from 1950 to 2050. Figure taken from Albino et al. (2012)

Race/Ethnicity	1950	2000	2010	2050
White	89.5%	75.1%	72.4%	74.0%
Non-Hispanic white		69.1%	63.7%	52.5%
Hispanic/Latino		12.5%	16.3%	22.5%
Black or African American	10.0%	12.3%	12.6%	15.7%
Asian American	0.2%	3.6%	4.8%	10.3%
American Indian and Alaska Native	0.2%	0.9%	0.9%	1.1%

Note: Percentages may not total 100% because of rounding and in the later years because of not reported data.

Sources:
 U.S. Census Bureau. Table DP-1. Profile of general demographic characteristics, 2000. At: <http://censtats.census.gov/data/US/01000.pdf>.
 U.S. Census Bureau. Overview of race and Hispanic origin, 2010. At: www.census.gov/prod/cen2010/briefs/c2010br-02.pdf.
 Day JC, U.S. Census Bureau. National population projections. At: www.census.gov/population/www/pop-profile/natproj.html.
 U.S. Census Bureau. Table 1. United States—race and Hispanic origin: 1790 to 1990. At: www.census.gov/population/www/documentation/twps0056/tab01.pdf.
 All accessed: December 1, 2011.

One initial effort for producing culturally competent clinicians outlined by Leadbeater and Holden, argues that the first steps to producing a culturally competent healthcare workforce is to institute and establish accreditation bodies that will require educational institutions to demonstrate that students know how to interact with culturally diverse communities (Leadbeater & Holden, 2020). These accreditation bodies must closely monitor and enforce their accreditation mandates and require programs which seek to achieve and/or maintain institutional accreditation to effectively engage with culture and cultural competence (Leadbeater & Holden, 2020). Currently, such accreditation bodies have been created. The Advisory Committee on Training in Primary Care Medicine and Dentistry has recommended that healthcare professional education programs incorporate learning that enhances access to care and integrates learning across multiple disciplines (Sabato et al., 2018). Additionally, both the Association of American Medical Colleges

(AAMC) and the Commission on Dental Accreditation (CODA) have enacted guidelines that require medical and dental institutions to implement curriculum that addresses cultural competence and health disparities (Jernigan et al., 2016; Lukes, 2020).

Despite these current institutional guidelines for accreditation, little has improved. The mean national average of medical curriculum devoted to cultural competence was still less than 10 hours in 2011 (Bi et al., 2020). Additionally, even when time was devoted to teaching cultural competence in dental institutions, many reports of efforts to teach cultural competence found that cultural competence education and training was only an incidental component of the curriculum, with little to no training activities specifically or purposefully aimed at educating on cultural competence. Likewise, many dental students who acquired any knowledge about cultural competence only received training and education in health disparities and the social determinants of health through voluntary involvement in outreach programs and initiatives; rather than through formal educational guidance through their academic institutions (Leadbeatter & Holden, 2020). Additional evidence from a scoping review conducted in 2013 which analyzed cultural competence training in dental education using an assessment tool known as the Dental Tool for Assessing Cultural Competence Training (D-TAACT), found that the implementation rating for cultural competence training across United States and Canadian Dental Institutions was still very low (Holyfield & Miller, 2013; Lukes, 2020). A similar tool for assessing the implementation rating for training in medical schools across North America yielded similar results (Holyfield & Miller, 2013; Jernigan et al., 2016). Given these unfavorable statistics, more must be done to implement and apply

cultural competence education into healthcare institutions. Leadbeatter and Holden agree that in addition to the implementation of mandates regarding education of cultural competence, more curricular guidance must be given to educational institutions on what must be taught, how to teach, and when to implement cultural competence training into the curriculum (Leadbeatter & Holden, 2020). Only through more guidance and a standardization of the approaches for teaching cultural competence will institutional and healthcare outcomes improve (Jernigan et al., 2016).

The What, When, and How of Cultural Competence Training.

At present, copious amounts of resources, ideas, and frameworks exist for implementing and training future and current healthcare providers on the inadequacies of the healthcare system and cultural competence. One common framework is shown in Figure 2 based on the acquiring knowledge, applying knowledge, and activating knowledge framework (Constantinou et al., 2018). This framework which was originally proposed by G.E Miller and later adapted by Constantinou et. al, proposes a basic model of building cultural competence in healthcare. This model takes the shape of a proposed pyramid which consists of three layers to teach students cultural competence (Constantinou et al., 2018). The first layer, “Acquiring Knowledge” encourages teaching students’ cultural competence through lectures. The second layer focuses on “Applying Knowledge” through enhancement of learning via lectures that bring in relevant real-life cases in which students can discuss the situation and bring in knowledge from the first layer. Finally, the third layer, “Activating knowledge, “teaches and trains students to

perform the knowledge acquired in the previous two layers in medical or clinical practice (Constantinou et al., 2018).

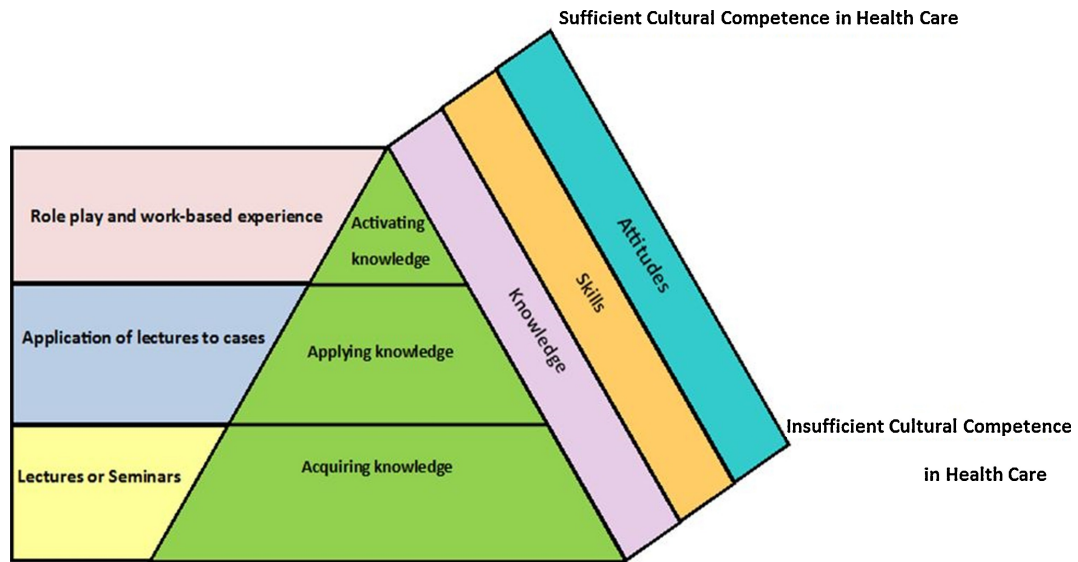


Figure 2. A Model for the Integration of Cultural Competence into Healthcare Curriculum. This figure depicts a pyramid model for integrating cultural competence into healthcare curriculum. The first layer entitled “Acquiring Knowledge” proposes that students acquire knowledge of cultural competence through a lecture-based seminar. The second layer entitled “Applying knowledge” proposes that lecture-based seminars can be enhanced by making lectures case-based or incorporating discussion groups into the learning process. Finally, the third layer “Activating Knowledge” focuses on initiating the learned practices from the previous layers into medical or healthcare practice. The model suggest that students will improve their knowledge, skills, and adapt their attitudes in a way to effectively improve care and communicate with patients. Adapted from G.E. Miller, 1990 by Constantinou et al., 2018.

With such a vast number of resources available for cultural competence curriculum, many U.S. dental and medical institutions are questioning what to teach in their cultural competence curriculum, when to teach cultural competence training, and the most effective methods for teaching cultural competence in an effort to ensure that their graduates are culturally competent providers (Albino et al., 2012; Lukes, 2020.).

In an attempt to answer the question of “what” to teach in cultural competence curriculum, the present literature suggests that cultural competence training should consist of any effort that challenges students to understand their own personal, social, and cultural backgrounds and how their individual cultural characteristics affect the way they feel about the world and how they interact within it (Albino et al., 2012). Furthermore, rather than supporting learning about individual cultures and their prospective characteristics, healthcare educators are encouraged to enhance a student’s awareness of diversity and cultural competence through discussion and interaction with race, sexual orientation, language, disability, and socioeconomic status (Behar-Horenstein & Feng, 2017). This multicultural approach to cultural competence curriculum, can stimulate more of an awareness of cross-cultural interactions and provide a foundation for the skills necessary to work with an ever-growing diverse society (Betancourt, 2006). The literature also emphasizes that topics such as the power-privilege dynamic in clinical encounters, discussions on race and racism and microaggressions in the clinical setting, and emphasis on the social determinants of health and how these factors play an important role in influencing health and access to high quality care are essential components of cultural competence curriculum (DallaPiazza et al., 2018; Manzi et al., 2020; Sandoval et al., 2018).

Previous studies attempting to determine the timeframe for implementation of cultural competence topics have shown that medical students' attitudes toward underserved, ethnic/minority populations decline over time (Song et al., 2018). Thus, current literature believes that topics such as health disparities and the social determinants

of health must be integrated and woven into medical and dental healthcare curriculum beginning day one of professional study (Albino et al., 2012; Lukes, 2020). Students who received early exposure in clinical training to these materials were more likely to develop the appropriate long-term skills needed to become culturally competent providers. Additionally, the early clinical exposure to cultural competence increased student investment in providing effective and compassionate communication to improve overall ethnic/minority patient health outcomes (Song et al., 2018).

Medical educators have employed a number of training programs and methods which include classroom lectures, workshops, standardized patient exercises, clinical clerkships, language training, immersion programs and various other interactive exercises to provide participants with the skills necessary to work with a diverse patient population (Constantinou et al., 2018; Kripalani et al., 2006). However, the question still remains how effective this abundant number of resources are in improving health outcomes and quality of care for those patients most in need. Until recently, training methods for teaching the concept of race and culture, key components of cultural competence, have been taught in medical and dental schools as a biological concept. Moreover, the practice of cultural competency is often taught using a didactic, lecture-based method in healthcare education. However, these didactic focused training have proven to not fully educate and equip future physicians to address circumstances in practice especially when addressing the concept of culture, race, and disparities in health (Manzi et al., 2020).

In an effort to depart from the traditional didactic lecture-based approach to the training of cultural competence, healthcare institutions across the United States have

proposed several curricular methods to enhance the number of culturally competent providers. Research conducted at the University of Louisville recruited first year health science students to participate in a study which used simulated patient exercises to better equip future physicians to provide effective care to refugee populations. Previous, related studies had revealed that simulated exercises were a successful alternative to a lecture-based, instructor-centric training approach to cultural competence and had urged healthcare educators to turn toward case-based, simulated learning to increase student's awareness of the cultural factors that can play a role in diagnosis of culturally diverse populations (Behar-Horenstein & Feng, 2017; Fitzgerald et al., 2018). Student survey results of the curriculum study at the University of Louisville revealed that the simulated patient exercises provided the students with a learning opportunity that the student's believed aided in their engagement with the material in a real time realistic environment (Fitzgerald et al., 2018).

In a similar study conducted at the Baylor College of Medicine, discussion groups and interactive learning exercises were utilized to teach the social determinants of health to first-year medical students. The results of a post survey given after participation in the course during first year orientation revealed that students felt an overall higher level of confidence when discussing topics such as access to care, race and ethnicity, and immigrant and refugee health after completion of the course compared to pre-survey results and participants. The study concluded that presentation of the social determinants of health, a component of cultural competence, in a case-based, small group discussion model cohesively highlighted disparities in health, and overall improved the first-year

medical students competence and comfort level with patients of diverse backgrounds (Song et al., 2018).

Another curriculum study at the University of Chicago School of Medicine proposed an interactive multimedia session in an attempt to address the gaps in medical education with regard to cultural competence. The 8-week course for first-year medical students educated students about health disparities and the role the physician must play in advocating for populations at risk for these disparities. A 2.5-hour video module containing video interviews with patients of color, a didactic lecture, patient video, discussion video, and question and answer session were employed for students. When students were asked about the overall effectiveness of the session, students recommended that future iterations of the session included small group exercises and role-playing exercises to better conceptualize the nuances of the health disparities (Bi et al., 2020). Additional studies at Rutgers New Jersey Medical School and the Southern College of Dentistry engaged students with curriculum that included both a didactic lecture based component and small-group case discussion component to educate students on cultural competence and the disparities in access to care. In both studies it was concluded by student assessment and survey data that students felt the small-group activity was a powerful tool in helping them understand the course and session objectives (Behar-Horenstein & Feng, 2017; DallaPiazza et al., 2018).

Background on Oral Health Masters and Evidence Based Dentistry

The Boston University Oral Health Sciences Master’s Program is a unique one-year full-time credential enhancing pre-dental master’s program aimed at preparing students as strong candidates for future admission to dental school. The 32-credit master’s degree yielding program enhances students' curricular and personal development through a rigorous biomedical sciences curriculum including several first-year dental courses (DMD-1) taken through both the Boston University Henry M. Goldman School of Dental Medicine and Graduate Medical Sciences (GMS) at the Boston University School of Medicine. At present, an emergence of programs currently exist that provide pre-dental students with the necessary skills to receive admission into dental school. Table 2, provides information on similar master’s degree programs that enhance a candidate’s admission to dental school (*Master of Science in Oral Health Sciences | Graduate Medical Sciences, n.d.*)

Table 2. U.S. Dental School Credential Enhancing Predental Masters Programs. This table shows an uncomprehensive list of several credential enhancing predental master programs along the East Coast of the United States.

U.S. East Coast Credential Enhancing Predental Masters Programs			
Program Institution	Program Type	Program Length	Location
Barry University	M.S.-Biomedical Sciences	12 months, 18 months, or 24months	Florida
Boston University	M.S.-Oral Health Sciences	12-24 months	Massachusetts
Georgetown University	M.S.-Physiology	12 months	Washington, D.C.
Louisiana State University	M.S. Biological Sciences	12 months	Louisiana
Nova Southeastern University	M.S.-Biomedical Sciences	12 months	Florida
Rutgers University	M.S. -Biomedical Scholars; Dental Scholars	12-24months	New Jersey
Tufts University	M.S.-Biomedical Sciences	12 months	Massachusettes
University of Pittsburg	Biomedical Masters Program	12-24 months	Pennsylvania
University of South Florida	M.S.-Medical Sciences	12 months	Florida

The Oral Health Sciences (OHS) program, initiated in 2005 as a track within the already established master's in medical sciences program, which is aimed at enhancing the credentials of applicants to medical schools, has graduated over 300 students with 90% of those students being accepted into 41 of the 68 accredited United States Dental Schools. In 2013, the OHS program received official recognition as new master's degree at Boston University School of Medicine due to its overwhelming success and recognition (*Master of Science in Oral Health Sciences | Graduate Medical Sciences*, n.d.).

The OHS program which boasts strong academic advising and mentorship includes over 19 required credits of coursework including Dental Medicine (DMD-1) level curriculum in Biochemistry, Physiology, Microbiology and Immunology, or Pathology and Graduate Medical Science (GMS) courses such as Biomedical Information and Prevention and Oral Health Promotion in Dentistry. The remaining 13 required credits, to make up the 32 mandatory credits for the master's degree, are fulfilled through elective coursework and a Capstone or Thesis Final Project. Electives include courses such as Head and Neck Anatomy and Clinical Manifestation of Infectious Diseases. Figure 3 provides a sample curriculum schedule for students completing the Oral Health Sciences Master's degree. Candidates who do not receive admission into an accredited dental institution or who have unique pathways to dental school are granted the option to complete the one-year master's degree in two years where they are able to conduct research with prestigious faculty at both the Medical and Dental schools at Boston

University (*Master of Science in Oral Health Sciences | Graduate Medical Sciences, n.d.*).

Fall 1	Spring 1
*OH 751 Biochemistry (6cr)	*OH 731 Physiology (2cr)
*OH 730 Physiology (6cr)	MS 640 Biomedical Information (2cr)
Electives (2-4 cr)	OH 750 Oral Health Promotion in Dentistry (3cr)
	Electives (8-10 cr)
Electives	
OH 770 Evidence Based Dentistry (2 cr)	OH 771 Head and Neck Anatomy (3 cr)
MS 600 Ethical Issues of Bioscience (3cr)	MS 700 Biostatistics (2cr)
MA 640 Cultural Formation of a Clinician (3cr)	**OH 740 Microbiology (4cr)
MS 793 Fundamentals of Biotechnology (2cr)	**OH 700 Pathology (4cr)
CI 670 Biostatistics with Computer (4cr)	OH 685 Infectious Diseases
Summer I	Summer II
MS 971 (Capstone) (2cr)	MS 986 Continuing Student
OR	
Fall 2	Spring 2
MS 971 (Thesis)(2cr)	MS 972 (Thesis)(2cr)

* DMD I courses in a blended live stream (50:50) format

** DMD 1 courses in live format

Figure 3. Sample Curricular Schedule in Oral Health Sciences Program at Boston University. This figure provides an outline on a sample curricular schedule of a master of Oral Health Sciences candidate. Figure taken from Master of Science in Oral Health Sciences | Graduate Medical Sciences, (n.d.).

One of the elective courses that students can choose to fulfill their required number of credits is a course titled *Evidence Based Dentistry*. In the course, students are provided with an understanding of the importance of evidence-based decision making and develop critical thinking skills through non-biased, analytical, and systematic reading of peer reviewed scientific literature in the broader dental field. In addition to guest presentation and talks from the faculty of the Henry M. Goldman School of Dental Medicine, the course consists of lectures, readings, and clinical cases that touch on topics such as professionalism, generation of superior clinical practice questions (PICO (Patient, Intervention, Comparison, Outcome) questions), and development of cultural competence skills (Davies 2017, 1). The *Evidence Based Dentistry* course serves as the template for the study conducted between 2017-2020 at Boston University within the Oral Health Sciences Master's Program which aimed to provide additional data and solidify results on the most effective training methods for teaching student's cultural competence. It was hypothesized that the most powerful tool for teaching the next generation of health professionals to be culturally competent providers is through role-playing, case-based, simulated exercises which emphasize the importance of the provider-patient relationship, holistic approaches to healthcare, and compassion when working with patients most affected by health disparity.

SPECIFIC AIMS

The research project at Boston University in the Oral Health Science Master's degree course *Evidence Based Dentistry*, has several main objectives; (1) provide a brief history of cultural competency training in healthcare, (2) understand the role of cultural competency in health care curriculum, and (3) describe an effective method for teaching cultural competence in health care graduate curriculum in preparation for professional school. This project will utilize student survey data from a Boston University course in the M.S. of Oral Health Sciences program from 2017-2020, in which a role-playing case study was used to teach cultural competence. The effectiveness of the cultural competence instruction will be analyzed based on student self-report. Through analysis of student survey data and current literature on cultural competence education, this study hopes to find how students successfully learn cultural competence in healthcare curriculum and provide a template for integrating this training into healthcare institutions.

METHODS

Creation of Course Session

The role-playing, case-based simulated patient encounter exercises, which were shown to be a highly effective way to teach pre-professional and professional healthcare students cultural competence, were developed and administered by the Program Director of the Oral Health Sciences Master's Program at Boston University, Dr. Theresa Heerema-Davies, who facilitated the previously mentioned *Evidence Based Dentistry* course where this curricular study was conducted, and Assistant Professor and Infectious Disease Specialist at the Boston University School of Medicine; Dr. Maura Kelley. The patient encounter cases as shown in Appendix A, were integrated, and administered during the Fall Semester elective course *Evidence Based Dentistry* between 2017-2020 as a portion of a role-playing activity for students beginning their studies in the Boston University Oral Health Sciences Master's Program to teach the importance of cultural competence and cultural awareness during patient encounters.

Course Outline for Fall 2017-2019

The course session instituted in the *Evidence Based Dentistry Course* between 2017-2019 was composed of three parts, (1) a real-time role-playing enactment of an abridged patient encounter facilitated by Dr. Davies and Dr. Kelley, (2). a real-time class group discussion and reflection following the role-playing exercise during which students were asked to work-through and discuss the theme and idea take-aways from the role play exercise, and (3). a PowerPoint presentation presented by Dr. Kelley emphasizing

take-away points from the role-play exercise. At the conclusion of the session, students were asked to participate in a post-session survey regarding student's feelings about the session.

Role-playing Reenactment of Patient Encounter Case 1 & 2

The cases used during the role-play portion of the course session were adapted from a personal physician encounter from Dr. Kelly. Appendix A provides information on each patient encounter scenario. Patient Encounter Case 1 composed of two subsections scenario encounters (1A & 1B), centered around a patient/physician interaction in which a pregnant patient presents with pain upon urination. The physician in 1A is short and terse with the patient immediately looking at a urine sample, prescribing medication for the urinary tract infection (UTI) and telling the patient to return for a follow-up in 2 weeks. In the subsequent scenario 1B, a similar situation ensues; however, in this scenario the physician takes more time with the patient providing similar care to the physician in 1A but asking more information about the patients personal and medical background. At the conclusion of the scenario, the patient is offered resources for an obstetrician and a dentist after more information is provided about the patient's background. The patient is then sent on their way and asked to follow-up in 2 weeks. The patient does not return.

Scenario Patient Encounter Case 2 follows a similar format to the case in patient Encounter 1. In patient encounter 2A, the same patient from encounter 1 returns this time with tooth pain after giving birth. The physician in 2A, like 1A, is short with the patient and quickly refers the patient to a dentist. In 2B, a similar scenario to 2A ensues,

however, in this encounter the physician again takes more time with the patient to receive background information on the patient and provides an antibiotic and dental referral. Each patient encounter explored topics such as the importance of a physician/patient relationship, the importance of asking a patient for patient history, and the importance of a physician taking all facets of a patient's circumstances into consideration.

Role-playing Course Session 2017-2019

During the role-play case enactment, facilitators and authors Dr. Theresa Davies and Dr. Maura Kelley dressed-up in clothing to mimic both the physician and patient in the case-based scenarios (Scenario 1 and Scenario 2). Dr. Kelly played the role of the physician while Dr. Davies served as the pregnant, homeless, patient experiencing a urinary tract infection. At the conclusion of the role play portion of each of the cases, the facilitators paused to lead students in a real-time class group discussion. After scenario 1, students were asked questions such as What did you think? Were the patient's needs met? Did you expect the patient to return? At the conclusion of the role-play of Scenario 2, similar questions were asked by the facilitators. At the conclusion of this portion of the session, the facilitators allowed students to generally discuss both cases as they related to one another. Finally, Dr. Kelly concluded the course session with a PowerPoint presentation that reinforced the take-home points from the session. Such take-aways included comments such as, treat every patient as if they were your mother and meet the patient where they are.

Switch in Teaching Modality in 2020

In Fall 2020, due to the COVID-19 Pandemic, a switch in course modality occurred as the *Evidence Based Dentistry* course was moved to an online platform. Due to the pandemic, many universities across the United States were forced to adapt to new curricular mandates. As such, Boston University was no exception and students were asked to complete most courses in the Oral Health Sciences Master's Program in a dual online/in-person environment. The study and course session conducted from 2017-2019 was adapted into a new virtual format to allow those students who opted to be entirely remote to participate. The course session conducted in 2020 consisted of a three-part format in which (1). students were asked to read each of the case-based patient scenarios on their own, (2). students were asked to reflect, discuss, and comment on each other's posts on the learning platform Blackboard Learn within the discussion forum, (3). students were then presented with a PowerPoint presentation by Dr. Maura Kelley on the key take-aways from each scenario. At the conclusion of the PowerPoint session, students were again asked to complete a post-session survey regarding students' feelings about the session.

2020 Course Session Discussion Board and PowerPoint Presentation

As stated previously, a switch in course modality occurred for the study conducted to determine the effectiveness of role-playing case-based studies on educating the future healthcare workforce the practice of cultural competency. Instead of the traditional role-playing exercise study conducted from 2017-2019, in 2020, students were asked to read the patient case encounter scenarios on their own, create their own post

reflection on the Blackboard Learn discussion board platform, and comment on two classmate's reflection posts. The online course discussion session took place over a two-week period in which during the first week students were asked to read and reflect on patient scenario 1 and comment on a classmate's post. In the second week, students were asked to read the patient scenario and similarly reflect and comment on two classmate's posts. Also, during the second week Dr. Maura Kelly gave a brief PowerPoint presentation, similar to the PowerPoint presentation given during the 2017-2019 course session, presenting on take-away points from both patient encounters.

Student Survey 2017-2019/Student Survey 2020 (Appendix B)

At the conclusion of the cultural competence training sessions in both 2017-2019 and 2020, students were invited to participate in a post-session survey administered electronically via Qualtrics Surveys (Appendix B). The surveys were designed to determine (1) the enjoyability of the role-playing exercise (2017-2019) or discussion board exercise (2020), (2) the helpfulness of either session format (role-playing or discussion board) in helping to identify the importance of communication in patient encounters, (3) the helpfulness of either session format in making the student more aware of strategies to improve patient interview skills, (4) the helpfulness of either session format in helping students to better identify the importance of building rapport and trust during patient contact, and (5) the helpfulness of either format in helping the students to understand their own bias and/or cultural awareness when working with patients. Quantitative survey data was collected, deidentified, and analyzed for the number of

participants who responded in each respective year to the choices; strongly disagree, disagree, agree, and strongly agree.

Coding and Analysis of the Discussion Board Posts in 2020

In addition to the quantitative data collected from the student survey responses from 2017-2020, in 2020, due to the unique nature of cultural competence training session, qualitative coding data was obtained from each Blackboard discussion board posts the students had written. Each of the student's discussion posts were analyzed and coded using 5 codes including codes such as holistic treatment, the importance of collecting a patient history, importance of the patient clinician relationship, improvement of health outcomes, and recognition of socioeconomic factors. The coding software NVivo 12 was used to code each student's response. This study was given IRB approval and considered exempt by Boston University (IRB #H-37232). A student's discussion post that coded for a holistic treatment demonstrated an understanding of the importance of a physician providing a holistic approach to patient treatment. Students' whose discussion response coded for importance of the patient-clinician relationship, the importance of collecting a patient history, and recognition of socioeconomic factors demonstrated that they understood the importance of a physician building a rapport with patients and recognizing the full set of socioeconomic circumstances a patient faced to generate a full patient history. Finally, those students whose discussion post coded for improvement of health outcomes recognized that improvement of patient health outcomes

could be achieved through recognition of the other codes. More details about each code are outlined and described in Table 3.

Table 3. Table of Codes and Descriptions for Analysis of Student Responses in 2020.

This table depicts the codes used to analyze student discussion board responses in the Boston University Oral Health Sciences study in the year 2020. Each student response was coded using the coding software NVivo 12.

Code	Description of Code
Holistic Approach to Care	The student demonstrated the importance of the physician providing holistic/overall treatment of the patient.
Importance of Patient History	The student demonstrated the importance of collecting a patient history to provide the best treatment.
Importance of the Patient-Clinician Relationship	The student demonstrated the importance of building rapport and trust between the patient and physician.
Improvement of Health Outcomes	The student recognized that by building rapport, collecting a patient history, and providing holistic care to the patient that there could be improvement of patient health outcomes.
Recognition of Socioeconomic Factors	The student recognized the importance of understanding the socioeconomic factors that could affect a patient's quality of care.

IRB Approval

This study was approved and considered exempt by Boston University. IRB # H-37232

RESULTS

Data Description 2017-2019

This section describes the student discussion and survey data (years 2017-2020) of the participant responses from the *Evidence Based Dentistry Course* in which students were presented with a Cultural Competence role-playing enactment, a group discussion on the role-playing exercise, and PowerPoint presentation to solidify the take-away points of the session. At the conclusion of the course session, students were asked to voluntarily complete a post-session survey on the effectiveness of the session on teaching cultural competence and cultural awareness.

Discussion Points from Class Group Discussion

During the session, students were presented with two patient encounters (1&2). Between the presentation of each encounter, students were asked to participate in a class group discussion. Students, after the completion of the first round of patient encounters, were asked as a class to comment on their thoughts on the encounter, whether the patient's needs were met, and whether students felt the patient would return. Student participants when asked about their thoughts on the encounter and whether the patients' needs were met in the encounter responded with comments such as,

The appointment was short, somewhat abrupt, but a successful and sufficient encounter as the patient left with a prescription for her UTI

and

Yes, the patients' needs were met.

When students were asked about the return of the patient for follow-up care, students responded with comments such as

It is not the responsibility of the provider if the patient decides not to return, as some patients are not ready for help.

Students also noted, that

There are many very busy clinics where events such as this patient encounter occur.

After the second patient encounter enactment students were asked similar questions about their thoughts on the encounter, whether the patients' needs were met, and whether the patient would return for a follow-up dental appointment. Additionally, students were asked to compare the two patient encounters. When asked about their thoughts on the encounter, students responded with comments such

Yes, the patient's needs were met, and the physician took the time to know their patient,

and

The physician took time to build rapport with the patient and make her feel more comfortable.

Additionally, students noted that communication was a key component of care especially when working with patients that are underserved or homeless who don't have the proper resources or the ability to find access to such resources.

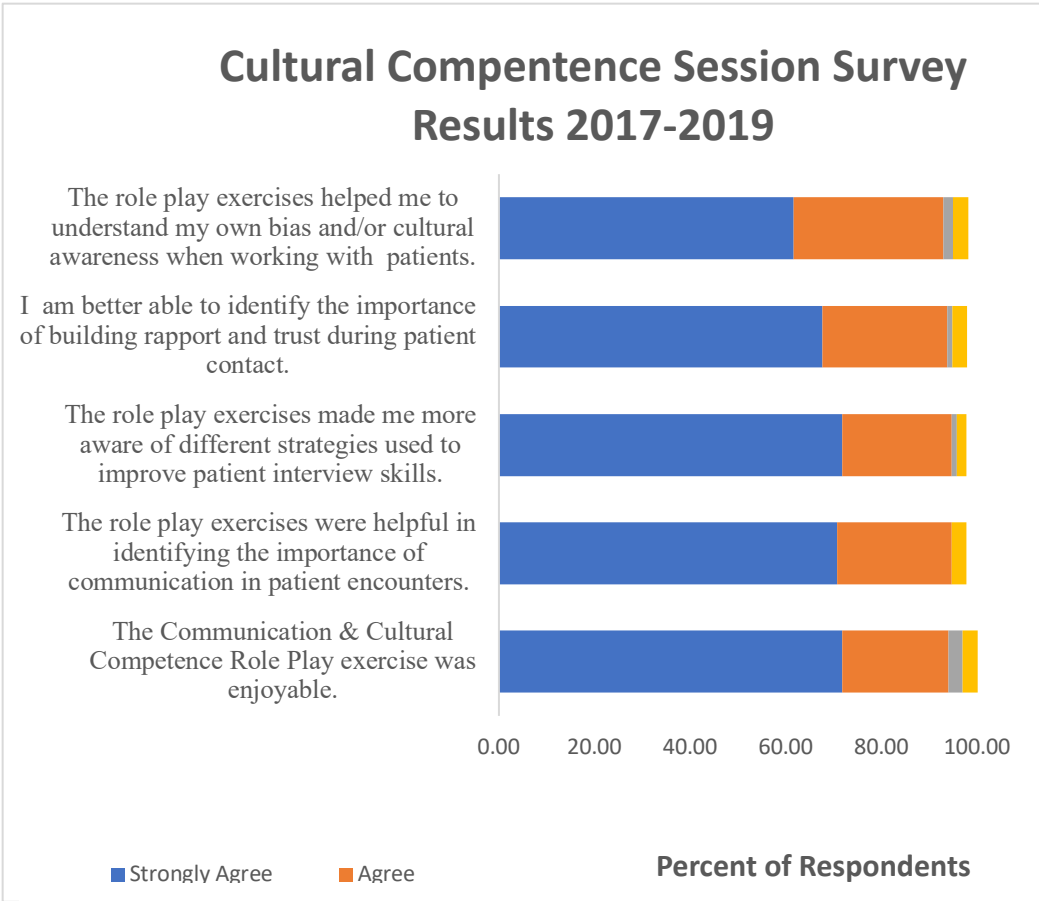
At the conclusion of the two patient encounters between 2017-2019, Dr. Maura Kelly facilitated a PowerPoint presentation on the important takeaways from the cultural competence course session. Dr. Kelly emphasized that

It is not the providers fault if patients decide not to return if the physician has done their best to build a relationship with the patient and has the best interest for the patients care. The patient may have other reasons as to why they don't return or trust healthcare providers.

Survey Results from 2017-2019

At the conclusion of the course session, students were asked to voluntarily complete a post-session survey on the effectiveness of the course session in teaching cultural competence and cultural awareness during patient encounters. The results from the years 2017-2019 when classes were held in person are shown in Figure 4. As represented in Figure 4, the majority of students from 2017-2019 viewed the Communication & Cultural Competence role-play exercises positively. Most students also felt that the role play exercise helped them to identify the importance of communication in patient encounters and made them more aware of different strategies to improve their patient interview. Additionally, the majority of students felt the after completion of the exercises that they were better able to identify the importance of

building rapport and trust during patient encounters. These results are summarized in Figure 4. In contrast to the years 2017 & 2018, in 2019, several students strongly disagreed or disagreed with the statements presented in the survey. Several students felt that the role-play exercise was not enjoyable and that the role-play exercise failed to teach them important components of communication and cultural competence training.



	The Communication & Cultural Competence Role Play exercise was enjoyable.	The role play exercises were helpful in identifying the importance of communication in patient encounters.	The role play exercises made me more aware of different strategies used to improve patient interview skills.	I am better able to identify the importance of building rapport and trust during patient contact.	The role play exercises helped me to understand my own bias and/or cultural awareness when working with patients.
■ Strongly Agree	71.72	70.71	71.72	67.68	61.62
■ Agree	22.22	23.96	22.92	26.04	31.25
■ Disagree	3.03	0.00	1.04	1.04	2.08
■ Strongly Disagree	3.13	3.13	2.08	3.13	3.13

Figure 4. Cultural Competence Session Survey Data from the Year 2017-2019. This figure shows the survey data from students at Boston University in the Oral Health Sciences Program for the years 2017-2019. Data is presented as percent of respondents (n =99) in response to the five survey questions.

The Role-playing Exercise Helped me to Understand My Own Bias and/or Cultural Awareness When Working with Patients.

Students completing the survey from 2017-2019 were asked to determine whether the role-play exercises helped them to better understand their own bias and cultural awareness when working with patients. Figure 5. compares the number of students between 2017-2019 that strongly agreed, agreed, disagreed, or strongly disagreed with the statement that the role-play exercises had had helped them to understand their bias and/or cultural awareness when working with patients. The majority of students agreed or strongly agreed with the survey statement between this time period. However, several students in the year 2019 strongly disagreed/disagreed with the statement that the exercise had helped them to understand their own cultural bias.

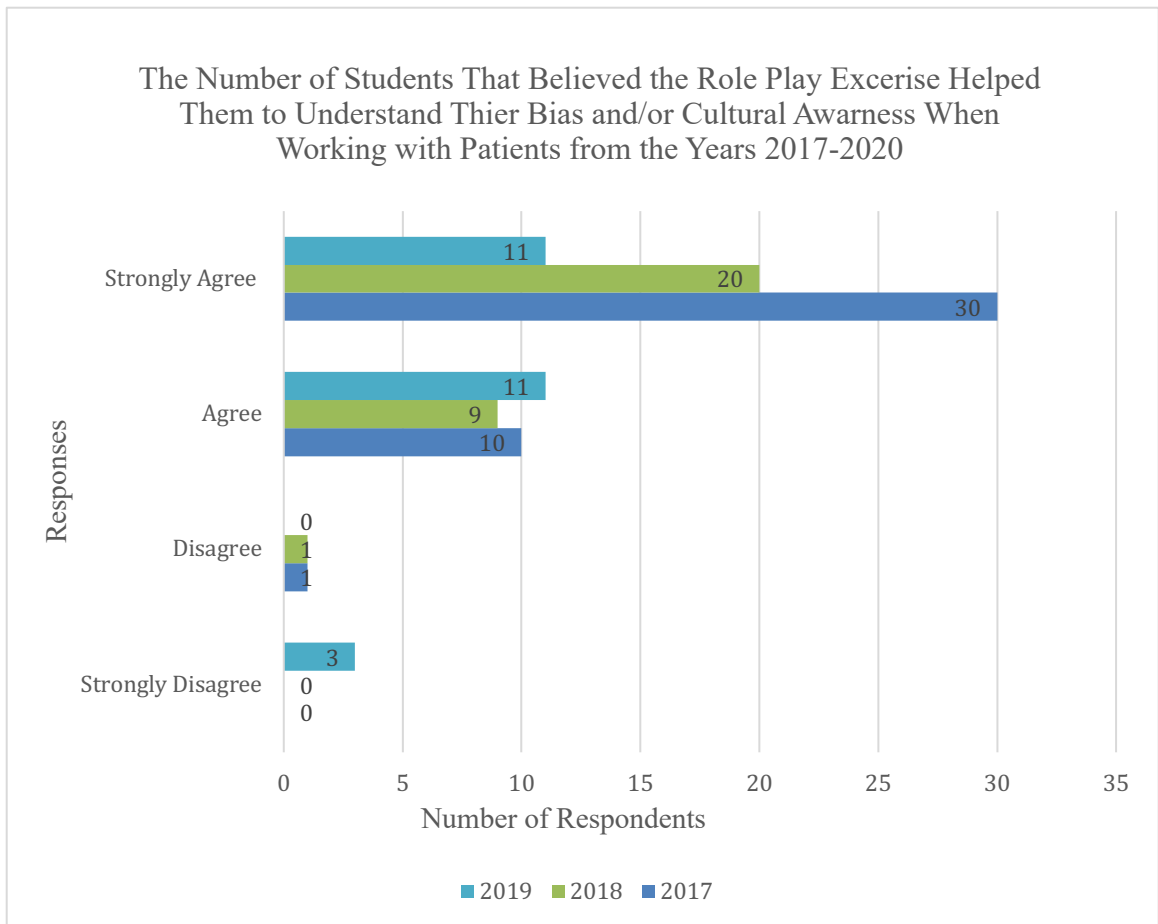


Figure 5. The Number of Students That Believed the Role Play Exercises Helped Them to Understand Their Bias and/or Cultural Awareness When Working with Patients from the Years 2017-2020. This figure depicts the total number of students and their responses to the survey question: The role play exercise helped me to understand my own bias and/or cultural awareness when working with patients. In the figure the lighter blue represents responses from the year 2019, the gray represents responses the year 2018, and the darker blue represents responses from the year 2017.

Data Description 2020

This section will describe the discussion board posts and student survey data of the participant responses from the year 2020. In 2020, due to a change in course structure to remote learning due to the COVID-19 Pandemic, students were asked to read each patient encounter case, reflect on the cases in a student discussion board format, and participate in a PowerPoint presentation on the key takeaways from both patient encounters. At the conclusion of the course session, students were asked to voluntarily participate in a post-session survey on the effectiveness of the course session on enhancing the student's cultural competence and cultural awareness.

Discussion Board Post Data (Appendix C)

In 2020, a contrast to 2017-2019, students were asked to read both case study patient encounters, reflect on the patient encounters through Blackboard's discussion board platform, and respond to two classmates' reflections. Each discussion board reflection and response were coded the coding software NVivo 12 with reference to how closely the student's comment aligned with cultural competence ideas including whether the student was able to demonstrate the importance of the physician providing a holistic/overall approach to patient treatment (Holistic Approach to Care), whether the student was able to demonstrate the importance of collecting a patient history to provide the best treatment (Importance of Patient History), whether the student was able to demonstrate the importance of the patient-clinician relationship during patient encounters (Importance of the Patient-Clinician Relationship) , whether the student was able to

recognize the importance of understanding the socioeconomic factors that could affect a patient's quality of care (Recognition of Socioeconomic Factors), and whether the student was able to recognize that through the patient-clinician relationship, collecting a patient history, providing holistic care, and recognition of socioeconomic factors that there could be an improvement in patient care and health outcome (Improvement of Health Outcomes). Each student response and code are shown and represented in Appendix C.

Understanding a Holistic Approach to Care

Participants were able to identify and demonstrate the importance of a physician providing a holistic and/or overall treatment of the patient for each patient encounter (Encounters 1 & 2). In discussion board posts following the reading of patient encounter 1A and 1B student recognized that to treat the patient in the case most effectively it was important that the physician in 1B considered the student's overall health and additional factors that could play a role in patient health outcomes. Terms and phrases such as *overall health and wellbeing, and holistic approach* were often used to describe patient encounter 1. One discussion board participant commented:

“Doctors and dentists should be more worried about the overall health of the patient and not just address the direct symptom or problem at hand”

Other student discussion board participants made comments after encounter 1 such as:

“Being a clinician means more than treating the illness, it means treating the whole person.”

“...the provider should consider the overall needs of the patient in order to treat the patient to the best of their ability.”

“For patient encounter 1B, the doctor took into account all concerns of the patient’s well-being.”

“Providing care to participants should be a holistic approach.”

After encounter 2, similar points were made. Student participants made comments such as:

“Scenario B [of patient encounter 2] shows the doctor is much more responsible for the overall wellbeing and health of the patient and her kid. It is important in the health field to connect the dots of different health issues but it most importantly to truly look out for the overall health of the patient.”

“The physician in 2B focused on overall health [of the patient] and not just the toothache.”

“It is essential for the physician to learn about the patient and develop a good understanding of their health, lifestyle, and well-being.”

“Encounter 2B shows that the clinician has chosen a more holistic approach and was trying to provide the patient with the appropriate resources that could help her quality of life and overall health.

Understanding the Importance of taking a Patient History

Student discussion board participants were also able to demonstrate the importance of collecting a patient history to provide the best quality treatment. Following the reading of patient encounter 1, student discussion board participants made comments such as:

“In scenario 1A, the clinician seemed like they were in a hurry and treated the patient carelessly. After the patient told the clinician that they were pregnant, the clinician didn’t ask any follow-up questions

regarding factors relating to the patient's pregnancy that might be related to the pain during urination."

"The clinician in 1A did not take the time to consider other important factors that may affect choosing treatment plan of the patient."

"In scenario 1B, a more detailed assessment was given with more detailed patient information regarding the patient's personal life, sexual history, lack of access to healthcare, lack of employment, or residence of living."

"Encounter 1B made me realize how important it is to ask the simple questions, because they can tell you a lot. From the encounter 1A, a care provider would never have known the patient was homeless or HIV positive, which is extremely important to note in the patient's history..."

After reading patient encounter 2, student discussion board participants were also able to understand the importance of taking a patient history to provide the best quality care.

Students made notes such as:

"In scenario 2A, the doctor didn't even try to gather more information, or try to assess the situation. He relied solely on the subjectives of the patient in proceeding with his suggestion. In scenario 2B, the clinician was more thorough in obtaining relevant information..."

"In scenario 2A, again the clinician addresses the immediate health concern without establishing a comprehensive patient health history."

"The clinician in scenario 2A missed a lot of important information about the patient just because they didn't take the time to ask a few simple questions."

Recognition of Socioeconomic Factors During a Patient Encounter

After reading both patient encounter 1 and 2 students were able to recognize the importance of understanding the socioeconomic factors that could affect a patient's

quality of care. Many student discussion board participants emphasized the importance of understating and asking about the patients living situation, finances, and social circumstances. After reading each patient encounter, students made comments and discussion posts such as:

“Money is always a factor in treatment.”

“Scenario 1B revealed that the patient did not have insurance or an alternative means of paying for treatment

“Underserved populations and patients often don’t have the resources or often the knowledge on how to get out of their current situation

“The patient in encounter 1, is displaying a large array of problems in her life aside from the UTI; she lost her child, she is homeless, and she is financially unstable.”

“I think focusing on the patient’s socioeconomic status, and their level of engagement is key when diagnosing patients.”

Understanding the Importance of Patient Clinician Relationship

Students were also able to recognize and understand the importance of building rapport and trust between the patient and physician. After reading patient encounter 1, students made posts such as:

“In scenario 1B, the clinician shows empathy toward the patient...”

“I think that scenario 1 emphasizes that being a clinician goes way beyond just knowing medical facts and that a very large part of healthcare is also relating to people one-on-one.”

“The scenario in patient encounter 1B seems like the physician or whoever was tending to the patient really tried to be more personal and thorough with the visit.”

“Scenario 1B the physician made sure the patient was comfortable. Overall, scenario 1B is a more ideal situation because the conversation is more patient focuses and has a good balance of the patient’s needs and the providers thoughts.”

Students made a similar assessment of the importance of the patient-clinician relationship after reading patient encounter 2.

Improvement of Health Outcomes

Finally, students were able to recognize that by building rapport and trust with patient’s, collecting a patient history, and/or providing holistic care to the patient that there could be improvement in patient health outcomes. After reading encounter 1 and 2 students made comments including:

“Really taking the time to explain what the patient’s medical condition can impact how they respond to follow-up treatment.”

“The patient in 1B receives better care.”

“I think in scenario 2, the doctor does a better job at providing care for their patient which leads to better outcomes and compliance to attend follow-up appointments.”

“Scenario 2B showed a greater level of care than scenario 2A.”

Survey Results From 2020

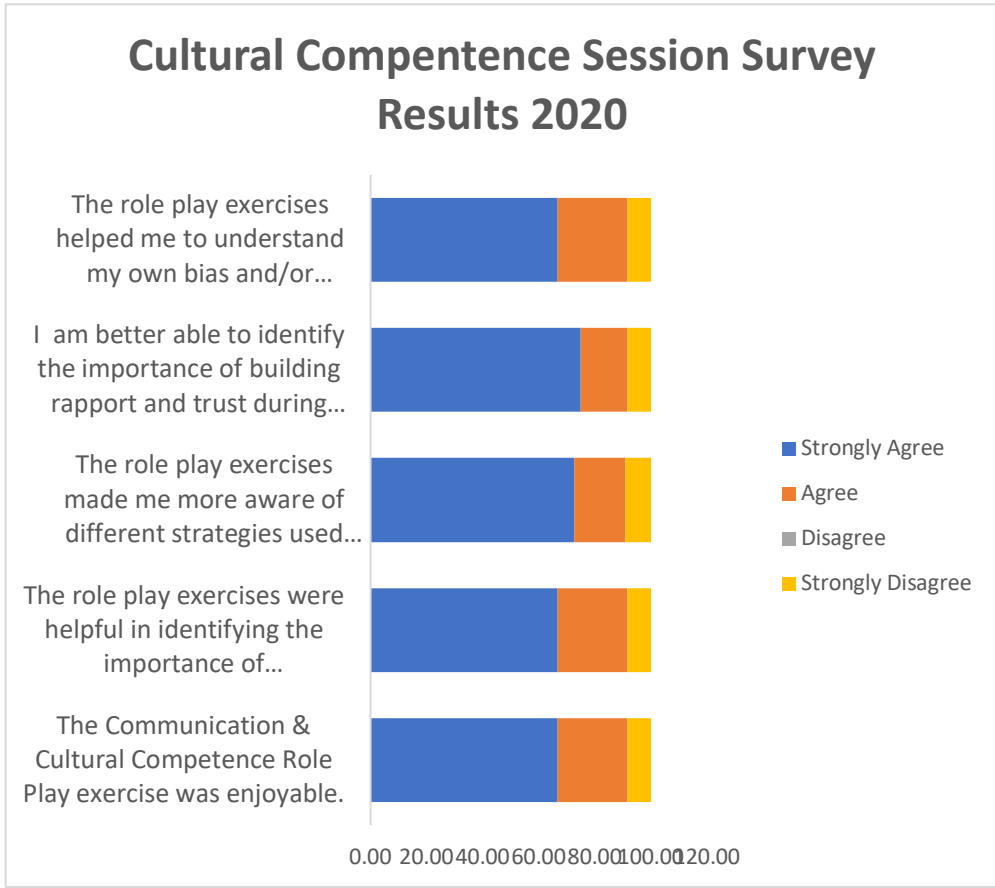
After completion of the discussion board posts and PowerPoint presentation in 2020, students were then asked to participate in post-session survey to determine the effectiveness of the session on teaching the cultural competence and cultural awareness

during a patient encounter. Of the 45 class session participants, 13 (29%) of students completed the course post-session survey.

2020 Survey Results

In a similar format to the years 2017-2019, the survey in 2020, asked students to respond to their level of agreement (strongly agree, agree, disagree, or strongly disagree) to statements such as how enjoyable the discussion session was, if the discussion board exercise helped the students in identifying the importance of communication in patient encounters, whether the discussion board helped students to understand strategies to improve patient interviews, if the student felt as if they were better able to identify the importance of building rapport during patient contact, and whether the discussion board helped students understand their own bias and/or cultural awareness when working with patients. The survey results for the year 2020 when classes were held remotely are shown in Figure 6. The majority of student survey participants viewed the Communication & Cultural Competence discussion board exercise positively, found the exercise helped them to identify the importance of communication in patient encounters, and made them more aware of strategies to improve their patient interview skills. Most students also felt that they were better able to understand the importance of the patient/clinician interaction and believed the discussion board exercise helped them to better identify the importance of building rapport and trust with patients during patient contact after the course session. Similarly, to 2018, several students did strongly disagree/disagree with these statements. When students were asked whether the discussion board helped them to understand their own bias and/or cultural awareness

when working with patients, most of the student participants agreed or strongly agreed with this statement. A couple of students felt that the discussion board exercise did not help them to understand their bias and/or cultural awareness. Figure 6. represents the 2020 survey data and responses from students from Boston University in the *Evidence Based Dentistry Course*.



	The Communication & Cultural Competence Role Play exercise was enjoyable.	The role play exercises were helpful in identifying the importance of communication in patient encounters.	The role play exercises made me more aware of different strategies used to improve patient interview skills.	I am better able to identify the importance of building rapport and trust during patient contact.	The role play exercises helped me to understand my own bias and/or cultural awareness when working with patients.
■ Strongly Agree	66.67	66.67	72.73	75.00	66.67
■ Agree	25.00	25.00	18.18	16.67	25.00
■ Disagree	0.00	0.00	0.00	0.00	0.00
■ Strongly Disagree	8.33	8.33	9.09	8.33	8.33

Figure 6. Cultural Competence Session Survey Data from the Year 2020. This figure shows the survey data from students at Boston University in the Oral Health Sciences Program for the year 2020. Data is presented as percent of respondents (n =13).

DISCUSSION

To address the lack of standardization and determine an effective means for teaching and training the next generation of healthcare professionals the practice of cultural competence, two iterations of a course session using case-based patient centered encounters were developed to teach pre-professional dentals students. The results of this study demonstrate that participation in the course, subsequent group discussion sessions, and take-away PowerPoint sessions significantly improved student participants understanding of socioeconomic, environmental, and cultural disparities that can affect a patient's health outcome.

According to results from the course session implemented from 2017-2019, overall, the role-playing exercise significantly improved participants understanding of important components that can be used to improve health outcomes that may be affected due to health disparity. From 2017-2019 students were strongly able to identify the importance of communication in patient encounters, were able to understand the strategies such as communication and compassionate care in patient encounters, were better able identify the importance of building a patient-physician relationship with patients, and most importantly, were able to recognize their own cultural biases when treating patients. Similarly, in 2020, even with a change in course modality and format to a discussion board, students were still able to understand the same key take-aways from the course session. Despite the promising implications of both iterations of the session, students in 2020 did appear to experience a percentage decrease in understanding/agreement with the survey statements; "I am better able to identify the

importance of building rapport and trust during patient contact after completion of the discussion board exercise,” and “the discussion board exercises helped me to understand my own bias/and or cultural awareness when working with patients.” These statements were more challenging to understand and really important components to the understanding and training of cultural competence. This decrease may be attributed to reorganization of the course session. Due to pandemic restrictions, students were unable to participate completely in person. Thus, the course session and discussion board forced students onto a remote platform. While the discussion board did have its strengths as discussed later, it is important to note that the percentage decrease in the last couple of questions could have been a result of students lacking the important strengths of the role-play enactment such as the ability to view a first-hand enactment of the patient encounter. It is important to recognize that additional learning components such as a video recording of the role-play enactment may be necessary if the discussion board is used as the primary learning method in the future.

Strengths & Limitations

In contrast to many previous studies that attempted to determine the effectiveness of cultural competence training methods, this session had many unique characteristics that made it more effective in determining the best mechanism for teaching cultural competence. Above all, this course session which relied on a role-playing based scenario encounter (2017-2019) or a discussion board reflection post (2020) provided students with a firsthand simulated encounter that provided an alternative to traditional

didactic lecture-based training models. In 2017-2019, the simulated role-playing exercise enabled student participants to see first-hand and up-close an interactive patient scenario that could be used as an example for use when students begin working with patients or communicating with patients who are culturally diverse. Additionally, the nature of the cases created for the course session which were divided into a part A in which the patient physician was more straightforward when diagnosing and treating the patient in the scenario and a part B with a more comprehensive and nurturing approach to care, allowed the students to compare and contrast the scenarios and make their own assumptions and comments on the effectiveness of each portion of the case. Another strength of this role-playing and discussion board cultural competence training, was a result of the faculty used to facilitate and create the patient case encounters. In each iteration of this session, faculty with cultural competence training and experience were uniquely involved in case creation and facilitation of the course session. According to previous studies with similar aims, it was noted that direct observation and feedback from a faculty member who had cultural competence training and direct contact with patients can provide students with a more memorable and useful experience when educating students (Kripalani et al., 2006). The facilitators of this session were able to emphasize from their own personal experiences how to work with culturally diverse populations.

An important aspect of the 2020 iteration of the course session in which a discussion board format was used to foster students' reflections on both cases was that the discussion board format allowed students who may be more uncomfortable with sharing their thoughts on the case, their own cultural biases, or their thoughts about

cultural competence in a classroom setting, to speak and share their opinions in more of a safe space.

Finally, in contrast to previous studies, this course session took place in a pre-professional master's program, the M.S. in Oral Health Sciences Program at Boston University. This program in which students were able to enhance their credentials for professional school, provided students with early exposure to cultural competence training. Students that completed this session in their early pre-professional curriculum should be more prepared than peers who did not receive any cultural competence training until they entered their designated professional school.

Even though this study had numerous strengths, there were some limitations that should be addressed in future iterations of either session. One such limitation to the study, was the number of survey participants that completed the post-session survey from the years 2017-2020. Survey completion was not a requirement after the course session on cultural competence. Thus, the number of student participants declined over the years, reaching its lowest number of participants in 2020 when the discussion board course session was implemented, and students have been over surveyed due to the pandemic. With this in mind, it is important to note that results may have been skewed. This decline in 2020, however, may be attributed to the uncertainties associated with pursuing the course session and master's program during the COVID-19 pandemic. Another limitation to this study, was the lack of both a pre and post survey that could be used to determine how student's understanding of cultural competence had evolved from their entry into the

course to the conclusion of the course. This information would have been beneficial to gain a better understanding of the effectiveness of both of the sessions.

Future Directions for the Course

In an effort to improve future repetitions of the course, the course should implement both a role-playing format and subsequent discussion board reflection within the same course session. It was shown in previous studies which attempted to determine the most effective mechanism for teaching and training the future healthcare workforce cultural competence that interactive educational methods for teaching the practice of cultural competence are most beneficial. Additionally, it was noted that role-playing exercises that allow students to provide feedback with student colleagues can provide students with more insight into their own behaviors. It was also shown in previous studies that student writing and reflection activities will also facilitate students to reflect on their own beliefs and biases (Kripalani et al., 2006). By combining both learning techniques students would be able to more deeply understand their own bias and their classmates and create a dialogue that could be more beneficial than just one learning method alone. Furthermore, by implementing the discussion board into the role-playing session, as stated previously, students more cautious of sharing their point of view on either case or about their own implicit bias in a traditional classroom setting would be able to more thoroughly express their opinions and facilitate a more comprehensive discussion.

Conclusion

The purpose of this research was to explore the effectiveness of role-playing case-based patient encounter on teaching pre-professional healthcare students' components of cultural competence. Through analysis of student survey data and, in 2020, discussion board posts on students' understanding of cultural competence, after completion of the session shows that this method of educating students cultural competence is an effective mechanism. It is important to recognize that standardizing health education and training methods for cultural competence is far from over. More research and studies must be conducted to bring about more answers to questions such when to teach cultural competence, the most effective mechanism for teaching cultural competence, and what to teach in cultural competence trainings. This study provides a small fragment of the work that must continue to be done.

APPENDICES

APPENDIX A

Patient Encounter 1

Scenario 1A:

C: What are your symptoms?

P: I have a lot of pain when I pee.

C: When did it start? How long has this been going on? Have you ever had something like this before?

P: It started 3 days ago and it's getting worse. This happened the last time I was pregnant too.

C: Do you have any fever or back pain?

P: No.

C: OK, let me look at your urine sample.

C: Well, it looks like you have a UTI. Here's a prescription for an antibiotic. You should come back for follow-up in 2 weeks.

Scenario 1B:

C: What brings you in today?

P: I have a lot of pain when I pee.

C: When did it start? How long has this been going on? Have you ever had something like this before?

P: It started 3 days ago and it's getting worse. This happened the last time I was pregnant too.

C: How many children do you have?

P: I have a son who is in foster care and then I'm pregnant now with my second kid. Different fathers.

C: Where do you live? Do you live with anyone?

P: I live on the streets because I don't have a job. I was arrested for drugs a couple of times, and then I lost my son and my job 2 years ago.

C: Do you have any regular care with an obstetrician to follow your pregnancy?

P: Not really. I just go to the ER or come here if I don't feel good.

C: So, let's try and make things better for you so you can stay healthy for you and for your baby.

When you pee, it hurts. Do you have any fever or back pain?

P: No.

C: Are you sexually active?

P: Not since I got pregnant.

C: Do you have any vaginal discharge?

P: No.

C: Have you ever been tested for HIV?

P: Yes—about a year ago and it was negative.

C: OK—that's important information for you and for your baby. Let me look at your urine sample and then we can make a plan together. How does that sound?

P: OK—sounds OK.

C: It looks like you probably have a urinary tract infection. We call it a "UTI".

P: Yeah—that's what I had before my son was born.

C: So, you'll need an antibiotic to treat that infection. We also have to use one that is safe for your unborn baby. We can do that. How do you get your medicines? Do you have insurance?

P: OK—I think I need an antibiotic too. I will have to pay for it because I don't have insurance. But I don't have any money right now.

C: OK—so let's get you samples to complete a full course.

P: Great.

C: I do want to talk to you about other important things regarding your general health.

P: Like what?

C: I would like to refer you to a social worker who could help us figure out a new living situation for you now and for you when the baby arrives.

Being homeless puts you and your baby at risk because it limits your diet and your hygiene.

Could we also arrange for you to see an obstetrician?

P: Sure.

C: I noticed that your teeth are in need of some care. Could we also make an appointment for you to see a dentist?

P: Sure.

C: Great. I would really like to help you. The UTI will be easy to fix. The other things will take some time, but I will help you do that. I want you to come back in 2 weeks to see me, and we can see how the other things are coming along. How does that sound?

P: That sounds good.

NOTE: The patient does not return for follow-up as planned.

Patient Encounter 2

She returns to clinic 3 months after baby is born because of “terrible toothache”.

Scenario 2A:

C: What are your symptoms?

P: My tooth is killing me.

C: OK—let’s send you to a dentist.

Scenario 2B:

C: What brings you in today?

P: My tooth is killing me.

C: That cannot be fun especially with a new baby. I think we met once when you were pregnant. How are things going?

P: About the same.

C: When did your tooth start to hurt?

P: It probably started after I had the baby but it is just getting worse and worse. I can’t take the pain at night.

C: What do you use to help with the pain?

P: I am not gonna lie. I am using still and that helps.

C: OK—I am going to be honest here. You need help more than just a dentist to fix this tooth. I am happy to help you work on all of these things, but you have to be willing and have to follow through. Not just for your own health but also for this beautiful baby girl you have now.

P: So what you do you mean exactly?

C: First, you have tooth that is infected and may need to be pulled. Your other teeth need attention. So, you need an antibiotic and a dentist to start with.

Most importantly, we need to find you and your baby a safe and clean place to live. This is going to be hard because it means giving up drugs altogether. We can help you all the way along but you have to be willing to start today.

P: I am. I can’t live like this anymore.

APPENDIX B

Boston University Oral Health Sciences Sample Survey 2020

Start of Block: Default Question Bloc

Q1 The following questions are related to three of the cases we discussed in Evidence Based Dentistry this fall semester. These cases are being evaluated as part of a research study. This survey is optional and anonymous. Thank you.

Q2 By checking this box (Y/N) and completing / submitting this survey I give permission to have my anonymous answers used for educational research purposes. If you have any questions, please contact Dr. Theresa Davies at tdavies@bu.edu and/or 617-358-9546

Confirm

Q3 Please indicate your level of agreement with each statement below regarding the Communication & Cultural Competence discussion board case.

	Strongly Disagree	Disagree	Agree	Strongly Agree
The Communication & Cultural Competence discussion board exercise was enjoyable.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The discussion board exercises were helpful in identifying the importance of communication in patient encounters.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The discussion board exercises helped me to understand different strategies to improve patient interview skills.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am better able to identify the importance of building rapport and trust during patient contact.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The discussion board exercises helped me to understand my own bias and/or cultural awareness when working with patients.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Q4 Please add any additional comments on the Communication & Cultural Competence Case and your experience using the discussion Blackboard discussion board.

APPENDIX C

Annex of Student Coded Responses

Annex: Patient Encounter 1

Coding Categories	Coded Data
<p>Holistic Approach to Treatment</p>	<p>Patient Encounter 1A & 1B:</p> <p>...it's treating the symptoms of a recurring problem instead of the cause</p> <p>I can understand their reluctance to spend money on something that maybe isn't immediately bothering them, but all I can do is to explain how preemptive treatment can save them money and pain in the long run and hope they take my word for it.</p> <p>I think that if the physician took the time to thoroughly understand where the problem came from ...</p> <p>patients tend to want to address their primary complaints instead of the contributing factors to the issue... I've noticed from my shadowing's especially that some patients think it beyond the dentist's duties to recommend treatments beyond simply address oral health concerns, without realizing that other contributing factors are what is leading to their primary complaints.</p> <p>it can be difficult to really get across the importance of overall health...</p> <p>The physician could have been more thorough like in the second scenario where they took every factor into consideration while trying to help the patient with her UTI and also trying to keep her unborn child safe.</p> <p>They [the clinician in 1A] should have asked to follow up questions regarding the patient's overall health like the clinician did in scenario 1b</p> <p>it is so important to meet the patient where they are at and not just treat the illness but the whole person.</p> <p>There is definitely an issue with relying on urgent care or the ER to really take care of your overall health.</p> <p>...especially after the clinician offered resources that would help the patient and their baby's overall health.</p> <p>...[physician] asked questions to get a better sense of the patient's general health.</p>

	<p>...and trying to get to see the big picture of what they may be dealing with outside of their primary concern.</p> <p>Being a clinician means more than just treating the illness, it means treating the whole person.</p> <p>If that's the case for the clinician in scenario A, hopefully he/she has an office manager or some kind of mechanism in place that'll remind him to treat patients holistically.</p> <p>...after reading the second scenario I realized how much of the whole picture the clinician could be missing by not asking more to follow up questions</p> <p>In addition, in encounter #2, the provider suggested that the patient see a social worker, an obstetrician, and a dentist in order to improve her overall health.</p> <p>I welcome the relatively recent acceptance of dentistry as an important and integrative part of someone's overall health...</p> <p>I truly believe that there needs to be a more collaborative approach to dentistry and healthcare overall. This will immensely improve overall health and well-being.</p> <p>...Which is important because the provider should consider the overall needs of the patient in order to treat them to the best of their ability.</p> <p>The first patient/doctor scenario was brief and there was no information contributed on the background of the patient and their overall health.</p> <p>The second appointment helped to show that doctors should not only focus on a problem area but overall health of a patient.</p> <p>Doctors and dentists should be worried about the overall health of the patient and not just address the direct symptom or problem at hand.</p> <p>it so important to listen and treat the whole person not just the illness.</p> <p>It is best when clinicians don't rush and learn more about a patient's situation so they can treat not just the illness but provide overall help to improve their well-being.</p> <p>In the second scenario (Scenario 1B), my impression was that the interactions between the physician and patient were very comprehensive,</p> <p>. The physician asked the patient more questions that I feel encompassed every aspect of her health.</p>
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	<p>I admire when a medical professional is invested in all aspects of my health and well-being.</p> <p>As a medical professional, I think it's always important to ask about the patient's overall health and well-being.</p> <p>The doctor in scenario 1B really took the time to communicate with the patient and overall to help the patient with the other health factors in her situation.</p> <p>I appreciate that clinician in encounter #2 took into account all other factors that affect her well-being</p> <p>It is also evident that in scenario two, the clinician was interested in helping the patient's overall health, and not just focusing on their chief concern.</p> <p>. Not only did the second clinician focus on the patient's overall well-being, ...</p> <p>clinician's interest to help with the patient's overall health in scenario #2!</p> <p>. I think that the physician cared more and was great for offering other resources to benefit the patient's overall health a</p> <p>For patient encounter #2, the doctor took into account all concerns of the patient's well-being,</p> <p>also think the second encounter was much better because the doctor was thinking about the overall health of the patient l</p> <p>The questioning in the first scenario was too vague and did not seem personalized to "who" the patient was and "how" to help not only her needs, but her child's as well.</p> <p>The doctors in patient encounter #2 not only asks questions regarding why she came in but they also ask questions about her overall care and well-being.</p> <p>...the physician wanted the best for the patient and her overall health and not just a payment from the visit.</p> <p>When interacting with a patient who is pregnant, it is important to understand how the problems and treatments will differentially impact the baby.</p> <p>the physician in scenario B seemed to genuinely care for the woman's holistic health...</p> <p>In scenario 1, the Doctor does not inquire about how the patient is feeling overall,</p>
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	<p>the physician in the first scenario seemed rushed and did not ensure the safety of the patient or her baby.</p> <p>In encounter 1, although the physician is treating the patient, they are not using their skills as a medical professional to provide for the patient as a whole. I think the second scenario shows a much more holistic approach to patient care.</p> <p>I think a good next step for the physician to take would be to contact the patient as the patient may not understand how serious their situation is which could have a big impact on the patients' health.</p> <p>This approach gives much better insight into <i>why</i> the patient has a UTI, as opposed to relying on lab results only to determine what. Given the patient's relationship to healthcare providers, though, perhaps the clinician could have been slightly less imposing on the patient and engaged in more dialogue about the importance of general health and following up.</p> <p>In Scenario 1A, the health professional does not take a holistic approach to diagnosis</p> <p>Demonstrating how her overall health will impact the baby does present a sense of urgency to the patient</p> <p>The health care provider was treating the patient on the basis of her medical condition, but the best treatment plans for any disease are formulated on the patient's own personal circumstances.</p> <p>1B shows a medical professional that is taking a larger view of the patient's well-being and is the level of care I (we) should aspire to.</p> <p>By taking care of their health needs that you are responsible for does not mean ignoring the rest, and the patient can be guided to resources and specialists that can help address some underlying issues.</p> <p>The provider in 1A did not focus on the health of a whole individual but only focused on what was the problem on the surface level. 1B provided a much more comprehensive care to the patient and looked at the patients' health at a deeper level.</p> <p>...and holistic in their approach with the patient.</p> <p>...and understood that the patient has several elements in her life that could impact her health.</p> <p>I believe the clinician in the second scenario shows a more holistic approach to interacting with the patient.</p>
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	<p>Not only did the first doctor not show much compassion and seemed to just want to diagnose quickly and move on but in doing so he/she might have missed crucial information pertaining to the overall health of the patient or the patient's wellbeing.</p> <p>However, there is no follow up with regards to the patient's overall wellbeing. The second scenario highlights a more holistic means of communication ...depicts what I believe to be how clinicians should interact with the patient, that is, a holistic approach.</p> <p>Providing care to patients should be a holistic approach.</p> <p>I strongly believe that there should be a holistic approach when treating patients.</p> <p>I also felt the second interaction showed a more holistic approach.</p> <p>I agree with the difference in a holistic approach versus a systematic singular observation to a treatment plan. Especially today with a shift in popularity towards holistic medicine, the natural and overall approach towards treatment planning is a better approach.</p> <p>taking care of the patient in all aspects (medically speaking), is what all health care providers should do,</p> <p>In the first scenario the doctor's questions were impersonal, just identified the problem, and created a treatment plan without completely understanding the needs of the patient. In the second scenario the doctor got to understand the patient, and her abilities, allowing the doctor to create a treatment plan that would improve the overall health of the mother while taking into account the health of the baby.</p> <p>he second encounter with the patient is more detailed, more involved and has a more holistic analysis of the patient and her general well-being and conditions.</p> <p>In the first scenario, aside from the general needs of the patient and over all well-being, the doctor did not find out that the patient was pregnant and that she/he should use an antibiotic that is safer for the baby.</p> <p>Not only does the clinician develop a more holistic understanding of the patient's health history,</p> <p>Physician was not only trying to treat the patient symptoms but was trying to improve their overall health so this wouldn't happen again.</p>
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	<p>I believe the second encounter is a more appropriate way of approaching a patient because a health care provider you are supposed to look for the root of the problem and try to assess and treat the patient as a whole...</p> <p>Scenario 2A, the doctor appears to be more removed from the patient and very systematic in diagnosis. The doctor simply brushes the patient off, rather than observing their cause of pain and overall health and wellness. In Scenario 2B, the doctor cares about the patient and checks in on her overall health and wellness.</p>
<p>Importance of Patient History</p>	<p>Patient Encounter 1A & 1B</p> <p>But this is no excuse to disregard important details that may alter the visit. Although the patient was prescribed medication to relieve the pain, they completely disregarded that the woman was pregnant and didn't take into consideration a safe antibiotic.</p> <p>I also thought it was strange that they seemed to disregard the fact that the patient was pregnant when prescribing the medication</p> <p>Physicians often try to rush their interactions with patients when they need to see a large number of individuals within a short amount of time. When doing this, they often miss obtaining valuable information about the patient that could be helpful for developing the best plan of treatment.</p> <p>in an ER there are usually many patients and only the problem area is looked at, diagnosed, and treated without further investigating into the patient's background.</p> <p>they [the physician] completely disregarded that the woman was pregnant.</p> <p>ER and drop in clinics often do not do as good a job with taking history and understanding some of the co-existing conditions of patients that a primary care clinician would know the patient.</p> <p>In scenario 1B, a more detailed assessment was given with more detailed patient information however regarding the patient's personal life, sexual history, lack of access to healthcare, lack of employment or residence of living</p> <p>...however the information revealed about the patient should have had the indication that the patient did not seem to prioritize her medical history beyond her primary complaint, and so a more beneficial scenario would have involved some way to make sure the patient would show up for a follow-up and get the treatment she needed, especially since her medical history indicates that she may be putting herself and her baby at risk.</p> <p>In scenario 1A, the clinician seemed like they were in a hurry and treated the patient</p>

	<p>carelessly. After the patient told them that they were pregnant, the clinician didn't ask any follow up questions regarding factors relating to the patients pregnancy that might be related to the pain during urination.</p> <p>The second encounter made me realize how important it is to ask the simple questions, because they can tell you a lot. From the first encounter, a care provider never would have known that the patient was homeless or HIV positive, which extremely important to note in that patients history...</p> <p>In this case the same antibiotic is appropriate but knowing more about her life style, encouraging prenatal care and nutrition for herself and the baby are critical.</p> <p>I changed providers and I realized how much better and comfortable I felt when I was asked more questions about my health rather than just going straight to the point.</p> <p>It is so important for a physician to ask as many questions as they can regarding a patient's health history...</p> <p>While I do think that the clinician did a god job helping treat patient 1A, it's clear that by asking more questions there is a lot of information that...</p> <p>These two scenarios show the importance of taking the time to get as much insight as possible about your patient's situation...</p> <p>The clinician in scenario 1A did not take the time to consider other important factors that may aect choosing a treatment plan for the patient.</p> <p>In encounter #1, the provider was very blunt with the patient and did not communicate eectively to obtain essential background information about the patient.</p> <p>The health care provider in encounter #1 merely realized that the patient was experiencing a UTI and prescribed the traditional treatment of antibiotics, without taking into consideration any other factors about the patient's needs or preferences.</p> <p>...and learned more about her in order to decide what treatment would be best for her. Not only did the provider in encounter #2 care about the patient's health, but also the baby's health.</p> <p>The second scenario displayed a better appointment as the doctor learned the background of the patient, explained the patient's condition, and helped to plan out a treatment plan for the patient.</p> <p>I think it is a doctor's responsibility to learn about the patient's entire set of circumstances in order to provide effective treatment.</p>
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	<p>Clinicians when they rush sometimes miss obtaining valuable information about the patient that could be helpful for developing the best plan of treatment</p> <p>The provider [in scenario 1B] asked more questions and was able to learn important factors that were effecting the patients' health.</p> <p>Scenario 1A was really brief and the provider didn't get as much information from the patient.</p> <p>it is best when clinicians don't rush and learn more about a patient's situation...</p> <p>He/she asked multiple questions to really pinpoint the problem...</p> <p>it was the doctor's responsibility to ask the patient her entire set of circumstances...</p> <p>Another point to make about situation one, is that without knowing the woman's full set of circumstances the doctor could have prescribed antibiotics that could harm the baby or could be used as a recreational drug.</p> <p>Like you mentioned, I thought it was extremely important in the second scenario for the physician to take the patient's baby into consideration.</p> <p>The physician was not only able to discover information about her medical and dental background (urine sample with UTI, HIV test, poor oral health, pregnancy) ...</p> <p>..however in Scenario 1B, the healthcare provider considered other potential factors that could be contributing to the underlying issue</p> <p>Clinicians when they rush sometimes miss obtaining valuable information about the patient that could be helpful for developing the best plan of treatment.</p> <p>The patient 2 encounter was definely more thorough and included asking about environmental factors when treating the patient, which was important.</p> <p>Patient encounter #2 was more interactive and tried following up with questions about symptoms to diagnose her. Patient encounter #1 did not consider any other factors, such as HIV, and ignored that she has had UTI with her pregnancies</p> <p>In the first scenario, the clinician failed to gather relevant background information,...</p>
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	<p>The second encounter which I would prefer was more in depth getting into detail of the patient's life</p> <p>the rst scenario seemed to demonstrate a lack of effort in diagnosing the patient and understanding their medical history.</p> <p>Because the patient is pregnant, the doctor should have asked more question revolving around that.</p> <p>The clinician should have asked more questions in regard to the patient's health history.</p> <p>The clinician in patient encounter #1 seemed to only want to treat the patient for their symptoms without asking any other questions related to the patient's past health history.</p> <p>The physician did not try to build a relationship or hear more about the patient's life and background before getting into what their complaint was. They went straight into testing and did not provide a possible means on to why they have a UTI, knowing a patient's background could be very beneficial for this in a means to stop it from occurring again.</p> <p>It also allows for the physician to know their lifestyle and when its noted they need advice on to remain healthy they can provide that for them.</p> <p>in the first interaction the doctor needed to ask more about the patient's background and lifestyle especially because she's pregnant.</p> <p>I felt as though the first encounter was too brief, the doctor should have asked some more questions about the patients' medical history.</p> <p>I do believe that physicians should ask a little more about the patient's background/circumstances.</p> <p>the physician in scenario B seemed to genuinely care for the woman's holistic health by asking more detailed questions about her symptoms and her background.</p> <p>In scenario 2, the Doctor spans all the corners of the patient's life in order to identify all contributing factors to the problem</p> <p>In both scenarios, I think the physicians should have followed up with the individual about her conditions</p> <p>Clinician 2 asked a lot more questions and was able to gather a lot more information about the patient so that the right medication could be prescribed that would not be harmful.</p>
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	<p>That writing a prescription in the first scenario without considering more of the patient's medical history could be dangerous</p> <p>The clinician in scenario B conducts a much more thorough line of questioning concerning the patient's medical history.</p> <p>...they made sure to account for the patient's history before suggesting a viable treatment option</p> <p>The patient encounter #1 displays the doctor/health care providers attempt to make a diagnosis/treatment plan on the basis of the patients' symptoms as opposed to trying to formulate a plan of action after assessing the contextual information as to which the patient was placed in these circumstances.</p> <p>The provider in 1A did not get to know the patient enough to know whether or not the patient will get the antibiotics or not, it is possible that she did</p> <p>Having conversations with patients is important to understand their state of mind, personal challenges, and root causes of the healthcare issues they are facing.</p> <p>The first scenario presents a clinician asking the patient clinically related questions to diagnose and prescribe medications</p> <p>The clinician asks questions regarding patient treatment but goes further to learn more about the patient (living situation, insurance, etc.). The clinician in the second scenario...</p> <p>Clinicians need to view their patients as humans- that includes looking at all aspects that could impact their health like income, housing or even family and social support.</p> <p>The patient encounter in the first scenario was very brief and the physician did not show any interests in having a better understanding of the patient's background. In most cases, understanding an individual's experiences/background could help with the diagnosis and prevent future complications.</p> <p>In the second scenario, the physician was very attentive and willing to ask more questions to understand the patient's medical history.</p> <p>It was definitely apparent that the clinician took a more active role in developing and addressing the patient's health history...</p> <p>Knowing the had HIV, the physician immediately took a urine sample to see if that was a possible effector.</p>
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	<p>In the first scenario, aside from the general needs of the patient and over all well-being, the doctor did not figure out that the patient was pregnant and that she/he should use an antibiotic that is safer for the baby.</p> <p>The first encounter, while effective in addressing the immediate health concern, did not help to develop the patient's health history and failed to address concerns for the pregnancy, which I thought could have been handled better.</p> <p>In Scenario 1B, the clinician elaborates on the patient's input and begins a conversation that develops a more comprehensive patient history that addresses both the patient's health and systemic problems.</p> <p>obtaining consent on getting the urine sample, asking if the patient have any known allergies prior to prescribing the antibiotics, nor bothered with prescribing antibiotics that is safe for her baby (given that he disregarded the key phrase). Scenario 1B, however, took into account the key phrase aforementioned above, followed up on it with important questions concerning her and her baby, asked her about some information in her history,</p> <p>The in the second scenario because the doctor asked questions to try and figure out the reason for the UTI it came to light that the patient needed help beyond treating the UTI,</p> <p>The first patient interaction was very brief and abrupt, not many questions were asked about the patient or their history.</p> <p>The second patient interaction was very informative. The provider asked a lot of questions that would help them diagnose the patient properly and even informed the patient about their diagnosis and came up with the proper treatment plan.</p>
<p>Recognition of Socioeconomic Factors</p>	<p>Patient Encounter 1A & 1B</p> <p>You can present a long and thorough list of problems and stress the importance of treatment to a patient, but from their point of view it's a long list of costs to their wallet. Most patients (especially those from a disadvantaged background) will choose to delay treatment until absolutely necessary in order to save themselves the cost.</p> <p>Also, money is always a big factor with treatment.</p> <p>Either a patient can't afford treatment, their insurance won't cover it or downgrades the procedure, or they just don't want to pay out-of-pocket. As a healthcare provider I want to give patients the best care available but it's hard to do so when insurance companies have a "what is the cheapest solution" mentality instead of "what is the best solution". On the up-side, dentists can't</p>

	<p>work for free. It's expensive to keep an office running and pay your staff. Definitely a balancing act.</p> <p>It can be difficult to really get across the importance of overall health especially if there is no pain or cost becomes an issue for the patient.</p> <p>The patient likely had financial trouble on their mind considering their homelessness...</p> <p>Scenario 1B also revealed that the patient did not have insurance or an alternative means of paying for treatments.</p> <p>you definitely have highlighted the problem with so many patients especially those from underserved populations. They don't have the resources or often the knowledge on how to get out of their current situation...</p> <p>I think it could either be that or possibly that the patient did not have the means to make it to the follow up appointment due to socio-economic factors.</p> <p>Many patients don't have the means to return.</p> <p>The physician was not only able to discover information about her medical and dental background (urine sample with UTI, HIV test, poor oral health, pregnancy) but also learned more about her social/economic background (homeless, arrested for drugs, no job, rst son is in foster care).</p> <p>I think that referring the patient to a social worker, an obstetrician, and a dentist was the right idea health-wise, but with no insurance and no job making those appointments at once can get overwhelming.</p> <p>Not having insurance and no job does make it overwhelming...</p> <p>since she [the patient] didn't have insurance to cover her visits.</p> <p>I know many people that are in need of treatment but getting assistance is too much for them to do without help, so they go without.</p> <p>However, I would like to add for patient encounter #2, because the patient did say she didn't have any money, the provider should have also connected her with organizations that helped homeless pregnant women, or any organizations related to her situation</p> <p>I think focusing on the patient's social-economic status, and their level of engagement is key when diagnosing patients. As we can tell the patient was probably overwhelmed as she did not return, aside from probably not being able to afford the treatments.</p>
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	<p>For example, lack of access to care and finances are some of the bigger factors but there are many more.</p> <p>I like how you touched on the part where the patient did not come to her follow up appointment, and by the doctor asking her all the introduction questions and learning about her life and lifestyle it makes more sense as to why she did not follow up.</p> <p>It could have been due to her not having insurance, a job, or place to stay</p> <p>I do think the patient was overwhelmed by the analysis provided by the Doctor and chose not to return, also due to their living situation and social economic status.</p> <p>...and is instead very quick to prescribe antibiotics without understanding what is going on in the patient's life and how she will be able to afford them.</p> <p>However, it is understandable that the patient did not return for a follow-up when considering that she is homeless and jobless which would undoubtedly make her fear the expenses associated with healthcare and make it difficult for her to keep a schedule.</p> <p>Money matters.</p> <p>The patient #2 is displaying a large array of problems in her life aside from the UTI (lost her kid, homeless, financially unstable),</p> <p>I've heard of insurance limiting amount of time that can be given for a patient,</p> <p>In patient 2, being homeless can cause a lot of unwanted health issues such as low nutrient and poor hygiene.</p> <p>Unfortunately, people who live on the streets tend to have poor hygiene due to the nonavailability of basic self-care products.</p> <p>...the patient needed help getting proper hygiene to keep herself and her future child safe. I</p>
<p>Importance of Patient-Clinician Relationship</p>	<p>Patient Encounter 1A & 1B</p> <p>...the physician in the second scenario paid much more attention beyond the patient's primary complaint...</p> <p>In scenario 1B, the clinician showed empathy to the patient...</p>

	<p>The clinician [in 1b] this time around, met the patient where they were and tried to do whatever they could to help. They showed empathy for the patient and their baby.</p> <p>I do agree that they did not do anything extra and doing more would have definitely benefited this patient homeless and pregnant person truly in need. This type of medical experience is not the type that builds trust in the profession and encourages patients to return.</p> <p>I think that these two scenarios emphasize that being a clinician goes way beyond just knowing medical facts and that a very large part of health care is also relating to people one-on-one...</p> <p>I agree that all clinicians need to be compassionate and care more even when rushed...</p> <p>It is important for the provider to build that trust with their patient.</p> <p>The provider in encounter #2 was more caring and compassionate toward the patient...</p> <p>I agree that the provider was much more compassionate in the second scenario...</p> <p>In scenario 1B the provider was able to give the patient all the information and educated him/her on what their plan could be and what the patients options were</p> <p>the health care provider in scenario 1B behaved as someone who cares for the health of the mother and unborn baby.</p> <p>The scenario in patient encounter #2 seems like the physician or whoever was tending to the patient really tried to be more personal and more thorough with the visit.</p> <p>All you can do is your best to encourage them to return and give them the best care that you can in the time you have.</p> <p>The second physician was far more thorough, trying to build a relationship with the patient.</p> <p>...the doctor still took time to offer her resources for her situation and didn't immediately choose to just prescribe the antibiotic and let the patient go.</p> <p>the doctor did their best to try to provide more resources, even though the sadly patient did not come back.</p>
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	<p>t seemed that the physician's end-goal was more than prescribing an antibiotic and sending the patient o immediately.</p> <p>I believe that this form of care shows how professional and compassionate they are. I</p> <p>I too agree that when the clinician seems to care, that makes a huge difference in the connection you feel with a provider. This can make a big difference in trust and compliance, two very important parts of a cooperative patient-clinician relationship.</p> <p>Scenario 1B they made sure if the patient was comfortable with that approach. Overall, Scenario 1B is a more ideal situation because the conversation is more patient focused and has a good balance of the patient's needs and the provider's thoughts.</p> <p>Communication is so important.</p> <p>The doctor in scenario 1B really took the time to communicate with the patient and oered to help the patient...</p> <p>You always want to try to build a trusting relationship and provide resources</p> <p>The doctor was interested in the patient and tried to help her as best as possible. She gave her great suggestions on how to take care of herself, helped her with medications, asking her to see an obstetrician and made the consultation feel warm and personal.</p> <p>the provider in encounter #2 was warmer and more personal</p> <p>In scenario two, the clinician was more inviting, and seeked relevant background information from the patient.</p> <p>but he was also welcoming, compassionate, and allowed the patient to be vulnerable in a safe place. It is important clinicians ensure their patient feels comfortable.</p> <p>and not only addressed her issues and came up with solutions, but the physician provided the patient with other resources</p> <p>I like how you pointed out that the doctor in the second encounter provided the patient with additional resources</p> <p>I think the second scenario showed how much care was put into understanding WHO the patient was, and HOW to truly help her,</p> <p>the clinician seemed more caring to the patient and wanted to help her,</p>
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	<p>I found the health care physician more caring in the second encounter. Although the patient did not return for a follow up, I do believe it is part of a physician's job to ensure their patients are living the best quality of life and to provide them with the appropriate resources when they are in need.</p> <p>The physician from the second encounter had the best intentions and I agree with you.</p> <p>You always want to try to build a trusting relationship...</p> <p>Now wit patient 2 there was way more dialog between the patient and the physician, and it allows the physician to understand why the patient might present with the current symptoms she has</p> <p>The conversation as way more personal and seemed caring compared to the first one...</p> <p>the second physician seemed to be more caring than the first when treating the patient.</p> <p>The Doctor in Patient Encounter 2 created a much more personable and comfortable setting for the patient.</p> <p>The second clinician also seemed to actually care about the patient as he/she wanted to arrange follow up appointments as well as other opportunities such as a dentist appointment that would probably be helpful for this patient. This shows how important communication with your patient is!</p> <p>I think you are making really good points about communication and directing a patient to other resources for help.</p> <p>The physician in scenario 2A was more communicative and empathetic towards the patient..</p> <p>...and also made referrals to other health care professionals that the patient would benefit from seeing.</p> <p>I also think the empathy the physician showed in scenario 2A is an underrated part of the treatment process, because it is showing the patient that you truly care about their given situation.</p> <p>Patient encounter #2 represents the health care providers attempt to understand the patient's situation by trying to reassure her that her problems can be fixed and creating a treatment plan after congregating all the necessary information she needs.</p> <p>I think that it is the job of the provider to encourage the right decision.</p>
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	<p>I B asked a lot of questions and provided good explanations to the patient...</p> <p>I believe clinicians should be compassionate...</p> <p>This eases the patient's anxiety and fosters better communication with the clinician.</p> <p>A good doctor is not necessarily one who makes the best diagnosis or cures the most patients. In the second scenario, however, the clinician was understanding, observant, respectful and understood that the patient...</p> <p>...depicts what I believe to be how clinicians should interact with the patient,</p> <p>I agree further that this is a more effective way of communicating with a patient.</p> <p>In the second scenario, the physician was very attentive...</p> <p>It was definitely apparent that the clinician took a more active role in developing and addressing the patient's health history, and the relationship developed between the patient and clinician</p> <p>In comparing both scenarios, I think that the conversation in Scenario 1B is not only more comprehensive, but it also develops a stronger foundation for maintaining continuity of care between the patient and the clinician. Despite the lack of follow-up, in my opinion, the clinician in Scenario 1B develops a more meaningful relationship with the patient and has a better understanding of the</p> <p>I truly believe a good patient-physician interaction is one of the most important parts of being a doctor.</p> <p>In Patient encounter #2 it seemed a little more personal.</p> <p>I believe the second encounter is a more appropriate way of approaching a patient because a health care provider you are supposed to look for the root of the problem and</p> <p>I think the second patient interaction was a lot more communicative than the rst.</p> <p>The doctor in the second patient interaction appears much more invested in the patient than the rst patient interaction.</p> <p>The doctor expresses much more concern and interest in B...</p>
	<p>Patient Encounter 1A & 1B</p>

<p>Improvement of Clinical/Health Outcomes</p>	<p>I think that if the physician took the time to thoroughly understand where the problem came from instead of just trying to solve it, it would have saved the patient many trips back to the doctors.</p> <p>Scenario 1B was performed better than scenario 1A,</p> <p>...to ensure they receive the best care!</p> <p>...[information] that can be learned about the patient and lead to better more practical treatment plans.</p> <p>...taking the time to get as much insight as possible about your patient's situation so that you can help them to the very best of your ability.</p> <p>The second scenario displayed a better appointment...</p> <p>[not asking patient information This can affect the improvements in clinical outcomes.</p> <p>I think that the encounter #1 could have multiple improvements to affect the clinical outcomes as in scenario 1B.</p> <p>Not only did the physician ask questions comprehensively, but he/she/they gathered information from the patient's answers and followed up with beneficial solutions (safe antibiotic for both patient and baby, obstetrician, dentist, social worker, follow up with physician).</p> <p>Also, really taking the time to explain what the patient's medical condition is can impact how they respond to follow up treatment.</p> <p>Scenario 1B they made sure if the patient was comfortable with that approach. Overall, Scenario 1B is a more ideal situation because the conversation is more patient focused and has a good balance of the patient's needs and the provider's thoughts.</p> <p>In B, the patient leaves more satisfied because there was that discussion.</p> <p>Making the patient feel comfortable and balancing the provider's thoughts and patient's desires is really important.</p> <p>Without this type of interaction, she wouldn't have told the provider about her past and current situation.</p> <p>I do agree that there was a big difference in how the care was delivered and that can have a great impact on compliance, connection, and return to the clinic for future needs.</p>
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	<p>...to ensure she lives a healthier lifestyle to mitigate future doctor visits.</p> <p>... I completely agree that it will make future visits easier and more comfortable, if the patient chooses to come back again.</p> <p>I think the physician was truly trying to help set her up with all of the resources to live a healthy life for her and her children.</p> <p>I believe scenario 2 is the better way to interact with a patient...</p> <p>I agree that communication is key to achieve the best treatment and outcome.</p> <p>From reading these two cases it was evident that the patient got substantially better care in Scenario B.</p> <p>...[Patient/doctor relationship]would definitely allow for more effective interventions should the patient return in the future.</p> <p>The second encounter with the patient is more detailed, more involved and has a more holistic analysis of the patient and her general well-being and conditions. This leads to a much more accurate, helpful and safe diagnosis for the patient.</p> <p>...to formulate a plan of care that takes into account their systemic and health issues.</p> <p>The patient in the second scenario experienced much different care than in the first scenario,</p> <p>As a result, the patient in the second interaction receives better care.</p> <p>The doctor's caring nature allows for the protection of the baby that is to be born, in helping her and a home where she can have proper nutrition and care. Therefore, he is not only protecting the patient, but also her baby.</p>
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Annex: Patient Encounter 2

Coding Categories	Coded Data
Holistic Approach to Treatment	<p>Patient Encounter 2A & 2B</p> <p>Scenario B shows the doctor is much more responsible for the overall wellbeing and health of the patient and her kid. It is important in the health</p>

	<p>eld to connect the dots of different health issues but most importantly to truly look out for the overall health of the patient.</p> <p>...and looks at the patient in a holistic manner.</p> <p>...improve her overall welfare.</p> <p>The second clinician absolutely helped in a way that felt better for the patient and their overall health moving forward.</p> <p>...due to the physician caring about her overall health and well-being.</p> <p>...the clinician didn't further their conversation relating to overall health</p> <p>In scenario 2b, I appreciate the clinician being forthright with the patient in letting them know that it's imperative for them to take their overall health more seriously.</p> <p>the clinician in 2B focused on getting the patient to a dentist, but also tackling other life issues at hand that needed to be addressed.</p> <p>...my well-being...</p> <p>...and assessing the patient as a whole, rather than an isolated issue.</p> <p>The doctor attempts to offer her his advice and multiple services but a key difference in the interaction is that he checks to see if she is willing/wants to change and take the next steps in improving her health.</p> <p>As future clinicians we must remember that we cannot assume that the patient is as enthusiastic on their overall health the way we may be.</p> <p>...this in turn encourages the patient to become a more involved stakeholder in their long-term health. In comparing both scenarios, the clinician in Scenario 2B accomplishes more in guaranteeing the long-term health of not only the patient but also the newborn,</p> <p>...2B was more thorough and seems like the physician was able to take their time treating and understanding the concerns of the patient while educating her as well.</p> <p>...emphasize the importance of taking the necessary steps to ensure an improvement in overall health.</p> <p>...her and her child's well-being not just trying to treat her concern with her toothache.</p>
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	<p>Scenario 2 leads to a much better outcome for both the patient and her child by expounding upon a previously built-up relationship and also recruiting the patient into buying into her long-term health.</p> <p>She focused on overall health and just the toothache.</p> <p>The second scenario does a much better job and reects a more holistic approach to healthcare.</p> <p>...but I think the clinician was concerned regarding the patient's and her baby's overall health...</p> <p>The patient not only has to take care of her own well-being, but also the well-being of her child.</p> <p>...how the provider in 2B opened the patient up to conversation and remembered when the last time she came in. It really shows that the provider is sympathetic and concerned about her health as an a whole.</p> <p>...which results in the treatment plan being focused on her overall health, rather than just her tooth.</p> <p>...the second scenario the provider looked at the bigger picture and considered the patient's and baby's health...</p> <p>...that it is more beneficial to ask question that investigate the patient's overall health not just her tooth ache.</p> <p>In Scenario 2B, a more global concern was applied...</p> <p>...but clearly showcased the attention at the patient's overall health and living situation rather than just the problem the patient initially came in to be examined. Having a more in-depth conversation, the practitioner was able to uncover that the patient was using drugs and was able to emphasize that the overall habits of the patient will affect their child. Clearly asking the patient if they are willing to be able to change their habits in order to help themselves AND the baby put into perspective of how important overall healthy habits are. I</p> <p>I like how you tied in encounter #2 with overall healthy habits!</p> <p>...our primary goal as future health providers are to aid the patient in long term.</p> <p>By the clinician having a short conversation with the patient, they were able to talk about finding a way to heal her whole body, not just the toothache.</p>
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	<p>...and to also get a holistic view on the patient's health.</p> <p>...for the sake of the patient's health.</p> <p>...just how much oral health is related to overall health.</p> <p>They learned that there was an important factor that could have been affecting the patient tooth and overall health.</p> <p>It is important all healthcare workers recognize how interconnected the body...</p> <p>It is essential for the physician to learn about the patient and develop a good understanding of their health, lifestyle, and well-being</p> <p>There was more of a holistic approach to treating this patient and an emphasis on preventative care.</p> <p>This provider is taking a rather holistic approach to treating this patient, as compared to the provider from 1B who is not.</p> <p>Asking a couple of questions really does help treat a patient holistically.</p> <p>...the provider in scenario 2A really didn't seem to care about treating the patient...</p> <p>In the second scenario the doctor had obtained more information about the patient and was able to holistically try to improve the health of the patient by going further than sending her to the dentist.</p> <p>I think the second physician offered a more holistic treatment by recommending a dentist as well getting help of the patient's addiction.</p> <p>...the clinician in scenario B takes a much more holistic approach in conversing with the patient...</p> <p>...for any healthcare provider getting to know the whole story rather than a discrete detail</p> <p>The second encounter shows that the clinician as chosen a more holistic approach and was trying to provide this patient with the appropriate resources that could help improve her quality of life and overall health.</p> <p>The physician in scenario 2b is more communicative with the patient and offers a holistic treatment plan that will better the lives of the patient and her baby.</p>
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	<p>I feel as though the first doctors' main goal was to just heal the immediate pain, and was not concerned with the overall wellbeing of the patient.</p> <p>In scenario B, the doctor chose a more holistic approach where he asked how the patient has been managing the pain, and above all expressed care for the patient and her child while taking affirmative action to help them.</p> <p>...because the doctor showed general interest in the patients' health.</p> <p>The doctor in the rst situation does not appear to treat the whole patient and all of her conditions. Instead, the doctor attempts to treat only the condition presented.</p> <p>just addressing the current pain, the patient is feeling without other questions to follow up or ask about her or her baby's general well-being. In scenario 2B, the doctor took the time to ask a few more question in regard to the patients general health and also her baby's.</p> <p>A doctor's job is more than just taking away the immediate pain, it is to look at the overall well-being of the patient and to facilitate further assistance if needed/implored.</p> <p>In the second scenario, the doctor definitely is thoughtful enough to care about his patient beyond the tooth ache.</p> <p>...and was able to get a better overall description of the health of the individual,</p> <p>...the doctor did more than address the toothache and refer her to a dentist. She made sure that the patient and the baby were safe.</p> <p>This conversation went beyond just addressing the appointment's chief complaint; the provider did her job to ensure that the patient's overall health and safety were addressed.</p> <p>Overall health should be the scope of clinicians.</p> <p>Scenario A: Very little patient interactions and didn't demonstrate any care for the patients overall well-being. Only accessed the problem and gave the patient an immediate solution.</p>
<p>Importance of Patient History</p>	<p>Patient Encounter 2A & 2B</p> <p>These two scenarios are a result of how a clinician initially approaches a patient with questions and getting to know the patient's background.</p> <p>In scenario 2A, the doctor didn't even try to gather more information, or try to access the situation. He relied solely on what the subjectives of the</p>

	<p>patient in proceeding with his suggestion. In scenario 2B, the clinician was more thorough in obtaining relevant information...</p> <p>Once again, we have a prime example of what NOT to do regarding scenario 2A. This encounter was an extremely short conversation with no questions besides, "what brings you in today?" There was no further investigation into the problem.</p> <p>The doctor asked further questions to delve deeper into the issue...</p> <p>...the physician in the second scenario is addressing the patient's underlying risk factors...</p> <p>...the first scenario was much too brief and gave the patient limited options and did not even reference any underlying issues the patient might have ...</p> <p>...it's imperative for the practitioner to bring up the overall patient habits and how those habits affect them and everyone else in their life.</p> <p>In Scenario 2A, again the clinician (assuming it is the same clinician as Scenario 1A) addresses the immediate health concern without establishing a comprehensive patient health history. I do not think there is anything wrong with this per se, but it does seem rather reductive. In Scenario 2B, the clinician builds upon the patient history...</p> <p>The first scenario was much too brief, the doctor didn't ask any background or follow up questions. There could be underlying medical problems that would become more apparent if the doctor asked about their medical history and personal background.</p> <p>...to open up about their personal and medical history. The doctor also did a good job in asking the right follow up questions and was able to get helpful information about the patients' medical history.</p> <p>I agree with you that the first scenario had a much too abbreviated conversation that failed to establish a relationship and background/history for the patient.</p> <p>I thought the doctor also did a great job in asking the right questions to find out more information about the patient's toothache.</p> <p>...the patient is still feeling pain and it is the responsibility of the clinician to thoroughly examine the problem and outline all possibilities that could lead to it. In scenario 2B, the clinician quickly remembers the patient, creating a more comfortable atmosphere for her. This leads to the patient admitting to continuing use of drugs for pain relief, which is essential for the clinician to know...</p>
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	<p>Those long-term components wouldn't have been possible if the physician didn't try to understand the problem and all the possibilities that led to it.</p> <p>...clinician did not ask any questions regarding the toothache. Simple questions such as where the toothache is causing pain or how long the patient has had symptoms could have been asked to identify more details about the patient's toothache. I thought the clinician in the second scenario is a lot more helpful with asking questions regarding the patient...</p> <p>The provider didn't ask anything about symptoms or the patient's other factors.</p> <p>It's so important for a physician to ask questions because sometimes the patients are uncomfortable or embarrassed about their own situation and might not want to speak on it. Having a more in-depth conversation revealed information that was extremely important for this patients situation.</p> <p>in scenario 2A the physician is concerned with the problem at hand and not the big picture. Also, the visit was very quick and important information was left out from the conversation just because the physician did not ask the patient enough questions.</p> <p>We see this in scenario 2B where the physician is invested in finding out how the patients baby is doing, when the toothache started...</p> <p>The clinician in scenario 2A missed a lot of important information about the patient just because they didn't take the time to ask a few simple questions.</p> <p>...the scenarios from Patient Encounter 1, we see the importance of asking questions to see the full picture.</p> <p>It is important for health care providers to ask questions to get to know their patients..</p> <p>He or she was trying to determine a particular reason for the change of health in the patient's mouth...</p> <p>..the doctor should have communicated directly with the dentist to explain the patient's background...</p> <p>In Scenario 2A, the physician seemed rushed and careless, because he did not take time to know the patient on a deeper level to understand what the root cause of her tooth pain and other issues maybe she may be facing.</p> <p>The provider from scenario 2B took the time to understand the dental issues and other problems the patient was facing.</p>
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	<p>...by gaining a better understanding of the issues beyond just the obvious/surface clinical presentation.</p> <p>...it is important for the clinician to dig deeper into the patient's situation to gain a better understanding of the root causes of the issue before just bouncing her to another healthcare provider.</p> <p>However, if the physician never asked about their history, they would never know.</p> <p>Also, in patient B, the physician is not only concerned with tooth pain. They are concerned with how the child is affected. The physician helped direct the patient to what is truly important in life and sacrifice drug usage for her child.</p> <p>This allows the clinician to really understand what is going wrong with a patient's life...</p> <p>By not getting to know the patient and their history, the scenario 2a physician is essentially allowing the patient to continue down a dangerous path.</p> <p>The clinician in Scenario 1 seems to be in a rush and pays no mind to ask further questions to better understand his patient's ailment.</p> <p>I think it's important to always remember that every patient is different along with their circumstances.</p> <p>I think the differences in both these scenarios displays how important it is to gather all the necessary information...</p> <p>he differences in care that the caregiver displays in scenario 2 vs scenario 1 illustrates the importance of establishing context and identifying all important sources of information before making a diagnosis on a patient.</p> <p>...the provider asked the patient further questions regarding her condition.</p> <p>The physician in the first scenario was not attentive and failed to ask for any further detail that could help the patient in the long term.</p>
<p>Recognition of Socioeconomic Factors</p>	<p>Patient Encounter 2A & 2B</p> <p>...regarding her living situation!</p> <p>I can see why you thought the doctor was a little overstepping in asking about the patient's living situation...</p>

	<p>The patient now has at least two children, both of whom may have been exposed to drugs during pregnancy and may now develop developmental problems because of them.</p> <p>Having a more in-depth conversation, the practitioner was able to uncover that the patient was using drugs and...</p> <p>...hopefully the organizations will help with the patient's money situation, too).</p> <p>...the patient was still using, and this problem is bigger than the toothache itself.</p> <p>I also think it's worth noting that at the end of scenario 2 the patient says that they want to stop using drugs</p> <p>...you pointed out that the patient said that they wanted to stop using drugs.</p> <p>The patient was using still as a pain reliever and on top of that she was pregnant.</p> <p>The provider also stresses the importance of dental care and healthy living conditions for the patient and her baby.</p> <p>...saw the importance of addressing the environmental and socioeconomic influences in the patient's life...</p> <p>It is possible the tooth pain could be drug related rather than poor oral health.</p> <p>A person who is abusing alcohol or drugs will have a hard time admitting it to a stranger.</p> <p>Urging the patient to do better with the availability of better resources, there is a better standard of care from the clinician in Scenario 2.</p> <p>The second doctor really made the patient feel comfortable and willing to take action for her and her baby's current condition...</p>
<p>Importance of Patient-Clinician Relationship</p>	<p>Patient Encounter 2A & 2B</p> <p>In Scenario 2B, the conversation was more interactive, especially with eort and sympathy from the physician.</p> <p>The physician still remembered this patient from the previous visit and the fact that she was pregnant at that time. I think it helps to remember some facts about your patients especially if they're seen regularly. I think this</p>

	<p>can lead to positive results, such as them being able to communicate with you more, feel more comfortable, and conde in you.</p> <p>It's important for the physician to communicate the importance of the patient's health and will overall lead to a better relationship with the patient.</p> <p>remembering certain characteristics about the patient helps a lot in the long run,</p> <p>it is important to remember for physicians to remember their patients. It not only makes the patient feel good</p> <p>I think it is so important for a physician to get to know their patients and make a bond with them to really get the best treatment to their patients but to also develop a trusting patient/doctor relationship.</p> <p>I think it is so important for a physician to get to know their patients and make a bond with them in order to really get the best treatment to their patients</p> <p>The doctor in the second situation approaches the patient with care...</p> <p>The clinician was very clear, got the consent from the patient for further follow up, and took control over the conversation in a way that led her to be cooperative and aware of her situation, as well as what to do to fix it. That is the kind of clinician we must strive to be...</p> <p>This discussion as seen in scenario 2 allowed the clinician to help with more than just a toothache</p> <p>It is clear that in scenario 2, a patient-provider relationship has been well established, so the clinician better understands the patient and is able to help her ...</p> <p>I think it is so important to start a dialogue with patients to really provide the most effective treatment. I also think it is very important to check in with the patient to see what they want and need; a practice that I think many doctors and even the doctor in the first scenario struggle with.</p> <p>In scenario 2B, the physician is more compassionate and caring towards the patient. The physician in scenario 2B acknowledges meeting the patient before and asks her how she is doing.</p> <p>The clinician in the second scenario definitely showed more compassion to the patient.</p>
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	<p>I think it is important a doctor shows compassion and empathy towards their patients as this will help make the patient feel more comfortable with them and be more open to their suggestions.</p> <p>I also noticed that the physician in 2B recognized the patient. I am sure that this connection was helpful in allowing the patient to trust the physician.</p> <p>Scenario 2b showed the clinician kind of breaking that fourth wall of the clinician-patient relationship and just kept it real with her, which was cool to see.</p> <p>.... seems like they care more about me...</p> <p>This scenario brings to the forefront the importance of communication in a patient/doctor relationship and the importance of checking in with the patient about what they want. Unlike the first situation, the doctor seems to approach this patient a little differently knowing that she didn't show up immediately after her first encounter with the doctor. The doctor attempts to offer her his advice and multiple services but a key difference in the interaction is that he checks to see if she is willing/wants to change and take the next steps in improving her health. I think as physicians it is easy to assume the patient wants what you want, but as shown in this situation that is not always the case.</p> <p>It is important to note that the physician mentioned her willingness moving forward because it takes effort on both sides.</p> <p>It's important for the practitioner to be able to understand the perspective of the patient and figure out what they really want.</p> <p>...scenario 2B consisted of a doctor who was truthful yet compassionate and tried to connect to his/her patient.</p> <p>With a compassionate physician, a patient is often times more receptive for treatment and open to discussing other issues that they have as well (sometimes even a little too much information).</p> <p>the patient MUST hear ALL of their options so they can choose the best route for themselves.</p> <p>I also thought it was important how you mentioned that this interaction is a 2 way street and the patient needs to want help in order to be helped and change their lifestyle.</p> <p>...and relationship with the patient that they had established in the previous visit. In addressing the root problems of the patient's situation, the clinician encourages the patient to pursue more beneficial long-term</p>
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	<p>interventions while at the same time positioning the patient to take ownership of their interventions;</p> <p>I like that you use the term "encourage" when describing the encounter between the clinician and the patient. I think it is crucial for health care providers to explain the circumstances surrounding the patient's health</p> <p>Scenario 2 allowed to physician to get to better know the patient and let her know she cared for...</p> <p>Scenario 2 leads to a much better outcome for both the patient and her child by expounding upon a previously built-up relationship and also recruiting the patient into buying into her long-term health.</p> <p>in scenario #2 showed more interest in the patient and did all she could to let the patient know that she cares for her and the child.</p> <p>In the second scenario the doctor was very empathic, which made the patient feel more comfortable...</p> <p>I agree with the doctor in the second scenario being more empathic to the patient!</p> <p>I like how the clinician in 2B acknowledged the fact that the patient has returned without making her feel guilty or any "told you so" attitude.</p> <p>The clinician in scenario 2B was clearly trying to make the patient feel as comfortable as possible</p> <p>The clinician's ability to quickly remember the patient help create a comfortable atmosphere allowing for the patient to open up more.</p> <p>Being conversational came a long way because it allowed the patient to open up about her drug use and her cry for help. This goes to show how a little ounce of care and the need to want to do more can help someone.</p> <p>I agree that sympathy is a very important role, especially in the health eld.</p> <p>...how the provider in 2B opened the patient up to conversation and remembered when the last time she came in. It really shows that the provider is sympathetic...</p> <p>Remembering the last time, a patient came in shows that the provider actually cares, and trust can be formed.</p> <p>By having a more in-depth conversation, the patient can get treated for more than just one problem and help the patient in the long run.</p>
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	<p>The provider remembered the patient's last visit and reiterated the patient needed more help than just a dentist. The fact that the provider used "we" in her statements (last lines in dialogue) will reassure the patient she is not alone and there are people to help (probably less overwhelmed than previous encounter).</p> <p>I agree with you that the use of "we" in the physician's sentences was meaningful and reassured the patient that he/she was there to help them.</p> <p>This gives the patient a sense of security that they are not alone and that there are people who are looking out for her with good intentions. Also, the fact that the physician remembered this patient from her last visit gives the patient a sense of happiness and comfort.</p> <p>By asking questions, a thorough conversation arises with great detail that can be used to aid the patient long term.</p> <p>...as future dentists to learn about the importance of building relationships with our patients. This can give us a better insight of what the patient is feeling or going through at that moment. This also helps the patient build that trust to be able to open up and be more comfortable about their health issues.</p> <p>In scenario B, the provider remembered the first patient interaction and followed up with the problems the patient was experiencing before. It is important for the provider to remember details because it makes the patient feel more comfortable and cared for.</p> <p>..visit the second physician who seemed more compassionate, personable, and wanted to actually prevent future or ongoing problems. It is important a physician is able to remember the patient in order to make the patient feel important and cared for</p> <p>In Scenario 2B, the physician recognized the patient, and asked her more questions to see how he can not only help resolve the problems she is facing...</p> <p>In scenario 2B, the health care provider spends more time talking with the patient and asks important questions, like how the patient is dealing with the pain.</p> <p>I believe every physician should have a strong relationship with their patients. Easiest way to do so is by simply getting to know them and remembering them.</p> <p>In Scenario 2B, the doctor showed compassion, made the connection that she knew her, and chose to continue asking questions even though the patient's issue was oral</p>
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	<p>he first thing I noticed in patient B is the physician's recall of the patient. A person who is abusing alcohol or drugs will have a hard time admitting it to a stranger. Therefore, having an excellent physician-patient relationship is essential. With a healthy relationship, the patient is more likely to be honest,</p> <p>Encounter 2 demonstrates a clinician who actually seems to care and wants the patient to be healthy rather than simply send her to a dentist.</p> <p>...second physician was a lot more communicative with the patient.</p> <p>This meaningful interaction may be enough for some patients to continue attending follow-up appointments...</p> <p>This may also allow the doctor to develop a trusting relationship...</p> <p>Health can be a very scary issue for many, so showing compassion as a doctor can go a long way in encouraging the patient to continue to seek treatment for their issues.</p> <p>The doctor spoke with no judgment, compassion and empathy, allowing the patient to accept the help she might need more easily and to feel comfortable</p> <p>In scenario 2, the caregiver explained interest into trying to establish the context as to why the patient was feeling such pain...</p> <p>I thought this encounter was very telling of what it means to be a compassionate doctor. The first doctor did not care or remember anything about the patient. Whereas in the second scenario, the doctor clearly showed care and interest in his patient, by even offering to help her find a safe place for her and her baby so she could be the best parent she could be. That interaction showed what a thoughtful doctor can be.</p> <p>Scenario B: The health provider was very interested in the patient. Demonstrated compassion for the patient and did all the best she could to help both the mother and baby. She went above and beyond to make sure her patient received proper care.</p> <p>As a dentist you might see this person as a healthcare provider more often than any other, so even though these issues are outside of the dentist's ability to treat, the conversation has a chance to save the patient and start the road to recovery.</p> <p>The second physician was noticeably different and also very caring, as they were able to recall important details. Additionally, the second physician was able to electively communicate to the patient and have them agree to seek help from other resources.</p>
	<p>Patient Encounter 2A & 2B</p>

<p>Improvement of Clinical/Health Outcomes</p>	<p>the physician still remembered this patient from the previous visit and the fact that she was pregnant at that time. I think it helps to remember some facts about your patients especially if they're seen regularly. I think this can lead to positive results,</p> <p>...but it also helps the physician to connect how certain aspects of the patient's life can be related to their health outcomes.</p> <p>I completely agree that such classes are extremely important because they can potentially help save many lives.</p> <p>As we can see in scenario 2B when the patient returns, because there was a discussion established between the patient and clinician from the previous visit, the clinician knows what to ask to figure out if the patient is using substances, by doing this the clinician not only helped the patient overcome the toothache by sending her to the dentist. But also helped her potentially overcome her drug addiction and live an overall better life.</p> <p>In scenario 2B, the patient is more likely to see a dentist and get the additional help she needs...</p> <p>...she is more likely to receive the best help possible not just for her toothache but also for her addiction to drugs in this case.</p> <p>with you that the patient in the second scenario is more likely to see a dentist and get additional help</p> <p>...the physician in the second scenario is addressing the patient's underlying risk factors and providing a much higher quality of care.</p> <p>I like what you said about how a physician should provide the best options for the patient is absolutely essential for a much higher quality of care.</p> <p>Scenario 2 leads to a much better outcome for both the patient and her child...</p> <p>I agree with your stand on scenario 2 because it did show a greater level of care...</p> <p>Overall, it was a pretty simple conversation but it could dramatically help the patient's outcome.</p> <p>Being conversational came a long way because it allowed the patient to open up about her drug use and her cry for help. This goes to show how a little ounce of care and the need to want to do more can help someone. In this case it came a long way and pushed things in the right direction.</p>
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	<p>It is promising that the patient has demonstrated a willingness to follow through with the clinician's suggestions (unlike the situation in Scenario 1B, where the patient refused to follow up) ...</p> <p>In addition, encounter #1 will probably have the patient coming back later...</p> <p>Lastly, because the provider mentioned those problems and suggested the patient seek help, she was more inclined to make a change...</p> <p>I would be more inclined to revisit the second physician who seemed more compassionate, personable, and wanted to prevent future or ongoing problems. It is important a physician is able to remember the patient in order to make the patient feel important and cared for, but to also develop the best solution.</p> <p>in order to provide the utmost care that is able to tackle many issues, rather than solely focusing on the problem that initially brought the patient to the office.</p> <p>I'm certain that the doctor in scenario 2B was more successful in getting the patient the help she needed because she...</p> <p>...that the more compassionate approach in 2B helped improve the patient outcome...</p> <p>... and by doing so, better their chances of treatment.</p> <p>Urging the patient to do better with the availability of better resources, there is a better standard of care from the clinician in Scenario 2.</p> <p>I think in scenario 2, the doctor does a much better job at providing care for their patient</p> <p>...leading to better outcomes and an increased compliance to attending follow-up appointments.</p> <p>...scenario 2 about how the patient may be more inclined to return for further checkups</p> <p>... offering a better course of action in treating the patient</p>
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