

ABSTRACT

Drink Your Garlic Tea and Take Your ACE Inhibitors: Mexican-American Alternative Medicine and Texas Medical School Cultural Competency Programs

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Current literature suggests that healthcare in the U.S. does not adequately address culture. This issue is important in border states such as Texas that have large populations of Spanish-speaking patients, yet Texas medical school training is insufficient for treating the growing Hispanic population. In particular, Texas medical schools are inadequately preparing students to provide culturally competent care to Hispanic patients. This lack of preparation often contributes to cultural and linguistic barriers between physicians and Hispanic patients. A physician's lack of understanding about a patient's cultural background can hinder the physician-patient relationship, thereby negatively affecting patient outcomes and adherence. Therefore, physicians should be taught common features of Hispanic cultures that impact healthcare, such as the use of complementary medicine, spiritual healing practices, undisclosed pharmaceutical use, and other cultural values pertaining to health. Through a review of sociological studies, medical school curricula, and historical records, this study argues that cultural competency holds a significant role in improving health equity for Hispanic patients. Recommendations are made for Texas medical school cultural competency programs to incorporate instruction on culture and require language components as an approach to more effectively teach students to provide culturally appropriate care.

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DRINK YOUR GARLIC TEA AND TAKE YOUR ACE INHIBITORS: MEXICAN-
AMERICAN ALTERNATIVE MEDICINE AND TEXAS MEDICAL SCHOOL
CULTURAL COMPETENCY PROGRAMS

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CHAPTER 1

The History of Alternative Medicine on the Border

Introduction

According to the Pew Research Center, the United States has experienced a significant population increase of 18.9 million, with Hispanics accounting for more than half of this growth (Krogstad, 2020). These values are astounding as a whole; however, they are localized to a population increase in three specific states: Texas (by two million), California (one and half million), and Florida (one point four million). These states accounted for 50% of the U.S Hispanic population growth according to the Pew Research Center (Krogstad, 2020). While there are unprecedented increases to the Hispanic population on the border, the resources specifically in Texas are insufficient to medically treat the individuals that are living on the border (Pillai & Artiga, 2022). As of 2021, many of the counties within the South Texas region are characterized as Health Professional Shortage Areas (HPSAs) and/or Medically Underserved Areas (MUAs) for primary care. In addition, these regions are associated with high rates of communicable diseases including tuberculosis and hepatitis as well as high rates of non-communicable diseases like cancer and diabetes (Rural Border Health). With the current shortage of physicians on the border, it is important for Texas Medical schools to teach future healthcare workers how to provide culturally competent care.

Current standards for cultural competency programs are not enough to adequately teach incoming medical students to work with patients of diverse backgrounds (Jernigan et al., 2016). While it is important for physicians to understand various cultural

backgrounds, this thesis will specifically focus on information regarding Hispanic Border culture. Within this small region, various complexities can cause barriers between patients and physicians. I will discuss multiple facets of cultural alternative medicine, such as herbal use, pharmaceutical use, and the practice of spiritually based treatments. These factors combine in creating a complex barrier in the physician-patient relationship, having negative effects on patient outcomes and patient adherence. Since various studies demonstrate how a lack of cultural competency leads to negative outcomes, there is a clear need to assess the current standards in place for cultural competency programs and how we could improve the education of Texas physicians. To conclude the thesis, I will offer recommendations on how to better the programs in Texas Medical schools.

A Brief History of Alternative Medicine Practices

Before examining the research on current alternative medicine practices, it is crucial to understand their origin. The United States–Mexico border region has a long and rich history that spans centuries. Within this region, a unique combination of traditional healing practices of indigenous communities and Mexican immigrants have blended together with modern Western medicine.

Before the colonization of North America, various Native American tribes inhabited the area along the Northern Mexico border and Southern Texas. Each tribe had their own unique culture and healing practices. The Coahuiltecan tribe were a large group that inhabited South Texas and Northeastern Mexico. They were known for their deep understanding of the local flora and fauna utilized for healing purposes. Their healing practices included the use of herbs, roots, and plants to treat various ailments. Due to

their nomadic hunter-gather nature and later colonization, many rituals were not preserved. The limited information collected on the Coahuiltecan tribe suggests that a shaman functioned among the tribe, performing religious ceremonies and healing rituals (Sheire 1971, p.3).

Like their sister tribe, the history of the Karankawa tribe is largely unknown as well. It was known to reside along the Gulf Coast of Texas, including areas near the border. The Karankawa were known for their intimate knowledge of the coastal ecosystem, according to Spanish sources. The tribe utilized medicinal plants like prickly pear cactus and yaupon holly for healing purposes. They also practiced “mitotes” which were ceremonies to thank or ask assistance of deities (Sheire, 1971). The purpose of mitotes vary; however, they were utilized with other spiritual rituals as a part of their healing traditions.

Unlike other tribes on the border, The Comanche tribe was well-known and powerful primarily for their skills as warriors. However, they also had a deep understanding of traditional healing practices. The Comanche utilized medicinal plants and had expertise in bone setting and other forms of traditional medicine. Their expertise is thoroughly documented in Newcomb (1961):

For treating injuries such as broken bones, gunshot wounds, and the like, Comanche medicine men had crude but apparently effectual techniques. They knew the use of the tourniquet, practices some surgery, and used a wide assortment of herbs and other medicines to cure other ills. Their most effective cures were probably of mild psychosomatic illnesses. (p.187)

Outside of their physical medical treatments, the Comanche also had spiritual traditions. They held various supernatural beliefs about powers being gifted to warriors

and how these powers could be used on others. “Victims of sorcerers could be anybody against whom they harbored resentment or jealousy, but their power might also be directed against innocent persons who had been pointed out in a sorcerer’s dream.” (Newcomb 1961, p.179) The types of healing practices and beliefs are still prevalent today under different terms like *huesero* for a bone setter or *mal ojo* for negative energy due to resentment or jealousy. The historical development of these practices provide background on the healing practices discussed later in the thesis.

Despite the rudimentary nature of Native American medical practices, they were effective in treating illnesses. When the Spanish first entered what is now northern Mexico and the southwestern U.S. in the mid-sixteenth century, European medicine was already undergoing hybridization of medical knowledge like the Hippocratic-Galenic theory of four humors from Muslims. The incorporation of Hippocratic’s theories in European medicine contributed to the distinct knowledge rift between European and indigenous medicine. The latter believed that the soul was detachable from the physical body. Aside from their differences, there were similarities between both groups through the use of witchcraft to bless and curse, and the use of herbal and nonorganic medicine to treat illness (Hendrickson 2014, p. 26).

Both similarities and differences played a role in the combination of European and indigenous medicine known as hybrid healing that occurred in the New World. One of the earliest examples was the interaction between the explorer Alvar Núñez Cabeza de Vaca and indigenous doctors in the New Spanish city of Culiacan. In their first interaction, Cabeza de Vaca wrote that they were faced with capture and possible death after surviving a shipwreck and wandering the desert. However, due to the condition of

Cabeza de Vaca and his men, the indigenous healers treated the explorers and went without food so that the sick could eat. The Spaniards were impressed by the effectiveness of the Native American healing practice of blowing and cauterization. According to Cabeza de Vaca's diary, this method describes an indigenous doctor making cuts on painful areas and sucking around the incisions. After the pain is "sucked" out, the wounds are cauterized by fire and then air is blown on the area where the pain was to cure the illness (Hendrickson, 2014). The Spaniards modified this practice to fit their own religious and cultural assumptions by incorporating religious healing through prayer and performing sign of the cross instead of blowing on the wound. After facing capture and the possibility of death, Cabeza de Vaca did not make a distinction between healing the Indians and the survival of his crew. Utilizing the "miraculous" indigenous cures with their religious beliefs became their lifeline in procuring necessities from their captors. The situation allowed both parties to discover resonances between their opposing beliefs on health and later contribute to the basis of hybridization, known as *mestizaje*, which signifies "the racial and ethnic mixing of Spanish and indigenous people, history, and culture" (Hendrickson, 2014).

As first demonstrated by Cabeza de Vaca's writings, various documents after the conquest of the New World mention Indian doctors.¹ These documents, consisting of travel logs, missionary journals, and medical notes, admitted to how effective indigenous healers were. Spanish "*conquistadores*," who were soldiers like Hernán Cortés, called

¹ Due to the nature and time of these documents, Native American healers are commonly referred to as Indian doctors. However, in accordance with current procedures of Native American tribe research, it is incorrect and informal to refer to this population as Indians.

them “doctors” in his writings, and he was even treated by them after being wounded in the battle of Otumba in 1520 (Treviño, 2001, p.49). Many of the Spaniards facing diseases were left to rely on Indigenous healers because of the scarcity of European doctors and surgeons. At some point in the integration of the Spaniard culture in the New World, Indian doctors were accepted and worked in hospitals. According to Treviño (2001):

These Indian doctors displayed their knowledge publicly regarding the diagnosis of illnesses. They spoke of changes in warmth and coldness, a method of understanding illness that was compatible with the Galeno-Hippocratic humoral medicine that Spanish doctors practiced. They also used medicinal plants, products, or parts of animals, and minerals in their cures that could be tested objectively. (p. 51)

Despite the role Indigenous healers had within the Spaniard community, it wasn't long until these individuals began to lose their professional legitimacy. With the increasing number of Spanish doctors arriving in New Spain and the founding of the Royal and Pontifical University in 1553, discrediting *curanderos* and the efficacy of indigenous medicine were ways to eliminate competition. Spaniard doctors like Francisco Hernández wrote a manuscript listing the principal reasons as to why a Renaissance Spanish doctor should reject indigenous doctors as physicians. Hernández focused his criticism on the fact that indigenous medicine was not the same as the teachings of European medicine which were based on the doctrines of Hippocrates and Galen (Treviño, 2001). Despite having a method that mirrored the understanding of the Galeno-Hippocratic method, Hernández's writings led to indigenous doctors being officially classified as *curanderos* despite having effective treatment and serving a large number of patients.

There are documents contending the existence of *curanderos*, acknowledging their practices with the knowledge and recognition of the local authorities. Local authorities recognized that *curanderos* were less ignorant of medicine than common citizens and preferred for people to go to them in the absence of Spanish doctors (Treviño, 2001). Indigenous doctors were tolerated in New Spain to counteract the lack of doctors who graduated from universities and to primarily treat indigenous patients and later other races. This tolerance also extended to the existence of “superstitious” practitioners, who were individuals suspected of hiding their faith in ancient gods and manipulating patients into believing their ancient gods were an important and secret aspect of their cures. It was the same tolerance of superstitious practitioners that led to the complete prohibition of folk medicine known as *curanderismo*. One of the first prosecutions against this form of medicine was of a Xochimilcan *curandera* named Ana, accused of her treatment relating to a pre-Hispanic cult. The case against Ana the *curandera* was the start of the end for indigenous medicine. While treating an Indian woman, Ana faked a healing ritual and blamed the devil “Tezcatlipoca” as the cause of the patient’s suffering (Treviño, 2001). With the Spaniards holding strong religious beliefs, the use of superstitious practices by a small number of *curanderos* was enough to cause an official ban of *curanderismo*.

The newly earned independence of New Spain, also known as Mexico, did not provide an advantage to the people who practiced *curanderismo*. In the nineteenth century, there were huge discoveries in the field of human biology. With these advancements, the field of medicine strove to establish itself in a more scientific light which also came with rigorous regulations that increased with every new discovery. The

Medical School of the Federal District and later the Consejo Superior de Salubridad (Higher Council of Health) “prohibited the practice of medicine by anyone who did not have a professional degree issued by an institution of higher learning recognized by the corresponding public authorities” (Treviño, 2001, p. 64). Nevertheless, *curanderos* continued to serve the population because of the scarcity of doctors who had graduated from school and the low concentration of doctors in large cities. Challenges like European colonialism, epidemics, and geopolitical isolation allowed a unique healing system to be created from premodern European medicine with considerable resonance from indigenous medicinal knowledge.

This new healing system grew in conjunction with the young United States. As modern medical doctors moved to Northern Mexico, so did a number of fake healers. Modern medicines were known for providing minimal relief since some methods were ineffective or actively harmful to patients with common prescriptions containing dangerous ingredients like mercury (Hendrickson, 2014). At the time, biomedical care did not provide a convincing holistic explanation of illness, nor did it deal with the socially or supernaturally caused maladies that were associated with curanderismo. For this reason, patients continued to seek *curanderos*, who offered more comforting care than the new doctors (Hendrickson, 2014). Within the growing nations of the United States and Mexico, healthcare was shaped by herbal remedies, prayer, and ritual acts.

The birth of Southwest in the United States came with the annexation of Texas in 1845 and then the integration of northern Mexico following the Mexican-American War in 1848. The Mexican population in the new region endured significant challenges stemming from their status as Spanish-speaking, predominantly Catholic, and racial

minorities. This population were now classified as foreigners by their Anglo counterparts. The newly coined Mexican-American citizens, whose identities stemmed from their cultural, religious, and healing practices, went against the social norms of the increasing Anglo-Americans settling on the border. Mexicans were excluded from the new American life as they faced various forms of discrimination for their religious beliefs, ethnic background, and healing practices (Hendrickson, 2014). With the rapid cultural and social change in the U.S. Southwest, Mexican-Americans retreated into specific cultural traditions like folk medicine and *curanderismo*. In addition, even after the development of the U.S. as a nation, these traditions are still strongly held by the Hispanic community on the border.

Alternative and Western Medicine in the United States Today

Fast forwarding to the present day, the use of cultural medicine currently receives mixed reactions among healthcare professionals. Folk medicine and Western medicine are categorized as “unofficial medicine” and “official medicine,” respectively. These labels are based on the source of authority. Scientific medicine is considered official in the U.S. because it is governed through a host of governmental bodies like the office of the Surgeon General or the AAMC that accredits medical schools. Folk traditions are not given official standings by these agencies and most lack formal authority structures on their own. However, Hufford (1997) describes folk medicine as having the “informal authority of life experience rather than the formal authority of licensure, certification, and accreditation” (p.726). This authority of life experience holds significant influence on communities like the Mexican-American population on the border who have faced racial

discrimination. Even after the Hispanic population adapted to American culture, there was still this shared understanding that they were different from their Anglo counterparts (Hendrickson, 2014). This shared identity created a cultural bubble within the border. In their own bubble, Hispanics on the border have developed a unique medical culture that combines both folk medicine and Western biomedicine.

Despite the centuries of advancement society has made, it is clear that indigenous healing practices have persisted. Healing began with the use of simple practices by Native American tribes that were later incorporated with Spanish medicine. The combination of indigenous medicine with “formal” medicine created the foundation of folk medicine that society sees today. While alternative medicine has been practiced and shared for centuries, these practices are no longer the social norm.

Through the complementary use of alternative medicine and Western medicine, there is a complex barrier between physicians and patients. Most Hispanic patients do not share their alternative medicine use with their biomedical doctors “because of distrust, uncertainty in working with physicians, or the belief that alternative medicine practice cannot possibly interfere with what the doctors may prescribe” (Yom-Tov et al., 2017). With the possibility of dangerous drug interactions or negligent folk practices, Western culture has often viewed these practices as irrational and part of superstitious occult practices (Sanchez, 2018). However, from my experience living on the Texas Border, these patients do not hide their folk medicine use out of ignorance, instead the practice provides a sense of comfort and fits within their perceived life experience. It is my recommendation that healthcare professionals develop knowledge about the use of folk medicine in minority communities to provide culturally competent care. Through the

application of culturally competent care, physician-patient relationships are better developed, which can lead to better “healthcare delivery and increased healthcare utilization among Hispanic patients” (Sanchez, 2018). Using governmental authorities or programs that emphasize individuals learning about other’s cultures and examining their own cultural identity known as cultural humility, physicians should begin learning different aspects of cultural medicine spanning from herbal use, pharmaceutical use, and spiritual practices.

The practice of healing has developed through centuries of human interaction. The Native American tribes on the Southwest border had developed their own rituals and traditions to cure the ailments they faced. Whether the conditions were spiritual or physical, the Native Americans applied their beliefs of the body and their deities to treat each other. Once the Europeans discovered the New World, healing practices changed through the spread of new diseases from both parties. By sharing prayers and rituals, the Europeans and the Indigenous tribes learned the differences between their respective traditions. Through colonization and the combination of formal and alternative medicine, a unique system of healing known as folk medicine was created. This unique system persisted throughout the United States and Mexico border, mainly because of the prejudice that Mexican-Americans faced within society and the healthcare system. Today, folk medicine is utilized by Hispanic patients as an easier alternative compared to Western medicine. This creates a complex barrier within physician-patient relationships that later influence patient outcomes. One of the biggest issues is when patients do not disclose their alternative medicine use, so it is important for physicians to be more

culturally competent so improve the cultural barrier between Hispanic patients and themselves.

Improved cultural competency in Texas physicians should result from developing better programs in Texas Medical schools. In this thesis, I will recommend a new cultural competency program covering the facets of cultural alternative medicine, such as herbal use, pharmaceutical use, and the practice of spiritually based treatments. In the next chapter, I will discuss current research of herbal use in Hispanic cultural medicine. Covering the most commonly used plants for cultural ailments, I will discuss the products' purpose, where they can be purchased, how they are prepared, and any possible risks associated with their use.

CHAPTER 2

Modern Analysis and Research on Herbal Medicine

Introduction

Native American people groups have utilized herbs and plants for medicinal purposes for centuries. This tradition managed to survive the era of colonization, and herbal medicine continues to have a significant role in non-traditional modern medicine. While these practices have been more readily accepted by Western medicine, it is important for physicians to have a strong scientific understanding about how herbs work. Various plants have been found to have pharmacological properties; however, they are not approved to be a standardized form of treatment (Mendoza et al., 2015). A handful of everyday plants that either have no scientific research proving its effectiveness or have detrimental effects that outweigh the benefits. Considering how commonly herbal medicine is used in combination with Western medicine, I will discuss the types of plants used for medicinal reasons, how they are obtained and ingested, and their effects. This information should be included in cultural competency programs to provide physicians a strong foundation in an important aspect of alternative medicine.

Remedios Caseros

There are over 1000 case examples of remedios caseros “home remedies” that are used in Mexican-American communities along the United States-Mexico border. However, remedios caseros consist of both botanical and non-botanical items. In this

chapter, I exclusively focus on botanical products that are used to treat ailments. The top ten botanical remedios caseros are depicted in Table 1, according to Trotter (1981).

Table 1

Top Ten *Remedios Caseros*

Common Name (Spanish)	Common Name (English)
Manzanilla	Chamomile
Savila	Aloe vera
Ruda	Rue
Yerba aniz	Anise
Yerba buena	Mint
Estafiate	Wormwood/Mugwort
Hojas de Naranja	Orange tree leaves
Albacar	Sweet basil
Oregano	Oregano
Ajo	Garlic
Pelos de elote	Corn silks
Canela	Cinnamon

Note: Adapted from *Folk Remedies as Indicators of Common Illnesses: Examples from the United States-Mexico Border*, by R. Trotter, 1981, pg. 210-213.

While there is variability between sources on the most commonly used plants, studies agree that chamomile is used most often. With the scientific name of *Matricaria chamomilla*, chamomile was originally used to cure colic in infants, but it does have other uses. Secondary uses include “soothing various types of upset stomach like nausea or cramps, treating mild infections of the throat and vagina, and is occasionally used to treat *susto* (fright or soul loss) [a folk illness of magical origin covered later]” (Trotter 1981, p. 212). Usually, chamomile is prepared as a tea and taken when needed. It can be purchased from any local grocery store in the U.S or Mexico. Most patients (83%) learn

about chamomile tea from their family members (Rivera et al., 2002). While there are no known side effects of taking chamomile tea, there are possible drug interactions as it may increase the risk of bleeding when taken with blood thinners. Despite this possible interaction, 69% of patients in a case sample admitted to not informing their physician about their use of an herbal product like chamomile. Considering how easy it is to fall into the fallacy that something is harmless because there are no negative side effects, it is important for physicians to always investigate any possible use of herbal medicine.

The second most common plant used is Aloe vera (scientific name, *Aloe barbadensis*), known for having the widest variety of uses. Reported uses include treating burns, cuts, skin sores, acne, infected wounds, ulcers, arthritis, diabetes, balding, constipation, and diarrhea. Aloe's most effective use, however, is the treatment of burns and ulcers. Aloe vera can be purchased and used in various forms. Whether directly collected from the plant or brought in a gel form, aloe vera is usually applied topically to treat various skin conditions. For other ailments, aloe vera can be ingested in a capsule or liquid form. Possible side effects include skin irritation, hives, cramping, and diarrhea. There are potential drug interactions with diabetes and heart medications, laxatives, steroids, and licorice root.

The third most used herb is Rue (*Ruta graveolens*), commonly used to cure earaches. The herb is ground, steeped in hot oil, soaked a cotton ball with the liquid, and placed it in the ear. In addition, the plant has been shown to treat upset stomach, induce menstruation, and reduce afterbirth pain for mothers. According to Abebe (2021), however, "the toxicity of the cholepension which is extracted from the herb, led to organ failure and death in rats before any meaningful infertility result was achieved" (p. 32082).

With a high risk of side effects, Rue also has the potential to interact with other drugs that increase sensitivity to sunlight.

The plant *Yerba Buena*, also known as mint (*Mentha spicata*), has been identified to cure a variety of ailments. These conditions range from colic, upset stomach, intestinal parasites, and colds, to menstrual cramps. Mint can be obtained from any grocery store in various forms. It can be ingested as a tea, sniffed, applied as an essential oil, or even decocted into a liquor. Despite mint's effectiveness, studies have shown that even safe doses raised liver activity in rats. This rise in liver activity stems from "pulegone and menthone [which] are the major harmful compounds present in the plant" (Mikaili et al., 2013). Experts suggest over-drying or cooking the plant before consuming it in order to decrease the number of compounds in the plant overall. In addition, there are possible drug interactions between drugs that induce P450 enzymes and mint.

The plant known with various names like wormwood, mugwort, *agenjo*, or *estafiate* has various purposes. Classified to treat stomach illnesses, it is primarily used for gas, nausea, diarrhea, colic, and stomach aches. Most of the time, this herb can be procured from a local herbalist or from plants that are growing outdoors. It is usually prepared as a bitter tea to "stimulate the digestive system and improve the appetite" (Torres & Sawyer, 2014). It can also be combined with other herbs in a bath to relieve arthritis or skin rashes. Fewer studies suggest that wormwood can be used to treat liver disorders or gallbladder illness. Due to the lack of active compounds, this plant has no measured level of toxicity other than possible skin irritation. Patients with nervous disorders and women who are pregnant, or lactating should avoid ingesting this plant (Stuart, n.d.).

Various remedies utilize every part of the plant, ranging from the root to the fruit it produces. For example, the bitter orange plant, also known as *Citrus aurantium*, can be obtained from any local grocery store or fruit market. A tea can be made from the leaves of the orange, making a general tonic and calming agent. The tea helps “aid digestion, cure insomnia, and even alleviate heart palpitations” (Torres & Sawyer, 2014). A more potent version of this tea—utilizing the peel and flowers—is used to calm nerves and combat insomnia. However, too much of this tea can have a toxic effect on the patient. In addition, another form of tea made from the bark of the bitter orange tree can be taken for several days to stimulate the appetite. Fortunately, data demonstrate that the use of bitter orange extract is safe for consumption (Stohs & Preuss, 2010). There are no known drug interactions with bitter orange extract; however, it is always recommended to talk to a healthcare provider before using this plant.

Some remedies are directly based on herbs themselves, such as oregano (*Monarda menthaefolia*). This herb is described as beneficial for the “treatment of colds, flu, and their symptoms. The ailments treated ... were coughs, sore throat, [and] congestion ...” (Trotter, 1981, p. 213). Using the dried leaves and heads of the flower to brew a tea would induce perspiration and loosen phlegm. Oregano could also be used as a gargle to soothe a sore throat or as a treatment for patients with bronchitis (Torres & Sawyer, 2014). An additional benefit of oregano tea is to regulate menstruation and relieve premenstrual pain and cramps. Obtaining oregano is not difficult since it can be purchased at any local grocery store or from an herbalist. While oregano oil or extract is tolerated well in lower doses, there are various side effects of higher doses. Side effects range from “abdominal discomfort, heartburn, constipation, or diarrhea, nausea and

vomiting, dizziness, and headache” (NIH, 2023). Due to the range in dosage, the use of oregano is not recommended during pregnancy or in women of reproductive age not using effective contraception.

The final top-ten remedy used by Mexican-Americans is garlic (*Allium sativum*), one of the most revered medicinal plants known for its effectiveness against multiple illnesses. By peeling a clove of garlic, roasting it, or wrapping it in cotton, one can place it in the ear to cure an earache. When garlic is crushed and mixed with olive oil, it can be used as a salve for burns and abrasions. Garlic has also been used to create a cough syrup for patients with asthma or coughing spells. The cough syrup is made with three to four cloves of garlic soaked in a pint of brandy, removed from light for two weeks, and later strained. Garlic can also be made into a tea used to treat stomach ulcers, liver, and kidney disorders. Due to garlic’s antibacterial and anti-inflammatory properties, records illustrate the herb being “mashed and mixed with honey or milk . . . and then applied to wounds” (Torres & Sawyer, 2014).

It is astounding how these treatments have been utilized throughout time without a clear understanding of why garlic is effective in its various forms. Aside from the practices that do not have scientific evidence, there has been research on garlic’s effect on high blood lipid levels and high blood pressure. According to the National Center for Complementary and Integrative Health, results suggest that garlic may reduce total cholesterol and low-density lipoprotein (LDL) cholesterol levels in people (NIH, 2020). However, garlic’s effect is minimal and usually takes more than eight weeks before any improvement. Overall, garlic is usually safe for most individuals in the amount found in food. Some side effects include breath and body odor, heartburn, and an upset stomach.

Despite garlic's effectiveness, there are possible drug interactions if taken as a supplement or other ingestible forms. Utilizing this herb can increase the risk of bleeding and may interfere with the effectiveness of some drugs that are used to treat HIV infection. For this reason, it is important to communicate with one's healthcare provider about any potential or current use of garlic supplements.

While various *remedios caseros* are utilized for physical symptomatic illnesses, some are utilized in spiritual practices. One example is sweet basil (*Ocimum basilicum*), whose most common use is the treatment of *susto*. According to Trotter (1981), the herb is used for "warding off evil spirits, using in part of a ritual called a barrida (a sweeping or cleansing) ... [also] has secondary uses as a treatment for insomnia and mild infections" (p.213). Sweet basil can be purchased at any grocery store. However, the herb is used differently from other remedies in that it is not physically applied or ingested. Instead, it is usually bundled with other aromatic herbs, and "swept" over the afflicted patient. There are no "official" side effects of using sweet basil since it's not ingested by the patient. A possible complication could be an asthma attack if the herb is burned or [the patient is] allergic to the plant. The use of herbal medicine for spiritual treatments goes all the way back to early Native American practices. While the use of sweet basil does not pose a serious medical complication, physicians should still be aware of these uses to gain a cultural understanding of spiritual illnesses that play a part in alternative medicine on the border.

All of the plants and herbs listed above overlap to treat difficult ailments, and they also share one similarity: they can all be obtained from a grocery store. It is understandable why these *remedios caseros* are easily practiced since most people can

easily stop by a grocery store. However, not all plants and herbs are alike, as there are certain remedies that can only be purchased from street markets, *curanderos* (folk healers), or *yerbalistas* (herbalists). An example of such markets is the Sonora Market, known as “one of the most important places in Mexico City for selling and buying medicinal plants, this market has sales of about 160 tons per month” (Mendoza, et al., 2015). Within the Sonora Market, a study was conducted on ten plants known for their antioxidant properties that cured and prevented illnesses. From the collected sample, three of the plants will be discussed in this section due to their prevalence.

First, the plant *Cáscara sagrada* (Bearberry, or *Frangula purshiana*) this plant was assessed to have aflatoxins and glycosides associated with it. These characteristics allow the plant to act as a laxative, which is why bearberry is usually only recommended for treating habitual constipation and indigestion (Mendoza, et al., 2015). The product is sold in various ways including oral tablets, capsules, syrup, or tea. The use of *cáscara* is recommended in low doses for a limited period to minimize the side effects of stomach cramping and diarrhea. However, with long term use of high doses, there have been several cases that present with apparent liver injuries (NIH, 2017). With the small number of cases available, current research suggests that liver injury can be reversed when the laxative is stopped. There are certain restrictions in place when utilizing *cáscara sagrada*. It is not recommended for individuals with a history of chronic intestinal problems or if they are pregnant or breastfeeding.

Gobernadora (*Larrea tridentata*) is called “creosote bush” as a plant and *chaparral* as a medicinal herb. Studies on its toxicity and antioxidant properties show that it contains nordihydroguaiaretic acid (NDGA), which is reported to possess

antioxidant/free-radical scavenging properties (Ulbricht et al., 2003). *Chaparral* is most used to treat kidney stones, diabetes, blood pressure issues, and even foot infections. The leaves are used to make a tea, or they are crushed and applied externally to disinfect wounds. Despite having antioxidant properties, the use of *gobernadora* has been associated with cases of hepatitis, cirrhosis, liver failure, renal cysts, and renal cell carcinoma (Ulbricht et al., 2003). These adverse effects lead the Federal Drug and Food Administration (FDA) to remove the plant from its “generally recognized as safe” (GRAS) list in 1970. There are also various possible drug interactions, for example with anticoagulants, since NDGA lowers platelet aggregation. Another interaction is with nephrotoxic medications since the plant is correlated with inducing renal toxicity, renal cell carcinoma, and renal cystic disease. Hepatotoxic medications combined with *chaparral* are known to induce liver injury. It is clear that despite the positive properties’ *chaparral* has, it should not be utilized for any condition unless approved by a healthcare professional.

With the English translation of “bitter shorty,” *chapparro amargo* is a thorny shrub found in semi-arid regions of Mexico and southwestern United States. The plant has many therapeutic applications, some of which have not been proven. Due to its antioxidant properties, drinking a *chapparro amargo* tea acts as an anti-protozoal and antiviral in the treatment of dysentery and chronic diarrhea (Mendoza et al., 2015). The plant can also be made into a decoction from the branches and later applied as a wash or tincture to treat eczema and acne. However, utilizing this plant comes with precautions as there is no safety precedent for pregnant or lactating women. Studies also indicate that prolonged consumption of this supplement can reduce the number of red blood cells,

causing anemia (Stuart, n.d.). There is also a possible risk of venous congestion and inflammation of the kidneys and liver. Consequently, it is not recommended that patients with liver or kidney diseases ingest this plant.

Sharing Information: Family and Curanderos

In this chapter, various *remedios caseros* were discussed in depth about their role as medicinal plants. It is also important to understand how information about these remedies are shared. According to a study conducted the *Journal of Human Pharmacology and Drug Therapy*, the primary source for alternative medicine was relatives and friends (Rivera et al., 2002). This finding is a major factor in understanding the cultural complexity of medicine on the border since patients often follow advice from their family with little concern for scientific support for the advice. Family advice is not the only way to obtain information since *curanderos* can also be referenced for assistance. There is a difference, however, between taking advice from a family member versus advice from a *curandero*, who may have more knowledge and experience with health-related practices.

A *curandero* is a folk healer within a Latin American specifically Mexican or Mexican-American community. *Curanderos* embrace different levels of healing: material (emphasis on objects like herbs), spiritual, and mental. This chapter will focus on the material aspect of their practice. *Curanderos* can specialize in certain areas of folk medicine. For example, “[a] *yerbero* is an herbalist, [who is] able to prescribe botanical remedies.” (Torres & Sawyer, 2014, p.9). These folk healers are not difficult to find in areas with large Mexican-American populations. On the United States-Mexican border,

these individuals usually obtain herbs from their neighborhood *yerberías* (*herbal shop*). Some patients even cross into Mexico and purchase the herbs from street markets like the Sonora Market previously mentioned. Nevertheless, these figures are not certified medical professionals. Most of their information has been passed down and taught from generation to generation. This fact is important to remember when asking for advice about the use or preparation of an herb, since in the U.S., these individuals know they can be violating the law by “practicing medicine without a license.” Since *curanderos* are not licensed healthcare professionals, patients have to take on the duty of due diligence and discuss their options with a healthcare provider when considering the use of herbal supplements.

Patient Disclosure to Physicians

Nevertheless, Mexican/Mexican-American patients are aware of the stigma attached to the use of complementary and alternative medicine (CAM). Patients commonly will refrain from sharing their CAM use because they know traditional physicians will disapprove. In Rivera’s (2002) study of 547 Hispanic patients from El Paso,

only 34% of [the] sample reported disclosing their use of CAM providers to their physicians, whereas 44% of our sample reported disclosing the use of nutritional or commercial products... the disclosure rates were lowest for herbal and home remedies, with only 31% of [the] sample disclosing the information to their physicians. (p. 263)

When analyzing the rates of patients disclosing CAM use with their physicians, there is clearly a barrier in place. Patients do not feel like they can talk to their

physicians, and it is causing serious health issues (Rivera, 2002). For example, within the same study, 268 patients were taking herbal products that could interact with other drugs, 98 patients were taking a potentially dangerous herbal product, and 12 of 50 surgical patients were taking products that could cause negative post-surgical outcomes. Patients are not aware that some medications cannot be replaced or supplemented by alternative medicine because they often are not communicating with their providers. Bercaw's (2010) studied the use of herbs, vitamins, over-the-counter, and prescription medications among pregnant Hispanic women and physician-patient communication. Fifty-nine percent of the participants utilized herbs and vitamins to improve their general health and energy levels (pp. 213-214). However, only one in five women believed that herbs and vitamins were better at treating medical problems than prescription medication. Additionally, one-third of the women had not disclosed information about their supplement use to their providers. These results demonstrate that at least within this population of pregnant Hispanic women, the use of herbal medicine is not a replacement for conventional medicine.

The practice of conventional and alternative medicine is growing; however, it cannot replace the scientific basis of biomedicine. Studies like Bercaw's (2010) demonstrate how patients understand that alternative practices cannot treat everything. Nevertheless, Hispanic patients still prefer the use of herbal medicine for various reasons. Due to language, cultural, and financial barriers, patients are opting to self-medicate themselves which can lead to more severe conditions. Consequently, healthcare providers must increase their knowledge of CAM and the scientific evidence associated to bridge the barriers between Hispanic patients and providers.

CHAPTER 3

Explanation of Spiritual Healing Practices

Introduction

Folk medicine is a mixture of traditional healing practices and beliefs that incorporate herbal medicine, manual therapies, and spirituality to diagnose, treat, or prevent an ailment or illness (National Center for Farmworker Health, 2018). The previous chapter described how herbal medicine was used to treat a variety of physical somatic illnesses; however, there was a case where a plant was used to treat a spiritual illness. Various attributes can contribute to the development of illnesses. According to Vaughn et al. (2009), some attributes are “factors within individuals themselves (e.g., bad habits), factors within the natural environment (e.g., pollution and germs), factors associated with others or the social world (e.g., interpersonal stress); and supernatural factors like God, destiny, and other indigenous beliefs.” These four attributes play a role in how individuals perceive illness, but there are differences in how ethnic groups choose to emphasize the four attributes. Ethnic minority groups rate supernatural beliefs as significantly more important than their Anglo-American counterparts (Vaughn et al., 2009). These supernatural beliefs vary between cultures, with each individual culture developing its own system. Spiritual illnesses within the Hispanic community are unique illnesses known as culture-bound syndromes. Cultural-bound syndromes are physical and mental illnesses that are particular to a culture and are influenced directly by the cultural belief system and other factors (Vaughn et al., 2009). These spiritual illnesses are understood within the culture and are not commonly shared with outsiders because of

superstition and judgment. This exclusive aspect of Hispanic folk medicine is an important facet in treating Hispanic patients as some treatments have been known to be harmful. The spiritual aspect in folk medicine should be considered an important factor in how physicians should treat Hispanic patients.

Traditional Healers

Spiritual illnesses cannot be cured by allopathic medicine or by conventional healthcare professionals. This context is where folk medicine is practiced, with *curanderos/as* driving the tradition as healers. Mentioned in the previous chapter, healers fall into three levels of practice: material use, spiritual practices, and mental practices. Healers that utilize materials in their healing rituals, like candles and herbs, are characterized in the material level of practice. The spiritual level of healing focuses on supernatural aspects of health, with individuals like mediums communicating with spiritual figures to cure ailments. The last level of practice emphasizes the mental aspect of health. Individuals like psychic healers work to improve conditions that could be caused by a patient's mental state.

Within *curanderismo*, levels can be emphasized or excluded within specialized areas of care. These specialties include: (1) a *yerbero*, who is an herbalist, able to prescribe botanical remedies, (2) a *partera*, or midwife, and (3) a *sobador* or *sobadora*, who is a masseur or masseuse (Torres & Sawyer, 2014). While most of these figures interact with various levels of *curanderismo*, some practices only emphasize single levels. For example, *señoras* read cards to foretell the future or reveal the influence of the past which emphasizes the mental/psychic level as it addresses situations that have an

effect a patient's health. *Espiritistas* (mediums) on the other hand work, only within the spiritual level, focusing on interaction with supernatural entities or energy as a form of treatment.

Believing in *curanderismo* borders between a religious belief and belief in the supernatural. The belief that all healing power comes from God categorizes *curanderismo* as a religious belief. On the other hand, the idea that certain rituals or practices can be used to control certain outcomes or change outside forces is considered a supernatural belief. *Curanderismo* is often categorized as both because it is a blend of indigenous Mexican healing practices, Catholicism, and folk beliefs. These factors are combined to create a belief that:

... all healing powers come from God makes it religious, as does the very prevalent idea that a curandero can only bring God's will. The belief that certain rituals or practices can effect a certain outcomes, is however, a belief in the supernatural- that is, a belief that outside forces can be changes, controlled. In this way, curanderismo partakes of both the religious and the supernatural (Torres & Sawyer 2014, p.10)

Since this form of healing combines various beliefs, becoming a *curandero* is not the same as becoming a physician. Often, individuals become healers once they recognize their God-given gift known as a *don*. Other times, some undergo long apprenticeships with current *curanderos* to inherit the knowledge (Torres & Sawyer, 2014). A common choice that curanderos make is to renounce their steady jobs to continue their study as healers. Whether it is a gift or a chosen apprenticeship, there is a standard that separates real curanderos from other individuals practicing folk medicine. This standard is based on the amount of time spent on healing and their expertise on the matter. While most

cities, or *barrios* “neighborhoods,” have someone to recommend teas or other herbal remedies for small ailments, *curanderos* handle more serious cases. These figures also do not have other jobs since healing is their primary livelihood. Another standard considered for their authenticity was whether the person charged for their services. In the past, a true *curandero* would take what was offered, even refusing payments offered by the very poor. However, this standard is not as common since some modern *curanderos* charge hourly rates.

Curanderismo thrives in Mexican and Mexican-American neighborhoods for various reasons. Hispanic patients prefer to circumvent conventional Western medicine because of the nature of *curanderismo*. *Curanderos* do not require patients to fill out complicated forms nor schedule appointments. Patients do not have to worry about any language barriers nor the impending costs since *curanderos* usually speak Spanish and charge small amounts for their services. Of equal importance, *curanderos* also treat ailments that are not recognized by formal medical practices. These ailments are known to incorporate the effects of emotions on health, for example, considering the physical manifestation of feelings like anger, sorrow, jealousy, and fear (Torres & Sawyer, 2014).

Traditional Ailments

Patients present different types of ailments. The most common ailments are *mal (de) ojo*, *susto*, *caída de mollera*, and *empacho* (defined below); however, other conditions are also often found in Mexico, as shown in Table 2.

Table 2

Folk Illnesses

Common Spanish Name	English Translation
<i>Mal (de) ojo</i>	Evil Eye
<i>Susto</i>	Magical fright
<i>Caída de mollera</i>	Fallen fontanelle
<i>Empacho</i>	Stomach Blockage
<i>Mal aire / aire</i>	Respiratory infection
<i>Espanto</i>	Serious loss of spirit
<i>Envidia, maleficio, brujería</i>	Witchcraft

Note: Adapted from *Healing with Herbs and Rituals*, by E. Torres & T. Sawyer, 2014, pg. 13-15.

These ailments and their causes vary from region to region, but the definitions below have been reported extensively. *Mal (de) ojo*, also known as Evil Eye, stems from excessive admiration, usually inflicted on individuals that are too weak to absorb it. Victims are usually babies, but animals can contract *ojo* as well. The symptoms are similar to colic, including “irritability, drooping eyes, fever, headache, and vomiting” (Torres & Sawyer, 2014). The ailment is usually prevented by having the victim wear a charm called an *ojo de venado*, an adorned seed resembling a deer eye. Other preventative measures include having a child wear their underwear inside out or wearing a red yarn bracelet with an image of the Virgin Mary attached (Risser & Mazur, 1995). If an admirer were to inflict *ojo* on someone, it can be counteracted by touching the admired person, animal, or object. It is important to understand that this condition does not result

from malice. Instead, individuals project part of themselves when they admire others, which can unknowingly cause the illness if the victim cannot handle the admiration.

Susto is translated as “loss of spirit or loss of soul.” It can easily be confused for shock, which is a life-threatening medical condition. In a general sense, it is known as fright or a magical fright that causes the spirit to temporarily leave the body (Torres & Sawyer, 2014). The condition usually occurs after a frightening experience, with symptoms such as “nightmares, insomnia, diarrhea, fever, loss of appetite, and the desire to not be left alone” (Risser & Mazur, 1995). The condition can affect anyone since receiving bad news, or even having a bad scare, can cause *susto*. In more severe cases, *susto* transforms into *espanto*, characterized by extreme fright due to supernatural causes that cause the soul to separate from one’s body (Lopez, 2005). *Espanto* has similar symptoms to *susto* but can escalate to include anorexia or insomnia. Various treatments for this ailment range from praying to “cleansing or purifying” a child with an egg or the use of herbs like Rue to sweep over the child. One of the more unusual cures includes a caregiver taking a mouthful of a distilled alcoholic beverage known as *mezcal* and spraying it over the child with their mouth (Risser 1995, pg. 980). While these cures are not particularly harmful to the inflicted individual, it is important for physicians to understand the background belief system behind spiritual illnesses for Hispanic patients.

Caída de mollera is a fallen fontanelle, describing a depression in space between the bones of the skull in an infant (Torres & Sawyer, 2014). Fallen

fontanelle only affects babies, since their bones have not completely fused together, creating a space where the skull plates are not yet connected. Symptoms of this condition are irritability, diarrhea, and vomiting. The baby becomes dehydrated and exhibits the prominent feature of a depressed fontanelle. (Torres & Sawyer, 2014). The condition is thought to be caused by roughly handling the baby or pulling the baby away from the bottle or its mother's breast while nursing. *Caída de mollera* is also believed to be caused by a fall from a bed or crib. Current medical research, however, suggests that a depressed fontanelle stems from dehydration. This condition highlights the dissonance between Western medicine and folk medicine. The difference in understanding this condition leads to variance in treatment. Formal medical treatment suggests rehydration therapy to treat the dehydration and relieve the ailment. In contrast, the treatment suggested by folk tradition usually “consists of prayers and attempts to raise the depressed fontanelle by suction or by pressing up on the hard palate inside the mouth. Infants also may be held by their ankles, head-down (to raise the fontanel) and tapped on their feet or shaken” (Pachter et al., 2016). When comparing the differences in understanding and treatment between formal and alternative medicine, there is a clear discrepancy that can lead to problems in the long-term condition of the patient. Possible dangers of traditional treatments for *caída de mollera* are brain damage and even death. Conditions like a fallen fontanelle demonstrate how important it is for physicians to have a comprehensive understanding of both Hispanic folk medicine and Western medicine to prevent negative patient outcomes.

Empacho is thought to be a stomach blockage that is worse than indigestion and caused by food or concentrations of saliva that cannot be dislodged from the sides of the stomach (Lopez, 2005). Symptoms of this condition are diarrhea and a feeling of weight in the pit of the stomach, usually followed by a loss of appetite. Adults can develop the condition, but it is usually children who are afflicted. Treatment for *empacho* focuses on dislodging the blockage which is identified in the next bowel movement. The child's stomach and back are massaged with a type of oil or grease. Usually olive oil is used, but baby oil, raw eggs, minced prickly pears, a decongestant ointment (VapoRub/Vicks), and lard can be adequate replacements (Risser & Mazur, 1995). While the condition can be treated at home by parents, parents may prefer to take their child to a medical professional or even a *curandero*. While a doctor would most likely prescribe a laxative, *curanderos* have been shown to utilize different techniques to treat *empacho*. According to Campos-Carrasco (1984), a study of *curandero* practices demonstrated that 40% of folk healers stretch the vertebrae, with the belief that it would cause the foreign substance in the intestine to be released (p. 58). This practice can have negative effects on patients, considering how children are more commonly affected by this ailment.

Mal aire "also known as *aire*" is directly translated as bad air, sharing similarities with an upper respiratory infection (Torres & Sawyer, 2006). Adults and children can both develop this condition, requiring different treatments for different symptoms experienced by the two groups. In certain areas of Mexico,

mal aire is associated with the use of magical acts and supernatural powers, known as bewitching. Noticeable symptoms include “paralysis, a twisted mouth, palsy, pimples, and aching joints,” with the first two indicators consistent with a stroke (O’Neil, 2006). In this context, *mal aire* is cured with the help of a *curandero* who heals the victim by rubbing the body with herbs or performing a *limpieza*, a “cleansing” with an unbroken chicken egg. Within Hispanic communities on the Southwestern border of the U.S., *aire* is attributed to a rapid change of temperature between environments. Consequently, children develop earaches, chills, dizziness, and headaches (Torres & Sawyer, 2014). Adults are thought to develop muscle spasms and facial paralysis. Both forms of *mal aire* can be treated through medication or other forms of alternative treatments like herbs or massage (O’Neil, 2006).

Folk illnesses also incorporate conditions based on mystic beliefs like evil or *brujería* “witchcraft.” Conditions like *envidia* “envy,” *maleficio* “maleficence” result from evil-doing or revenge. These conditions are not accidentally incurred as they are brought on by an individual or by a *brujo/bruja* “witch” (Torres & Sawyer, 2006). These figures use various methods to cause harm. For example, *brujos* use rituals, incantations, potions, and even the victim’s hair or fingernail clippings to cast a spell (Graham, 2019). The act of using witchcraft against someone is often a serious act, because of the potential harm that can be inflicted. The symptoms caused by *brujería* are numerous and not only set in physical manifestations. Prolonged serious illnesses (physical and mental), bad luck in business and love, and even death are all possible

characteristics of *brujería* (Graham, 2019). Aside from death, *brujería* can be reversed with the help of a *curandero*. A folk healer's treatment of witchcraft consists of rituals, herbal remedies, potions, or counter magic depending on the illness.

A significant characteristic of spiritual healing is the idea of balance (or harmony) within the body, with imbalances resulting in illness. This health belief stems from a combination of the Hippocratic theories of humors and indigenous Mexican traditions (Lopez, 2005). Historically, physical health depended on a balance of the body's four humors: "the hot fluids of blood and yellow bile, and the cold fluids of phlegm and black bile.... Symmetry is thought to be restored through ingesting foods and herbs with opposing qualities" (Lopez, 2005). While the understanding of humors was soon left behind, the theory of hot/cold illnesses persisted within the Mexican communities. Today, the belief in hot/cold illness persists and is categorized as part of folk medicine. This belief can be applied to numerous situations like food, the environment, and even illnesses themselves. While the theory of hot/cold is observed in various regions, there is little agreement between regions as well as members in the same community to the categorization of which foods are hot or cold (Currier, 1966). Despite the disagreements, evidence proves that it is more important for a food to have a *calidad* "quality" in general, because it makes little difference in the classification of a particular substance (Currier, 1966).

Considering the differing opinions on "hot" and "cold" foods, research was collected from the opinions and practices of Zapotec Indian women near

Oaxaca, Mexico. Within this community, various foods were “cold” because of their botanical characteristics. For example, green vegetables were considered “cold” because they required a lot of water, and potatoes were classified the same way because they grow underground (Molony, 2010). Corn, on the other hand, is considered “hot” because it doesn’t require much water (Molony, 2010). Furthermore, chickens are then classified as “hot” due to their diet of corn. The interactions between nature, plants, and animals help define the qualifications of “hot” or “cold” for these products. Humans also participate in the interaction of the hot/cold theory of disease since cooking can change the classification of food. Frying foods that are “cold” converts their classification since oil/lard is considered “hot.” In addition to food, experiencing a rapid change in environmental temperature can also cause an imbalance that can lead to illnesses. Conditions that stem from environmental imbalances are treated with its opposing force. For example, a hot condition like a sore throat can be resolved with drinking a cold beverage. The following tables depict some conditions classified by hot or cold changes.

Table 3

Cold Diseases

Ailment	Development
Chest Cramps	Cold air enters the chest when a person is overheated
Earache	A cold draft of air enters the ear canal
Headache	The coolness of mist or of the night air (called mal aire also)

	known as aigre in certain communities) penetrates the head
Paralysis	A part of the body is struck by mal aire
Rheumatism	Cold from some outside source lodges in the afflicted bones
Tuberculosis	Cold enters the body from water or carbonated beverages, especially when the body is overheated from work or travel

Note: In this research, respondents categorized illnesses as hot or cold. Adapted from *The Hot-Cold Syndrome and Symbolic Balance in Mexican and Spanish-American Folk Medicine*, by R. Currier, 1966, pgs. 253-254

Table 4

Hot Diseases

Ailment	How it is developed
Dysentery	Usually accompanied by bloody stool, and since blood is “hot,” it’s classified as a hot disease. Can also be caused by consuming too much hot food
Sore eyes	A person may overstrain the eyes which can overheat the organ. Alternatively, cold, wet feet can cause the body heat to rise to the head and lead to the eyes overheating
Sore Throat	Wet feet cause a sore throat by driving the body heat up to the throat
Warts and rashes	Warts and rashes are irritating, and irritation is always associated with heat and never to cold

Note: In this research, respondents categorized illnesses as hot or cold. Adapted from *The Hot-Cold Syndrome and Symbolic Balance in Mexican and Spanish-American Folk Medicine*, by R. Currier, 1966, pgs. 253-254

As previously mentioned, an understanding of spiritual healing practices and their application is an important factor to evaluate as a physician. Many ailments discussed throughout the chapter simply require patients to eat, drink, or use a specific substance to cure their condition. Other illnesses have treatments that can increase the risk of harm to a patient. It is important for healthcare professionals to understand that spiritual healing is a combination of rituals, ceremonies, and herbal remedies. Within this form of healing, *curanderos* use “symbolic objects” like crosses or pictures of saints to help channel their God-given powers. These objects are not exclusive to folk healers; the symbols are shared with other religious individuals that are not healers like priests (Torres & Sawyer, 2014). In addition, *curanderos* utilize everyday materials in their cures, like olive oil, water, or even an egg (Torres & Sawyer, 2014). Simple objects, like eggs, are combined with other components of folk medicine to form healing rituals.

An example of a healing practice is a *limpia* or *limpieza* “cleansing,” known to combine the use of herbs, symbolic objects, and prayers to have the soul return to the body naturally (Zuñiga, 2014). Usually, an egg is rubbed on the patient’s body, absorbing negative energy or pain (Zuñiga, 2014). Other forms of the ritual replace the use of the egg with branches of herbs and the use of herbal teas. However, all *limpias* require the spiritual component of prayer during the process, with *curanderos* reciting the Apostles’ creed or asking God to cure an individual. Once the cleansing and a prayer are completed, the egg is broken into a glass cup with water to interpret the results. The shape of the yolk, the color, or consistency of the egg whites, and even the smell of the egg are studied to determine if the patient has been suffering from *ojo*, has been cursed, and if the individual is cured. There is no standard for reading a *limpia* since

tinterpretations vary according to the *curandero*. For example, a diagnosis might suggest “if the white becomes solid and forms an oval (an eye-shaped ring), people believe that the patient has indeed been suffering from a case of *ojo* and that he has been cured” (Torres & Sawyer 2014, p.24). This ritual is not harmful to the patient and does not directly interfere with any medical decisions. Nevertheless, there are patients that hold this practice as sacred to their health. It is important for physicians to understand the background behind a cleansing and to develop an understanding of how to treat patients who utilize non-harmful spiritual healing without judgment.

While folk medicine has coexisted alongside Western medicine in regions with large Hispanic populations, potential challenges can arise between modern medicine and folk medicine. These ailments present with real symptoms and are attributed to spiritual/supernatural causes. Since the causes are not based on objective scientific research, the illnesses require other forms of treatment from folk healers that can pose significant risks to the patient, for example, patients suffering from *caida de la mollera* “sunken fontanelle.” Scientifically, a depressed fontanelle is a sign of dehydration and requires immediate attention (Pachter et al., 2015). Folk cures can delay the process of obtaining medical care or fatally aggravate the condition. This danger was evident in the death of a Mexican-American infant who died of complications of a subdural hematoma from a folk cure for *mollera caída* because the child was held “by the ankles with his head partially submerged in boiling water while shaking him and slapping his feet” (Risser & Mazur, 1995). Other potentially dangerous cures include the use of herbs that can interact with prescribed medical treatment. Nevertheless, not all folk remedies pose risks to Hispanic patients. Examples include *limpias* or wearing a red bracelet to prevent

a spiritual ailment. Despite not having scientific reason behind them, folk treatments are commonly performed to ease the patient's unease and discomfort while also allowing the individual to understand and participate in healthcare decisions. The ailments and cures described are not practiced among all Hispanic patients. The research in this thesis aims to focus on folk medicine on the United States-Mexico border.

In conclusion, the use of spiritual healing within the Mexican-American population along the border is held sacred for its religious background. These practices are not commonly shared with healthcare professionals because of possible judgment from their doctors. Hispanic patients already face various barriers in medicine, so it is up to healthcare providers to help overcome cultural barriers by striving to understand the use of folk medicine in the Hispanic community and learning how to safely incorporate Western medicine in a patient's treatment without disrespecting their cultural beliefs.

CHAPTER 4

The Abuse of Pharmaceutical Medication

Introduction

Medical Pluralism

Since Hispanic patients practice medical pluralism, physicians should also consider possible pharmaceutical use when creating a treatment plan. Due to low costs and easier access, Hispanic patients on the border engage in medical tourism to obtain their medications. This chapter will discuss the Mexican pharmaceutical system and how its structure allows patients to self-medicate. In addition, employees like pharmacy clerks have a major impact in a patient's healthcare decision. When patients self-medicate with medications based on their family or clerk's recommendations, there are possible risks. I next discuss the population that engages in the practice of self-medicating, why they engage in the practice, the types of medication they utilize, and any negative outcomes that resulted from their use. I investigate why Hispanic patients are choosing to self-medicate without sharing their medical history with their physicians in the U.S.

Hispanic patients combine allopathic and traditional medicine to fit their healthcare needs. As mentioned previously, there are benefits and consequences of patients practicing medical pluralism. Folk healers can be utilized to spread accurate information on healthcare treatments from a biomedical perspective while also being trained on the dangers of certain folk practices. There are also possible challenges that arise from the integration of both forms of medicine. Due to the scientific basis of

biomedicine, it is easy for allopathic physicians to overemphasize their form of treatment while also minimizing the importance of cultural beliefs and lowering the impact of folk healers within their communities (Cosminsky, 2001). Since Hispanic patients utilize medical pluralism, physicians should consider biomedicine specifically pharmaceuticals when considering treatment plans. While most patients prefer to utilize herbs or other traditional forms of healing, the use of pharmaceutical medicine among Hispanic patients is still common. The use of pharmaceutical medicine is a key factor in treating Hispanic patients, specifically because of how the medication is obtained. There is a growing issue on the United States-Mexico border, where Mexican-American residents cross the border to obtain pharmaceuticals because of its low cost and low regulation (Homedes and Ugalde, 2013).

Mexican Pharmacies

The Mexican pharmaceutical system varies greatly from its northern neighbor. Purchasing medication in Mexico is convenient since “regulators only enforce the prescription requirement for controlled substances and antibiotics” (Homedes and Ugalde, 2013). Throughout the United States-Mexico border, pharmacy chains tend to set up shop in shopping centers and in proximity of the international bridges as close as one to three blocks away (Homedes and Ugalde, 2013). The pharmacies themselves do not face many forms of regulation from the Mexican government; however, there are rules in place that do not permit physicians to practice in the pharmacy itself (Homedes and Ugalde, 2013). Despite the laws in place for physicians in pharmacies, most pharmacies have arrangements with physicians at nearby clinics. Some of these clinics are connected

to a particular pharmacy but separated through different entrances to comply with the law. Due to the convenience of walk-in clinics being paired with pharmacies, physicians can offer consultations at affordable prices. Consultations within the pharmacy are not necessarily equated to formal medical visits since patients utilize these consultations to “request a specific, self-prescribed antibiotic or other medications to treat episodes of infectious diseases” (Rivera et al., 2009). Even if physicians accurately determine the condition of the patient and prescribe the appropriate medication, patients also rely on medical advice from pharmacy clerks themselves.

Pharmacy clerks are not doctors; they are not required to have any educational prerequisites beyond completing secondary education to obtain a position as a pharmacy clerk. However, the lack of higher education does not disqualify the impact of their role on patients. Clerks are often characterized as professionals in white coats with 60% of clerks feeling like they were “well-or very well-qualified to advice clients on medications” (Homedes and Ugalde, 2013). The role of the pharmacy clerk in Mexico is inflated because they mostly work unsupervised since chemist-pharmacobiologists (QFBs) can only be present for a few hours per week in pharmacies where controlled substances are sold (Homedes and Ugalde, 2013). Despite the lack of educational background and supervision, patients respect and trust the advice of pharmacy clerks (Homedes and Ugalde, 2013). The trust shared between patients and pharmacy clerks is a significant factor in medication adherence since clerks have been shown to offer alternative products to a patient’s prescription. The clerks’ recommendations were accepted 69% of the time, demonstrating the clerks’ impact on patients’ healthcare decisions (Hormedes and Ugalde, 2013). It is crucial to acknowledge that clerks have

been known to give inadequate advice on medications for common infections (Rivera et al., 2009). Pharmacy clerks hold a substantial role in a patient's healthcare network but should not rival the recommendation from a physician. Mexican-American patients utilize the Mexican pharmaceutical system to self-medicate based on family members' experience or the suggestion of underqualified individuals like pharmacy clerks.

Medical Tourism and Self-Medication

Since patients resort to travel for medical access, physicians must reflect on the conditions that push patients to engage in medical tourism. With the current disparities of access to healthcare services on the United States-Mexico border, "travel[ing] across jurisdiction for medical care," known as medical tourism, has grown to meet the health needs of patients (Taylor, 2013). There are other influencing factors contributing to medical tourism such as "cost, insurance coverage, availability of services and public policies that allow or prohibit access to services" (Byrd and Law, 2009). The influential factors listed affect both parties on the border. Residents from both countries resort to informal healthcare options like buying medication without prescriptions, using drugs that were prescribed to friends or family members or resorting to folk healing practices (Essigmann et al, 2022). The practice of self-medicating is found in all age groups from children to senior citizens, only differing in the type of medication used to treat their conditions (Alonso-Castro et al., 2022; Balbuena et al., 2009). When Hispanic parents decide to medicate their child, they often preferred to use allopathic medicine over CAM practices to treat non-severe symptoms like fever. Most of the medications utilized were classified as over-the-counter (OTC) medications ranging from Vicks VaporRub,

acetaminophen, buscapina compositum, and nonsteroidal anti-inflammatory drugs (NSAIDs) like ibuprofen, and ambroxol (Alonso-Castro et al., 2022). While the medications themselves are not harmful on their own, there are possible risks of adverse drug interactions and overdose even with OTC medication. In the same study conducted, “27.1% of the respondents indicated that their children experienced at least one adverse drug reaction” (Alonso-Castro et al., 2022). On the other hand, Hispanic elderly patients face a different set of symptoms that require serious forms of medication. A study found that patients reported self-medicating themselves to treat muscle and joint pain, upper respiratory tract problems, and most importantly hypertension (Balbuena et al., 2009). When examining the classes of medication utilized, elderly patients used NSAIDs, antihistamines, antihypertensives and antibacterial drugs to treat their symptoms. Of the four medicine classes utilized, two-thirds of the medicines were consumed as self-medication, meaning that individuals began using them without the recommendation or prescription from a physician (Balbuena et al., 2009). Most NSAIDs and even some antihistamines can be found as OTC medicine, but the unauthorized use of antihypertensives and antibacterial drugs increases risk to patients experiencing adverse drug reactions. Self-medication is not only isolated to patient groups like children or the elderly.

In any age group, antibiotics were shown to be the most purchased drug in Mexico since they are available without a prescription (Hormedes and Ugalde, 2013). While antibiotics are not usually the first choice of treatment by patients, the illness experience plays a role in their decision. A study found that patients believed that “physician visits for a diagnosis and prescription were unnecessary” if the patient was

familiar with the symptoms and had success with antibiotic treatments previously (Grigoryan et al., 2019). Whether obtained through a pharmacy or by taking old unused medication, patients are utilizing their medical experience to treat themselves. The unregulated use of antibiotics poses a major public health risk due to the possibility of antimicrobial resistance which is a global health problem (Essigmann et al., 2022). The practice of self-medication has wide-spread effects, from causing adverse reactions in patients to posing a public health risk for the world.

Patient Disclosure

An important consideration is that patients are not disclosing their medication use with their physicians. Patients withheld information about their medication habits out of “concern about being mistreated or judged by healthcare providers” (Grigoryan et al., 2019). In a study about self-medication with corticosteroids, only 19.5% and 55.6% of patients had informed their physician at the time they started self-medicating and at their next appointment, respectively (Mesonero et al., 2021). When patients had informed their physician, only 36.4% of patients had a physician offer alternative options in case their pain got worse (Mesonero et al., 2021). Self-medicating behaviors are not isolated to pharmaceutical medication, as similar behaviors were observed with herbal and supplement use. In a study concerning pregnant Hispanic women, one-third did not inform their physician about their herb or vitamin use (Bercaw et al., 2010). Despite the lack of data available on the safety of herbal supplement use in pregnancy, 24% of obstetrician-gynecologists did not always ask their patients about alternative medication use (Bercaw et al., 2010).

Cultural Values and Medicine

To combat the fear that patients have about sharing their self-medication, health care providers should develop cultural values like *confianza* (trust), *familismo* (familism), and *respeto* (respect) to develop a better relationship with their patients. The correlation of cultural values and effective physician-patient relationships is exemplified in Erzinger’s (1991) research when the resident, Dr. Silva, exhibited *respeto* by helping the patient elaborate on her condition using encouraging body language and avoiding directive comments until the patient was done speaking. The interaction between Dr. Silva and the patient was cited as a form of supportive communication (Erzinger, 1991). The importance of cultural values is exemplified when patient “recommendations for improving health care delivery were in line with what the literature has reported about Latino cultural constructs” (Magaña, 2020).

By identifying and incorporating Latino cultural constructs in healthcare, physicians can develop a better bond with their patients to encourage communication without fear of judgement. According to Magaña (2020), there are five cultural constructs in the table below that impact the relationship between a physician and their patient.

Table 5

Latino Cultural Values and Definitions

Cultural Value	Definition
<i>Confianza</i>	“Trust” Trust and intimacy
<i>Familismo</i>	“Familism” Prioritizing a family-orientation over an individual one

<i>Personalismo</i>	“Friendliness” Making an interpersonal connection before an institutional relationship
<i>Respeto</i>	“Respect” Deferential behavior based on age, gender, and social position of interlocutor
<i>Simpatía</i>	“Kindness” Friendly/relaxed exchange over interpersonal conflict

Note. From Magaña, D. (2020). Local Voices on Health Care Communication Issues and Insights on Latino Cultural Constructs. *Hispanic Journal of Behavioral Sciences*, 42(3), 300–323. <https://doi.org/10.1177/0739986320927387>

Magaña (2020) states that “providers who take these [cultural] values into account decrease patient distress in seeking treatment and increase treatment effectiveness, while those who do not meet patients’ cultural expectations produce inferior health outcomes.” Each value can be identified in patient behavior and addressed by the physician. Hispanic patients have a deep-seated mistrust of the healthcare system for various reasons, from historical medical abuses to current healthcare disparities. When Hispanic patients were questioned on their experience within the medical system, many indicated that they often viewed providers as “not being on their side but working against them to ‘capture them’ and inflict pain or harm” (Magaña, 2020). The feeling of opposition from the healthcare system directly conflicts with the cultural value of *confianza* that contributes to patients feeling unseen and unheard. When healthcare providers take the time to learn Spanish and develop cultural competence, they can mitigate the feeling of opposition and build trust with their patients.

In addition, patients developed a mistrust of healthcare services because of poor experiences with interpreters. Patients felt that they could not trust interpreters’

competence, which contributed to the feeling of being misunderstood (Magaña, 2020). *Familismo* can play a role in alleviating negative experiences with interpreting, since patients feel that bringing family can help overcome language barriers and encourage treatment adherence (Antshel, 2002). While *familismo* can be used “as a way to mitigate patients’ negative experiences with interpreting,” family members should not be used as primary interpreters (Magaña, 2020). Using untrained interpreters in a medical setting can have detrimental effects, like the case of eighteen year old Willie Ramirez. The combination of interpretation difficulties and cultural misunderstandings resulted in Willie being left as quadriplegic for the rest of his life (Price-Wise, 2008). Considering the risk, untrained family interpreters should not be utilized in place of a formal medical translator. Family members can still be used in treating patients since having family present can offer protection or comfort in settings where patients feel vulnerable.

Personalismo stresses the importance of personal relationships over institutional one, demonstrating that significance that comes when trust is established. Body language and communication play a significant role in how *personalismo* is established between a physician and a patient. Antshel (2002) found that when non-Latino healthcare providers place themselves three feet or more away from their Latino patient, the patient perceived them as distant and disinterested. When a physician takes the time to engage in small talk and adjust their body to indicate that they are listening, the patient feels understood and is more likely to return with the same provider (Antshel, 2002). Once that relationship is established, a patient will have a sense of loyalty to their provider. For instance, if a health care provider transfers to a nearby clinic, a Hispanic patient is more likely to follow the provider. If the healthcare provider leaves the area completely, a Latino patient

may stop treatment unless the former provider establishes a new relationship between the patient and a new physician (Antshel, 2002). The development of personalismo in a physician-patient relationship can lead to better health outcomes because patients are more likely to keep their appointments.

The value of *respeto* is an important value embedded in every aspect of a Latino culture. Healthcare providers are assigned a high level of respect as authority figures because of their education and training. A way that Latinos may demonstrate *respeto* to healthcare providers is “avoiding eye contact with authority figures” (Antshel, 2002). In addition, *respeto* encourages the patient to “conform to the position ascribed by the doctor, [often deferring] to the conversational direction of the doctor” (Erzinger, 1991). The characteristic of *respeto* should also be reciprocated by the healthcare provider to their patient. Physicians can demonstrate respect to their patient by “attempting to speak several Spanish words even if the health care provider is not fluent in Spanish” (Antshel, 2002). By acknowledging the principle of *respeto* and trying to return it, providers show an appreciation of the Latino culture and encourage treatment adherence.

The last value listed is *simpatía*, which is simply defined as kindness. It is often that *simpatía* and *personalismo* are paired together because of their interacting nature with patients. Importantly, *simpatía* is a principle that is applied to both the physician and the patient. The practice of small talk and eye contact by the physician are important factors in establishing *simpatía* with patients. If a physician is rushed and does not take the time to demonstrate these social customs, the patient perceives the provider as unfriendly or rude (Magaña, 2020). For patients, *simpatía* is upheld by being agreeable, avoiding conflict, and confrontation. An example of this principle is a patient that “may

nod or shake their head during the discussion, giving the impression of comprehension, while this may or may not necessarily be the case” (Antshel, 2002). To avoid conflict or confrontation with their provider, Latino patients may be reluctant to share negative treatment side effects or failure to treatment adherence.

Each cultural value listed by Magaña (2020) can be utilized by physicians to develop rapport with their patients and later create an effective physician-patient relationship. With a relationship being formed, patients are more likely to share their self-medication use, which allows physicians to address the possible risks that arise from obtaining medication from Mexico. Self-medicating can pose serious risks for the individual themselves like aggravating their current condition or developing a more serious illness (Essigmann et al., 2022). But when a patient self-medicates without informing their physician, there is an increased risk in negative drug interactions with other medications prescribed (Alonso-Castro et al., 2022). Considering the danger of possible drug interactions, physicians should utilize Hispanic cultural values and communication skills to appropriately question patients about their medication use without sounding accusatory or disrespectful. If cultural values are violated during physician-patient interactions, the cycle of mistrust and shame from patients may be reinforced against the healthcare system.

The practice of medical tourism and self-medication among Hispanic patients can have severe consequences when not shared with their physicians. Physicians need to be aware of these practices and foster an environment of communication by developing cultural values to build physician-patient relationship. Integrating cultural values like *respeto*, *simpatía*, or *personalismo* in cultural competency programs can better equip

medical professionals to treat Hispanic patients effectively. This outcome leads to the next chapter, which covers the dangers of complex cultural barriers in medicine and identifies how the current standard of cultural competency is contributing to the cultural barriers.

CHAPTER 5

The Dangers of Complex Cultural Barriers in Medicine

Introduction

Throughout the previous chapters, I have touched on various barriers that prevent Hispanic patients from obtaining healthcare. For instance, lack of health insurance, fear of costs, and language barriers are common obstacles patients face in the healthcare system. These barriers often lead patients to resort to informal healthcare strategies like self-medicating with unauthorized prescriptions or using folk medicine instead of Western Medicine. This chapter will discuss the dangers of these cultural barriers for patients when paired with poor communication skills from healthcare providers. I will begin by assessing the current communication between physicians and Hispanic patients, which is demonstrated to have severe adverse patient outcomes. An example of a severe negative outcome is Willie Ramirez, a Hispanic teenager paralyzed for life due to linguistic and cultural miscommunications between the patient's family and the physician. Other possible consequences may not be as severe as Mr. Ramirez's case, but they can still pose a risk to patients. After identifying its importance, current forms of communication among physicians will be analyzed for their impact on patient outcomes and retention. I will then discuss the role of patients' cultural expectations and how they impact interactions with healthcare providers. By combining the influence of culture and the newly understood role of communication through updated cultural competency programs, physicians can assist in overcoming some of the cultural barriers that patients face.

Effective Communication

Various factors influence the growth of a physician-patient relationship; however, effective communication is a central clinical function in achieving the best patient outcomes and satisfaction, which is essential for effective healthcare delivery (Ha & Longnecker, 2010). By developing appropriate doctor-patient communication, patients “are more likely to be satisfied with their care, especially to share pertinent information for accurate diagnosis of their problems, follow advice, and adhere to the prescribed treatment” (Ha & Longnecker, 2010, p.39). Countless benefits derive from having good doctor-patient communication, but the question is why this barrier exists in the first place and if it affects every patient in the healthcare system.

According to Schouten and Meeuwesen (2006), culture and ethnicity are often cited as obstacles to establishing an effective doctor-patient relationship. Significant differences in doctor-patient communication stem from patients’ ethnic backgrounds (Schouten & Meeuwesen, 2006). The study identified that “doctors behave less effectively when interacting with ethnic minority patients compared to White patients. Ethnic minority patients are also less verbally expressive; they seem less assertive and affective during the medical encounter than White patients” (Schouten & Meeuwesen, 2006, p.21). Whether the difference in communication between white and ethnically non-white patients is inherent or acquired, the current form of communication poses a risk of severe adverse outcomes.

The Case of Willie Ramírez

A case that exemplifies the severity of poor doctor-patient communication is the tragic story of eighteen-year-old Willie Ramirez. After developing a headache and collapsing in front of his girlfriend's house, Willie was taken by ambulance to a South Florida hospital in a comatose state. In this state, Willie became “quadriplegic due to a misdiagnosed intracerebellar hemorrhage that continued to bleed for more than two days as he lay unconscious in the hospital” (Price-Wise, 2008). The Emergency Room (ER) and Intensive Care Unit (ICU) physicians did not request a neurology consult because they believed Willie suffered an intentional drug overdose. The misdiagnosis comes from the initial physical exam, which pointed to a drug overdose and confusion about the patient's medical history because of a misunderstanding over a simple Spanish word: *intoxicado* (Price-Wise, 2008).

Within the Cuban community, the term *intoxicado* does not hold the same meaning as its English translation of intoxicated. *Intoxicado* is used as an “all-encompassing word [to mean] that something is wrong with you because of something you ate or drank” (Price-Wise, 2008). When Willie was taken to the E.R. with his mother and his girlfriend's mother, they assumed that he had a headache due to the Wendy's burger he had earlier that day (Price-Wise, 2008). With their suspicions in mind, Concha (Willie's girlfriend's mother) made sure to share with the doctor that it was the hamburger that made him sick by emphasizing “intoxiCAted” in a thick Cuban accent (Price-Wise, 2008). Despite the language conflict, “neither the ER doctor nor the family requested a professional medical interpreter because each side believed they were communicating adequately” (Price-Wise, 2008). In addition to the miscommunication, cultural

differences could have complicated the situation since the ER doctor did not consider the role of cultural values like *respeto* “respect”, which may have influenced the family's decision not to question or contradict the physician's beliefs or treatment plan. When Willie finally got a CT scan discovering the “left intracerebellar hematoma with brain-stem compression,” it was too late to prevent the brain damage that left him quadriplegic (Price-Wise, 2008). The lawsuit against the hospital resulted in a 71-million-dollar settlement to be awarded over Willie Ramirez's life, assuming he lived to be seventy-four (Price-Wise, 2008). Even with the large settlement, there is not enough money in the world to change the fact that Willie's outcome could have been prevented.

Miscommunication Due to Cultural Barriers

Not all miscommunication between physicians and patients results in outcomes as severe as Willie's case. However, we should not discount the other possible health risks resulting from cultural barriers in medicine. Violating cultural values such as *confianza* (trust), *respeto* (respect), and others listed in the previous chapter is likely to foster a lack of trust and inadequate communication in the physician-patient relationship that may influence a patient's healthcare decisions. When patients believe that their providers are “working against them” or that they are unseen/unheard, they are less likely to follow up on healthcare recommendations, thereby producing inferior health outcomes (Magaña, 2020). Inferior health outcomes do not only depend on patient's adherence to physicians' recommendations; patients will also self-medicate with herbal remedies or unprescribed medications from Mexico without sharing their medical history with their primary healthcare provider. Previous chapters have illustrated the possible health risks of

utilizing herbal and prescription medications without a doctor's recommendation, such as aggravating the original condition or triggering other diseases. Due to strained communication between physicians and patients, patients may prefer to rely on their illness experience over the physician who may misinterpret their condition or disregard possible cultural causes of their disease (Magaña, 2020).

The consequences of poor physician-patient communication are evident through cases like Willie Ramirez and experiences that Hispanic patients share in studies like Magaña (2020). Since the outcomes above can be attributed to miscommunication in either language or culture, it is crucial to evaluate the current standard of communication by physicians and how it impacts outcomes and retention. Beginning with the physician's communicative behavior, Schouten and Meeuwesen (2006) analyzed a collection of articles that identified “significant differences in doctors' behaviors when comparing consultations with white patients and ethnic minority patients. The differences concerned doctors’ affective and instrumental verbal behavior as well as consultation length” (p.23). All the studies demonstrated that when compared to white patients, ethnic minority patients experienced “less social talk and rapport-building, [and] doctors were rated as less friendly and concerned. Patients' comments were ignored by their doctors more often” (Schouten & Meeuwesen, 2006, p. 25). The authors point out that rapport, friendliness, empathy, and respect relate to the cultural values of *personalismo*, *simpatía*, and *respeto*.

Complying with cultural values does not necessarily mean that physicians must completely change how they interact with this subset of patients. By taking the time to greet the patient and allowing them to ask questions, physicians utilize values like *respeto*

and *simpatía* to improve the patient's healthcare experience and build a foundation for effective communication (Magaña, 2020). Patients have also emphasized that “a language barrier [should] not prevent basic courtesy in the form of greetings and being respectful” (Magaña, 2020, p. 13). In fact, Hispanic patients with English-speaking providers were tolerant of “the language discordance as long as providers demonstrated respect and elicited trust (*confianza*)” (Zamudio et al., 2017, p. 381). While having more Spanish-speaking providers can help reduce misunderstandings and support healthcare communication, understanding and speaking medical Spanish is insufficient to address the linguistic barrier between physicians and patients (Magaña, 2020). Doctors must also reflect an ability to listen, understand, and encourage their patients' responses in Spanish (Erzinger, 1991).

When physicians ignore cultural values due to a lack of knowledge, a strain is placed on the doctor-patient relationship. If physicians can identify and integrate cultural values while talking to Hispanic patients, they can overcome cultural and linguistic barriers that hinder effective physician-patient communication. First, doctors must understand and fulfill their “communicative tasks” when interacting with patients (Erzinger, 1991). According to Erzinger (1991), a doctor’s four communicative tasks are to: explore symptoms, provide feedback regarding follow-up data in medical records, adequately explain to the patient while repeating information as necessary, and try to understand the patients on a personal level. The success of a medical encounter is dependent on how a doctor and patient assist each other in completing their respective communicative tasks (Erzinger, 1991).

Supportive Communication

By analyzing detailed audiotape interviews from patients in a family practice clinic, Erzinger (1991) was able to “illustrate the relationship between the cultural rules that underlie the encounter, the conversational style or manner, and the language of the participants” (p. 95). Two doctors in her study demonstrated supportive communication with their patients: Dr. Silva and Dr. Day. Dr. Silva was a resident who immigrated to the United States from Central America as a child (Erzinger, 1991). Dr. Day was a resident who is described as having passable Spanish skills and working with a fair number of Spanish-speaking patients on a regular basis (Erzinger, 1991). Dr. Silva exhibited the cultural value of *respeto* by helping the patient elaborate on her condition by using encouraging body language like nodding her head and accepting a language correction from the patient (Erzinger, 1991). In the second example, Dr. Day utilizes *respeto* and *simpatía* to encourage her patient despite the slight language barrier. By avoiding directive comments, Dr. Day allowed the patient to recount her medical history fully and only asked questions once the patient was done speaking (Erzinger, 1991). Both examples demonstrate that the emphasis on cultural values, despite Spanish proficiency, can improve doctor-patient communication.

Conflictual Communication

Within the same Erzinger (1991) article, there are examples in which physicians violate cultural values that result in conflictual communication throughout the medical encounter. The doctors who demonstrated conflictual communication were Dr. O'Neill and Dr. Forest, each with some experience with Spanish-speaking patients. Dr. O'Neill

was a resident who did not speak Spanish before residency but developed enough Spanish skills to provide regular health services for Spanish-speaking families (Erzinger, 1991). Dr. Forest was a resident who had traveled to Central America and interacted with a moderate number of Spanish-speaking patients in the practice (Erzinger, 1991). In Dr. O'Neill's patient encounter, he did not observe *respeto* since he interrupted the patient while she was describing her concerns (Erzinger, 1991). The patient was never encouraged to describe her worries, which later contributed to her resistance against Dr. O'Neill's explanation of her condition (Erzinger, 1991). Dr. O'Neill's interactions persisted with "some degree of professional intimidation." The intimidation was illustrated when the patient recognized that the doctor did not understand her use of *estornudo* (sneeze), and Dr. O'Neill responded by introducing a term *quiste* (cyst) that the patient did not know (Erzinger, 1991). With the patient trying to maintain respect and Dr. O'Neill not following suit, the rest of the encounter exhibited progressive miscommunication.

In the second example, Dr. Forest's interaction with her patient indicated neither *simpatía* nor *respeto*. At the beginning of the interaction, the patient barely provided a single-line statement before Dr. Forest interjected with a premature explanation of why she [the patient] had pain (Erzinger, 1991). In addition, Dr. Forest placed the responsibility of language instruction on the patient by only using English medical terminology and expecting the patient to assist with translation (Erzinger, 1991). The examples of conflictual communication demonstrate that knowing how to speak Spanish is not enough to bridge the cultural gap. Physicians must understand and integrate these cultural values into their interactions with Hispanic patients.

Patient Communication: Values and Goals

Building a physician-patient relationship falls on more than just the physician. Hispanic patients need to fulfill their communicative tasks and reflect on their cultural expectations to ensure a successful medical encounter. Erzinger (1991) summarizes a patient's communicative tasks as describing their concerns, clarifying information conveyed by the doctor, obtaining an adequate explanation by challenging the doctor's advice or providing additional details on their condition, and developing a personal relationship when prompted by the doctor. As doctors are encouraged to adapt cultural values to satisfy their tasks, patients are obligated to follow their cultural values even if it is in their best interest. Commonly, the patient will practice *respeto* by “deferring to physician expertise and a pragmatic view that visits are scheduled to address symptomatic problems... this common frame resulted in patients tending to defer their own questions until the end of the visit if there was time and to expect tangible solutions to symptomatic problems” (Zamudio et al., 2017, p.384). Utilizing cultural values to dictate their behavior during medical encounters, Hispanic patients cannot fulfill their communicative tasks outlined by Ezinger (1991) until physicians reciprocate the cultural value demonstrated. Lack of reciprocation from physicians result in miscommunications, poor medical encounters, and poor healthcare outcomes (Magaña, 2020). By having physicians integrate cultural values, the physician-patient relationship is promoted because Hispanic patients feel comfortable and communicate more effectively with physicians that are also participating in the practice of cultural values.

Aside from cultural values, patients utilize other cultural constructs that influence

their expectations of medical encounters. *Familismo* (familism) is a significant construct within the Hispanic community, referring to the importance of family in the culture (Antshel, 2002). The family has a considerable influence over the course and outcome of treatment as “the total family system [is considered a] supportive, integrated network; the family as a group has precedence over individual interests” (Antshel, 2002, p.439). Some characteristics of *familismo* include obedience and respect towards authority figures; helpfulness, generosity, and loyalty towards the family; and responsibility, sacrifice and hard work for the benefit of the family (Antshel, 2002). Under the description of *familismo*, there are inherent gender roles that impact the family structure and its decisions.

Machismo (masculinity) is a cultural construct that describes the beliefs and expectations regarding the role of men in society (Nuñez et al., 2016). *Machismo* is composed of positive and negative aspects of masculinity like bravery, honor, dominance, aggression, sexism, sexual prowess, and reserved emotions (Nuñez et al., 2016). An important aspect of *machismo* is the “attitudinal belief that it is appropriate for women to remain in a traditional role, encouraging male dominance over women” (Nuñez et al., 2016, p.3). *Marianismo*, the female counterpart of machismo, is a set of values and expectations concerning female gender roles (Nuñez et al., 2016). *Marianismo* emphasizes the role of women as family-centered and encouraging “passivity, self-sacrifice, and chastity” (Nuñez et al., 2016, p.3). The constructs of *machismo* and *marianismo* combined with *respeto* affect patients' expectations of their doctor, and the values play a role during the medical encounter itself. According to Zamudio et al. (2017), “many of our patients with uncontrolled diabetes, particularly the men, had the

expectation that the provider should be fully knowledgeable of what needs to be done at the visit” (p. 384). Hispanic patients will defer to a physician’s authority and place the burden on communicative tasks like asking specific questions to pinpoint the patient's concern and strategically discovering other asymptomatic problems (Erzinger, 1991). Patients become less proactive in identifying important issues, forcing the physician to drive the overall visit agenda and patients forfeiting their questions until the end of the visit (Zamudio et al., 2017). This “transactional model of care” focuses less on preventive care and ongoing chronic disease management (Zamudio et al., 2017, p. 384). Transactional medicine is described as the patient being viewed as “a consumer whose medical problem must be solved as quickly as possible instead of exploring appropriateness of care, patient values, and unexpressed patient needs” (Ruzycki et al., 2018).

Another aspect of the *familismo* construct is the woman’s responsibility for the family overall within the healthcare visit, resulting from *marianismo*. *Familismo* is often utilized to help with language barriers and also assist in decision-making (Zamudio et al., 2017). Women (figures like the mother or grandmother) are seen as the nurturers and caretakers of the family (Antshel, 2002). Despite the fact that Latino culture is rooted in patriarchy, women substantially impact the healthcare decisions for the entire family. For example, when questioned about agenda-setting during a healthcare visit, a male patient stated, “The conversations already took place with my wife and the doctor... she is the one that is in charge of everything” (Zamudio et al., 2017, p. 382). Since the woman is responsible for the management of the family’s health, it is common for a Latino man to have difficulty interacting with health care providers on behalf of their

family, and he may feel inferior if he feels that he is not fulfilling his role as the protector (Antshel, 2002). Hispanic patients make culturally informed decisions that can negatively impact the physician-patient relationship if the physician is not aware of the cultural background and perspectives behind these behaviors. Additionally, physicians should understand traditional women's roles in a healthcare encounter due to the cultural constructs provided.

Currently, cultural barriers in medicine are aggravated by a lack of appropriate cultural competency and practical communication skills from healthcare professionals. Cases like Willie Ramirez and the risk of harmful drug reactions stemming from self-medication are enough to illustrate that the current form of physician-patient communication should be more culturally informed to provide effective healthcare. Analysis of medical interactions between doctors and Hispanic patients highlights the significance of cultural values/constructs in patient interactions. When cultural values are used effectively, patients are more likely to trust their provider, even if there is language discordance. Patient expectations can also impact the success of a medical encounter since patients rely on cultural constructs and values to lead their healthcare decisions. Due to cultural values like *respeto*, patients will defer to their doctor to lead the appointment, ask questions, and expect the physician to reciprocate *respeto*. When cultural values are violated or expectations are not met, the physician-patient relationship is hindered and the cycle of mistrust against Western medicine is reinforced again.

To prevent the cycle of mistrust, Texas medical schools should reflect on their current cultural competency programs and their effectiveness in teaching future Texas physicians how to interact with complex cultural values/constructs. In the next chapter, I

will review the current Association of American Medical Colleges (AAMC) standards of cultural competency programs in Texas medical schools and their effectiveness in preparing culturally competent physicians.

CHAPTER 6

Cultural Competency Programs in Texas Medical Schools

Introduction

The previous chapter highlights the importance of cultural values in building a physician-patient relationship. By learning cultural values, physicians gain context on a Hispanic patient's culturally-informed healthcare decisions and can utilize their cultural understanding to foster effective communication with their patient. Even with a language barrier, patients prefer English-speaking physicians who utilize values like *respeto* over Spanish-speaking providers who did not reciprocate their cultural values (Magaña, 2020). However, understanding complex cultural values like *familismo* (family-oriented) and *machismo* (masculinity) is not inherent even if you are from that specific culture. For physicians to apply cultural values with Hispanic patients, they must first learn why these values are important and how they are characterized through behavior. Cultural competency programs should be teaching physicians about the cultural background of their future patient population.

In this chapter, I first will explain the current resources and models used to implement cultural competency training. I will then identify the current standard for cultural competency programs in Texas medical schools and their effectiveness in preparing future physicians to deliver culturally competent care. After reviewing current programs, I will elaborate on the importance of better cultural competency training in

medical schools and its role in formally integrating traditional and biomedical sciences in the United States healthcare system.

Cultural Competency

LCME and AAMC Requirements

According to Jernigan et al. (2016), culture refers to “integrated patterns of human behavior that include the language, thoughts, actions, customs, beliefs, and institutions of racial, ethnic, social, or religious groups” (p. 2). Competence is defined as having the “capacity to function effectively within the context of cultural beliefs, practices, and needs presented by patients and their communities” (Jernigan et al., 2016, p. 2). Defining culture and competence separately allows us to understand cultural competency as “a set of congruent behaviors, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations” (Jernigan et al., 2016, p. 2). The term “cultural competence” emerged when the accrediting body for US medical schools, the Liaison Committee on Medical Education (LCME), instituted the requirement that medical students demonstrate a standard level of cultural competency upon graduation (Jernigan et al., 2016). The LCME standard for cultural competence states:

The faculty and students must demonstrate and understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient (AAMC, 2005, p. 1).

The cultural competency requirement was created to address racial and ethnic disparities in healthcare quality and outcomes documented in the Institute of Medicine's seminal publication of *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Jernigan et al. 2016). Studies suggested that incorporating cultural competence in physician training may reduce provider bias and improve patient-provider communication (Magaña, 2020). Despite the good intentions of cultural competency programs to address healthcare disparities, there were wide variations in the conceptualization, implementation, and the evaluations that led to differences in quality and outcomes of the programs (Jernigan et al., 2016).

To address the variations between training programs and assist medical schools to integrate cultural competence in the curriculum, the Association of American Medical Colleges (AAMC) developed the *Tool for Assessing Cultural Competency Training* (TACCT) (AAMC, 2005). The TACCT is a self-administered assessment tool that is used by medical schools to examine all components of a medical school curriculum (AAMC, 2005). TACCT is comprised of domains, which monitors overall curricular offerings (where teaching is occurring) and specific components which provides an outline to identify what learning objectives are being met (Jernigan et al., 2016). The domains are broken into five categories:

- I. rationale, context, and definition
- II. key aspects of cultural competence
- III. understanding the impact of stereotyping on medical decision-making
- IV. health disparities and factors influencing health
- V. cross-cultural clinical skills

The domains are divided into subdomains to provide a more granular assessment of a given curriculum (Jernigan et al., 2016).

The second portion of TACCT, specific components, provides a detail assessment of the learning objectives in a curriculum in terms of knowledge, skills, and attitudes around race, culture, and bias (Jernigan et al., 2016). By using each component of TACCT, schools can identify both portions of the curriculum where culturally competent care is being taught and areas that lack TACCT domains. While TACCT provides medical schools the opportunity to isolate the portions of the curricula that pertain to cultural competence, it does not allow an in-depth analysis regarding which teaching strategies are beneficial or whether actual learning outcomes are achieved (AAMC, 2005). The AAMC (2005) also emphasized that the TACCT “does not address the informal curriculum that may influence student learning or achievement of desired cultural competency” (p.8). Since TACCT cannot address every possible aspect of cultural competency training, medical schools are encouraged to carefully examine which teaching strategies are being used, how students are responding to the teaching methods, and if the assessments are appropriate to the objectives (AAMC, 2005).

Even though TACCT is meant to be used as a self-evaluation tool of school’s curriculum, evaluating programs seems pointless considering there are no standardized cultural competency training among accredited medical schools. Some states have taken the initiative to mandate cultural competency training for healthcare professionals through legislative means. There are no bills that require Texas medical schools to mandate any sort of cultural competency training. However, Texas representative Shawn Thierry introduced the H.B. 719 bill (2019) to require medical schools to offer

coursework in cultural competence and implicit bias. The H.B 719 bill was referred to the House Public Health committee and did not progress to the Senate floor.

Educational and Communication Models

Medical schools utilize different educational and cross-cultural communication models that may fulfill the components of TACCT but can provide different cultural competency outcomes (AAMC, 2005; Jernigan, 2016). Various representative educational methods used to teach cultural competency are noted below.

Table 6

Education Models and Descriptions

Education Model	Description
Personal and Professional Development (PPD)	A longitudinal portfolio focused on self-reflection and self-evaluation. The goals of the PPD program are to foster compassionate, ethical, and professional behavior; teamwork; rational decision making; self-awareness; commitment to colleagues; and appropriate professional skills. Designed to promote self-directed learner awareness, prompts are used and then translated into personal portfolios to reflect each student’s explorations of the PPD goals and curriculum. The student portfolios are reviewed by faculty at the end of the year, to allow meaningful exchange between faculty and students to promote awareness and understanding.
Culture of the Community Model	The goal of this program is to elevate the quality of faculty teaching directly and indirectly through behavioral modeling. The curriculum uses GNOME (Goals, Needs, Objectives, Methods, and Evaluation) applied through workshops using interactive lectures, role-play exercises on cultural-needs assessment, patient-centered interviewing, feedback on cultural issues, and the use of the community to enhance cultural understanding.
Culture and Diversity Course Model	This course is a theoretically based, year-long, cultural-competency training program for second-year medical students based on the 27 core competencies outlined by AAMC. The goal of the course includes effective communication, self-directed independent learning,

	critical thinking and problem-solving, and facility with technology. The course incorporates interactive lectures, videos, simulations, demonstration, role play, workshops, patient interviews, community-based service learning, and online problem-based learning cases.
Immersion Model	The immersion model is designed to promote learning about other cultures and provide opportunities for students to learn some of the principles associated with cultural safety. By learning about culture, it can address the problem of unconscious inherited racism in medical training. The model is implemented as a one-week program for third-year medical school students. Students learn about culture and how to assess a community's health needs by being placed in primarily minority region.

Note: Adapted from *Teaching Culturally Appropriate Care: A Review of Educational Models and Methods*, by C.Hobgood et al., 2006, pg. 1290–1292

The table above does not provide an all-inclusive list of educational models used by medical schools. The models were selected based on their diverse approaches, illustrative nature, or unique applicability to teach cultural competency (Hobgood et al., 2006). Learning about culture is an important aspect in cultural competency training; however, it is also important that medical students, residents, and physicians understand how to communicate with their patients (Hobgood et al., 2006). Therefore, cross-cultural communication and negotiation models are utilized to instill the critical skills that “underpin all successful cross-cultural clinical encounters” (Hobgood et al., 2006, p.1292). Various models of effective cross-cultural communication and negotiation are listed in the table below.

Table 7*Effective Cross-Cultural Communication and Negotiation Models*

Models	Description
BATHE	Background (What is going on in your life?) Affect (How do you feel about what is going on?) Trouble (What troubles you most?) Handling (How are you handling that?) Empathy (This must be very difficult for you.)
BELIEF	Beliefs about health (What caused your illness/problem?) Explanation (Why did it happen at this time?) Learn (Help me to understand your belief/opinion.) Impact (How is this illness/problem impacting your life?) Empathy (This must be very difficult for you.) Feelings (How are you feeling about it?)
ETHNIC	Explanation (How do you explain your illness?) Treatment (What treatment have you tried?) Healers (Have you sought any advice from folk healers?) Negotiate (Mutually acceptable options) Intervention (Agreed on) Collaboration (with patient, family, and healers)
LEARN	Listen with sympathy and understanding to the patient's perception of the problem Explain your perceptions of the problem Acknowledge and discuss the differences and similarities Recommend treatment Negotiate treatment
Kleinman's Questions	What do you think has caused your problem? Why do you think it started when it did? What do you think your sickness does to you? How severe is your sickness? Will it have a short or long course? What kind of treatment do you think you should receive? What are the chief problems your sickness has caused for you? What do you fear more about your sickness?
Model for Cultural Competency in Health Care	Normative cultural values Language issues Folk illnesses Patient/parent beliefs Provider practices

Note: Adapted from *Teaching Culturally Appropriate Care: A Review of Educational Models and Methods*, by C. Hobgood et al., 2006, p. 1293

Medical schools use educational and cross-cultural communication models combined with TACCT to create cultural competency training programs. Since medical schools use different models to implement cultural competency, it should be noted that not all cultural competence education is “effective in improving the attitudes and skills of health professionals” (Kripalani et al., 2006). Ineffective cultural competency skills can produce negative patient outcomes such as decreased treatment adherence and physician-patient communication (Magaña, 2020).

Now that TACCT and various models have been discussed, Texas medical schools will be evaluated on their current cultural competency programs. There are thirteen allopathic medical schools (MD) in Texas. All of the Texas medical schools are listed below with their respective classification and location. The UT Tyler School of Medicine was not included in the table because the school has not yet graduated any students. The first graduating class will be in 2027.

Texas Medical Schools

Table 8

Texas Allopathic Medical Schools

School	Classification	Location
Baylor College of Medicine	MD	Houston
Texas A&M Health Science Center College of Medicine	MD	Bryan
Texas Tech University Health Sciences Center in Lubbock	MD	Lubbock

The Joe R. and Teresa Lozano Long University of Texas School of Medicine at San Antonio	MD	San Antonio
The University of Texas at Austin- Dell Medical School	MD	Austin
The University of Texas Health Science Center at Houston McGovern Medical School	MD	Houston
The University of Texas Medical Branch at Galveston	MD	Galveston
The University of Texas Rio Grande Valley School of Medicine	MD	Edinburg
The University of Texas Southwestern Medical Center	MD	Dallas
University of Houston College of Medicine	MD	Houston
Texas Tech University Health Sciences Center Paul L. Foster School of Medicine at El Paso	MD	El Paso
TCU Burnett School of Medicine	MD	Fort Worth

Six of the thirteen Texas medical schools are housed within the University of Texas system. The six schools include the UT Long School of Medicine at San Antonio, Dell Medical School in Austin, UT McGovern Medical School in Houston, UT Medical branch–Galveston, UT Rio Grande Valley School of Medicine, and UT Southwestern. Despite being housed in the same academic system, each school has developed its own training programs incorporating cultural competency through diversity, equity, and inclusion (DEI) initiatives. It is important to note that cultural competency is a skill measured in both individuals and organizations whereas DEI initiatives are focused on the organizational level (Stubblefield-Tave, 2021). DEI programs will be considered in the evaluation of Texas medical schools and their cultural competency trainings. The components of DEI initiatives are cited as being “foundational for promoting and achieving health equity ... [by including] the need to recognize and mitigate stigma and bias interactions with patients, families, and other health professionals” (Skorton & Ford,

2022, para.6). Cultural competency and DEI programs overlap in their goals to address the inadequate treatment that minority patients face in the healthcare system. The AAMC DEI competencies were created to guide curriculum development across all phases of medicine from medical students to attending physicians and faculty members (Skorton & Ford, 2022). The AAMC separate cultural competency objectives and DEI competencies since they both work to achieve the same goal through different means.

Diversity, equity, and inclusion programs focus on the recognition and mitigation of stigmas, racial bias, and race-based health care inequities within healthcare by adjusting the current educational standard for the topics. An example of a DEI strategy is teaching physicians to understand and correct systemic biases and cultural misrepresentations that perpetuate racial bias like “knowing that race is a social construct that is a cause of health care inequities and not a risk factor for disease” (Skorton & Ford, 2022). Cultural competency, on the other hand, works to address healthcare disparities by implementing trainings to learn about the diverse cultures and belief systems influencing health and illness (AAMC, 2005). Since both programs promote healthcare equity through different frameworks, TACCT does not include DEI initiatives. However, the AAMC has recently established new DEI competencies to assist in promoting and achieving health equity (Skorton & Ford, 2022). Both DEI and cultural competency trainings aim to achieve health equity to provide effective and compassionate care for patients, which highlights the importance of both programs when reviewing Texas medical school curricula.

Dell Medical School

The mission of Dell Medical school is to “revolutionize how people get and stay health[y] through new models of care, educating leaders who transform healthcare and redesigning academic health as a way to better serve society” (Morgan, 2023, p. 3). To fulfill its mission, Dell Med created its own medical educational model known as EDGE (Essentials, Delivery, Growth, and Exploration) (Morgan, 2023). The core competencies of the EDGE curriculum are leadership and innovation, patient care, medical knowledge, communication, practice-based learning and improvement, systems-based practice, professionalism, and health equity (Morgan, 2023). The expected outcomes of medical knowledge and health equity relate to cultural competency the most. The two core competencies focus on recognizing the important non-biological determinants of poor health like racism and oppression and the historical/current context of health inequities; unconscious bias; intersectionality; and physician-patient concordance respectively. In addition to the EDGE curriculum, Dell Med combines the efforts of its Office of Health Equity and its Office of Diversity, Equity, and Inclusion to address the “systemic inequities that prevents the achievement of optimal health” (Morgan, 2023, p. 4). Dell medical school models their curriculum to address several issues in healthcare like personal conscious/unconscious biases and the root cause of health inequities for minority patients. However, there is no specific culture or language component in the curriculum that can help providers be more culturally competent. The curriculum does not provide courses that discuss any form of culture or incorporates language education like Spanish. While students learn the history of health inequities for patients and other social determinants of health, no cultural clinical skills are being taught to apply the

information they are learning. Learning about health inequities and historical oppression will not be enough to bridge the language barrier between physicians and patients, let alone teach students how to utilize their knowledge to interact with patients in a culturally sensitive manner.

UT Southwestern

UT Southwestern had utilized the ARISE framework (anti-racism; recruitment, retention & research; inclusion & quality improvement; social justice, service, & sustainability; and education, empowerment & engagement) to promote their DEI initiatives. However, as of October 2022, UT Southwestern has removed all references to the A.R.I.S.E framework and has updated its DEI website (Morgan, 2023). There are trainings and workshops that promote DEI within the family and community medicine department. Examples of DEI trainings and workshops are inclusive team-building, cultural humility and unconscious bias, unconscious bias in healthcare, and addressing health inequities in clinical settings (*Training & Workshops*, n.d). Within the curriculum, there are optional programs known as “tracks” that medical students may add to enrich their medical education. The community action research track (CART) integrates community based participatory research (CBPR), population medicine, health promotion/disease prevention and the social determinants of health into the curriculum (*Medical Student Involvement*, 2019). Medical school students enrolled in CART participate in various electives, community service, and seminars in community health practice. Within these seminars, there is one called “principles of cultural competency for the health professional” (*Medical Student Involvement*, 2019). When reviewing the UT

Southwestern curriculum and educational objectives, there is no mention of how cultural competency is integrated into their medical school education. There is a language course provided through noncredit electives like Medical Spanish or the Spanish Interpreter Apprenticeship Program (*Pre-Clerkship Period*, n.d). While language and culture cannot be separated, the optional electives are not enough to inform future physicians about cultural values and constructs that influence physician-patient interactions. The electives in learning medical Spanish can be utilized to fulfill a component of cultural competency; however, since there is no credit offered for participation students are less likely to enroll in the course. The same issue is posed for the CART track which has great potential in cultural competency training but is an optional track for students that might want to pursue other activities to bolster their resume.

Long School of Medicine

Located in San Antonio, the Long School of Medicine (LSOM) emphasizes diversity “as a catalyst for change resulting in health equity” through its integration in the curriculum and as a core value. The Office for Inclusion and Diversity conducts implicit bias training and provides several anti-racism resources (Morgan, 2023). In addition to the Office for Inclusion and Diversity initiatives, the curriculum itself does emphasize cultural competency through its educational objectives and the Medicine, Behavior, and Society (MBS) longitudinal module. The MBS longitudinal module a required six credit course taken throughout the first two years of medical school training labeled pre-clinicals. The MBS course covers various topics in the context of medicine like history, law, ethics, clinical, social, and culture (*Preclinical Curriculum*, n.d). Another aspect of

the course focuses on global issues like the health care system to local issues like physician-patient relationships, by introducing communication skills, professionalism, and cultural competency (*Preclinical Curriculum*, n.d). LSOM utilizes three educational objectives (altruism, knowledge, and skills) to guide its students into becoming an effective and caring physician. The “skill” objective fulfills various cultural competency components like how to create appropriate management strategies for common conditions through the ability to identify commonly used complementary and alternative medicine modalities (*Competencies and Objectives of the M.D. Degree program*, n.d.). LSOM also expects graduating medical school students to apply the principles of relieving total pain, by understanding the various mechanisms of pains and its manifestations as physical, psychological, spiritual, or social pain. By teaching medical school students complementary and alternative medicine modalities and accepting the various manifestations of pain, the LSOM provides the skills for physicians to effectively communicate and treat Hispanic patients. Despite the listed courses and objectives, language is not an integrated component throughout the curriculum. There is no official medical Spanish elective for students, which would be a great supplement to the cultural competency goals listed by LSOM. While the LSOM educational objectives are well developed, they are not enough to cover the full scope of cultural material necessary to teach cultural competency. Language is an important component of culture, and it cannot be substituted by cultural awareness.

UT Health Houston McGovern Medical School

UT Health Houston McGovern Medical School is cited as the ninth largest and most diverse medical school in the country with nearly 2,000 medical students, residents and fellows in the program (Morgan, 2023). The McGovern Office of Diversity and Inclusion aim to educate their program participants by providing several resources discussing implicit bias, microaggressions, and “Race and Medicine” (Morgan, 2023). Reviewing their medical education program objectives (EPO) provides small snippets of cultural awareness being taught to graduates. Under the patient care and clinical skills EPO, the seventh and ninth subpoint seem to subtly relate to cultural competency since they address care for patients while being mindful of relevant spiritual, cultural, and psychosocial constructs and being able to collaborate with health care professionals from other disciplines to provide coordinated healthcare services (*Medical Education Program Objectives*, n.d). The interpersonal and communication skills EPO also incorporates the cultural construct of *familismo* by having graduates demonstrate skills to establish rapport, empathic communication, and educate patients and their families. Aside from the EPO, there are two electives that may relate to cultural competency training. The first elective is “Culture Conversations,” designed to educate students on cross-cultural implications in medicine and how to incorporate this knowledge into caring for patients of different backgrounds (*Culture Conversations*, 2019). Topics covered in the course include tackling language barriers, transgender health, mental health in minority populations, and complementary medicine. Medical Spanish is also offered as an elective, with eight language-focused classes and two culture-focused classes (A.P. Gomez, personal communication, November 1, 2023). The medical Spanish course aims to provide students a solid foundation to communicate with Spanish-speaking patients in a

medical setting, gain skills to accurately obtain a patient's medical history and provide feedback on a patient's health conditions, and develop cultural competencies to understand and manage the cross-cultural barriers they face (A.P. Gomez, personal communication, November 1, 2023). McGovern Medical school provides opportunities for students to engage in cultural competency through specific education objectives and electives. The school incorporates a cultural and language component but would benefit from having these components as a requirement for all students instead of as optional courses. Considering the diversity of the school and the Houston Metropolitan area, every medical student would benefit from having a multifaceted understanding about the cultural backgrounds of their future patients.

UT Medical Branch John Sealy School of Medicine

Founded in 1891 as the first medical school in Texas, UT Medical Branch (UTMB) John Sealy School of Medicine is committed to promoting health equity by embracing DEI as a core factor in its mission (Morgan, 2023). The DEI aspect is interwoven throughout the UTMB general competencies and medical education program objectives. The patient care (PC) competency emphasizes graduates making informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgement (*JSSOM Medical Education Program Objs*, n.d). The PC competency teaches physicians to reflect on possible treatments based on patients' information and healthcare preferences while also allowing patients to participate in their treatment and feel valued. Another applicable EPO is "knowledge for practice" (KP), which assesses the impact of psychosocial and

cultural influences on health, disease, care-seeking, care compliance and barriers to and attitudes toward care (*JSSOM Medical Education Program Objs*, n.d). Teaching the cultural influence on health and disease is one of the major aspects of cultural competency as Hispanic patients make culturally-informed decisions on their health. The subpoint of cultural influence on health under the KP competency is a great example of cultural competency being taught in combination with other educational objects to produce culturally aware physicians.

Aside from the required curriculum, UTMB offers optional scholarly concentrations to enrich a student's education. The bilingual health scholarly concentration (BHSC) was developed to produce culturally and ethically competent bilingual Spanish physicians. The BHSC curriculum consists of ten volunteer visits to a non-profit clinic in the first two years, a summer preceptorship in a predominant Spanish patient population clinic, and a mandatory class on clinical conversational Spanish for English and Spanish speaking healthcare professionals in the last year (*Bilingual Health Scholarly Concentration*, 2023). Another required course within the BHSC concentration is "Cultural Competency in Hispanic Health" which introduces students to basic research on population health and the implications of culture on the health of Hispanics (*Bilingual Health Scholarly Concentration*, 2023). The class guides students to produce a 10 to 15-page scholarly written report and an oral ten-minute PowerPoint presentation (*Bilingual Health Scholarly Concentration*, 2023). While BHSC participants are required to take the medical Spanish class, other students can utilize the course as an optional elective credit. The current integration of cultural competency within the educational program objectives and certain programs is a great step to improve health equity for Hispanic patients. It

would be beneficial if all students were obligated to participate in summer preceptorships around areas with a high minority populations and if coursework was supplemented with the medical Spanish class. Obligating preceptorships and the medical Spanish class would incorporate cultural and linguistic components of cultural competency training through language learning and first-hand interactions with patients.

UT Rio Grande Valley (RGV) School of Medicine

The last and the newest addition to the UT Texas system is the UT Rio Grande Valley (RGV) School of Medicine. UTRGV states its commitment to diversity, inclusion, and health equity through the Office of DEI (Morgan, 2023). Utilizing AAMC resources, various definitions and “diversity categories” are listed on the website as a form of educating students, faculty, and senior administrative staff (Morgan, 2023). Examples of the terms listed include female, Hispanic, African American, decolonize, genderqueer, and implicit bias (Morgan, 2023). Aside from providing educational definitions, the Office of Institutional Equity & Diversity provides DEI and social justice-related training using a workshop series named “LEAP” (Morgan, 2023). LEAP stands for “Learn about diversity. Empower yourself and others. Advance initiatives. Promote inclusion” (Morgan, 2023). The LEAP workshop covers various topics including, but not limited to race, ethnicity, language, and oppression. Utilizing a range of teaching methods such as lecture, historical overview, group activities, and individual reflective exercises, participants learn about diversity and inclusion through a medical lens. The UTRGV school of medicine utilizes its commitment to DEI incentives within the established EPO. The school incorporates aspects of cultural competency in characteristics like altruism

and professionalism, knowledge, and skills. Under altruism and professionalism, graduates are expected to apply social-behavioral principles when providing patient care including spiritual, attitudinal, and cultural influences on health (*Educational Program Objectives*, n.d). Another aspect under altruism and professionalism includes being able to recognize the “medical, economic, and socio-economic, psycho-social, cultural, spiritual, and religious determinates of health, and the need for interpretive or adaptive services, seek conceptual context of illness, and demonstrate active listening skills” (*Educational Program Objectives*, n.d., p.1).

By emphasizing patient-centered care, students also learn important cultural determinants of health that can impact patient outcomes. The knowledge EPO demonstrates cultural competency by having students apply knowledge of health disparities and principles of disease prevention and intervention to identify culturally appropriate strategies to improve the health of patients and communities (*Educational Program Objectives*, n.d). The final EPO requires graduates have the skill to recognize the various manifestations of pain while considering personal and cultural variations. An additional subpoint under the skill EPO is for graduates to demonstrate awareness of common complementary and alternative medicine practices (*Educational Program Objectives*, n.d). By integrating cultural competency values throughout its EPOs, UTRGV essentially teaches students how to consider culture within the scope of medical practice.

Cultural competency is also identified within the medical education curriculum, through the longitudinal course MEDI 8111 also identified as Medicine, Behavior and Society (MBS). The UTRGV SOM course catalog describes the MBS module as

exploring the history, law, ethics, clinical, social, and cultural contexts of medicine (*School of Medicine Catalog*, n.d). This is the only course within the required curriculum that explicitly addresses cultural competency education. A review of the course catalog verified that there are no electives that teach medical Spanish or incorporate language to supplement cultural competency objectives. While UTRGV SOM emphasizes cultural competency through its EPO, its curriculum does not illustrate the same points. The MDS class is not enough to fulfill all the educational objectives concerning cultural competency. It is important that UTRGV SOM incorporates a medical Spanish class to help bridge the cultural gaps between patients and healthcare providers.

Texas A&M University College of Medicine

Outside of the UT health system, there are seven other schools that participate in the training of future Texas physicians. Texas A&M University (TAMU) College of Medicine (TAMU-COM) offers multiple MD degree paths across five locations in Texas (Morgan, 2023). TAMU-COM states its' mission as created to serve while emphasizing areas with great healthcare need like rural medicine and military medicine. TAMU-COM plans to fulfill its DEI initiatives through promoting recruitment representative of the schools' diversity categories and advocating for DEI scholarships and pathway programs (Morgan, 2023). The DEI strategies were 86.5% effective using the AAMC Diversity, Inclusion, Culture, and Equity (DICE) inventory, meaning that TAMU-COM had substantial DEI efforts throughout its policies, practices, procedures, and programs (AAMC, 2022).

The medical educational program objectives (MEPO) are statements of knowledge, skills, behaviors, and attitudes that medical students are expected to exhibit by their graduation (*Medical Education Program Objectives*, 2021). Despite earning an above average DICE inventory score of 86.5%, the MEPOs do not illustrate any specific points relating to cultural competency. For the knowledge MEPO, students are expected to recognize the interplay of individual and health system science factors that impact the quality, safety, and value of patient-centered care (*Medical Education Program Objectives*, 2021). The subpoint within the knowledge MEPO subtly references possible individual factors that could impact the care a patient receives but does not elaborate on which factors or how they impact patient-centered care. The “attitudes and behaviors” (AB) MEPO displays is similarly vague in addressing possible cultural competency points. A subpoint in the AB MEPO requires students to demonstrate awareness of social determinants of health in communication, treatment plans, and all aspects of delivering quality care (*Medical Education Program Objectives*, 2021). The brief and ambiguous subpoint about social determinants does not identify how awareness of social determinants will improve health care delivery. The MEPO does not seem to provide any clarity on how cultural competency or DEI initiatives are being taught. Likewise, the pre-clerkship and clerkship curriculum do not contain descriptions of how cultural competency is included in the courses. TAMU-COM houses organizations that address cultural competency, such as the student-led Multicultural Awareness Program (MAP). By providing programs and support in areas of cultural competency, future physicians can be better informed and understand different aspects of diversity (*Multicultural*

Awareness Program, n.d). The MAP program illustrates the student's initiative to address cultural competency; however, the impact of the program cannot be assessed.

Aside from student organizations, TAMU-COM offers an elective medical Spanish program. The program introduces several levels of medical Spanish, ranging from novice to advanced speakers (*Medical Spanish Program*, n.d). The course provides “instruction to introduce and develop the linguistic and cultural skills necessary to facilitate basic communication and negotiate a number of primary difficulties posed by an English-Spanish language barrier between patients and providers” (*Medical Spanish Program*, n.d, para.2). While providing a medical Spanish course can help ease the linguistic barriers between physicians and Hispanic patients, it is not enough to address the other cultural values that influence patients' decisions about their health. The course description notes that students will also develop the cultural skills necessary to facilitate basic communication. However, to develop and understand cultural skills, students must understand the historical and cultural contexts to understand why patients make culturally-informed decisions. Culture and language cannot be separated easily, but they both must be taught effectively to provide culturally competent care to Hispanics in Texas.

Texas Tech University Health Sciences Center (Lubbock)

The Texas Tech University Health Sciences Center (TTUHSC) in Lubbock offers a medical education that emphasizes principles of primary care, inter-disciplinary and inter-professional training that integrates concepts of “basic science, clinical skill, diversity, and a humanistic approach focusing on high standards and comprehensive

evaluation” (Morgan, 2023, pg.16). The TTUHSC Office of Diversity, Equity, & Inclusion (ODEI) provides various resources like online modules defining DEI, understanding conscious and unconscious bias, and how to practice allyship for LGBTQIA+ identities (Morgan, 2023). In addition to the ODEI, there is a Diversity, Equity, & Inclusion Committee whose aim is to continue transforming healthcare by holding TTUHSC accountable on DEI-related matters. TTUHSC use the Liaison Committee on Medical Education (LCME) standards to guide their educational program objectives (EPO). The LCME requires that the curricular content include opportunities for students to recognize and appropriately address the manner in which patients perceive health and illness, the basic principles of cultural and structural competent health care, and the importance of health care disparities and health inequities (*LCME Standards and Elements*, 2023). The LCME standards are integrated within the TTUHSC curriculum through the patients, physicians, and populations (PPP) 1 course during pre-clerkship. The year-long module provides a framework for students to gain the skills essential to professional identify formation as physicians including cultural competency, teamwork, collaboration, and addressing ethical challenges to medical practice (*4 Year Curriculum Overview*, n.d). Within the PPP 1 course, students are introduced to health systems, health policy, and possible social/cultural issues that impact health through various learning styles. Another required course for all students is an online course that covers basic medical terminology Spanish to prepare students to interact with patients who speak primarily Spanish. According to the AAMC DICE inventory score of 86.4%, TTUHSC fulfills its duty in teaching cultural competency and DEI initiatives through the required courses like medical Spanish, PPP 1, and its LCME influenced EPOs (Morgan, 2023).

While the PPP 1 course addresses certain cultural issues that impact health, the course should also incorporate a historical background on how the cultural issues came to be and how they perpetrate healthcare decisions.

Paul L. Foster School of Medicine

Under the Texas Tech University system, TTUHSC El Paso has a medical school known as Paul L. Foster School of Medicine (PLFSOM). The mission of the PLFSOM is to “improve the lives of patients and the community by focusing on unique health care needs of socially and culturally diverse border populations (*Educational Programs Goals and Objectives*, 2018). Three specific educational program objectives fulfilled aspects of cultural competency training. The first objective, knowledge for practice, requires students to “apply principles of social-behavioral sciences to patient care including assessment of the impact of psychosocial, cultural, and societal influences on health, disease, care seeking, adherence and barriers to care” (*Medical Educational Program Goals and Objectives*, 2018). The interpersonal and communication skills EPO expects students to communicate effectively with patients and families across a broad range of socioeconomic and cultural backgrounds (*Medical Educational Program Goals and Objectives*, 2018). The last objective that fits within cultural competency education is systems-based practice, where graduates must demonstrate the ability to identify patient access to resources that are relevant to patient healthcare (*Medical Educational Program Goals and Objectives*, 2018).

Aside from the objectives, PLFSOM has a unique Spanish program that requires all medical and dental students to take medical/dental Spanish throughout the first two years of their education. Used to address the high percentage of Spanish-speaking patients in El Paso, students are taught both conversational and medical Spanish in the Society, Community, and Individual class (PSCI 5221). The course incorporates Spanish, population health, culture, and environmental/occupational health to address the issues on the border. The class culminates with field experiences to apply lessons from the class and provide exposure to border community and culture. PLFSOM has a strong cultural competency foundation for its students through the required language and cultural class. The curriculum goes beyond just teaching students, as it also incorporates application through field experiences like service-learning projects and community-based research.

University of Houston College of Medicine

The Tilman J. Fertitta Family (TJFF) College of Medicine at the University of Houston (UH) is one of the newer schools within the state of Texas. Commonly referred to as the University of Houston College of Medicine (UHCM), the program received preliminary accreditation status from the LCME on February 2020 and await full accreditation by July 2024 (Morgan, 2023). The medical education program objectives are similar to other schools discussed, and UHCM fulfills various components of cultural competency through objectives like patient care, knowledge for practice, interpersonal and communication skills, and professionalism. The objective of interpersonal and communication skills adds an interesting component: Graduates will learn how to listen to and communicate effectively with patients, families, and the public

as appropriate, across a broad range of socioeconomic and cultural backgrounds (*TJFFCOM MD Program*, n.d). However, the curriculum does not address how students develop the communication skills needed. UHCOM cites its curriculum as unique and innovative with emphasis on primary care in underserved populations, social determinants of health, community and population health, and behavioral health to improve health care disparities in urban and rural areas (*TJFFCOM MD Program*, n.d). In the first phase of its curriculum known as pre-clerkship, students participate in clinical focus sessions that discuss different interdisciplinary topics related to the school's mission and societal medical challenges today. Some of the clinical focus sessions relate directly to cultural competency education; for example, exploring health disparities or the unique aspects of health care for refugee and immigrant populations (*TJFFCOM MD Program*, n.d). In pre-clerkship, students take a physicians, patients, and populations (PPP) course which is meant to develop physician-patient knowledge and competencies related to clinical skills. The clinical skills include topics like medical ethics, social determinants of health, health disparities, patient safety, and health systems and policy (*TJFFCOM MD Program*, n.d). The physicians, patients, and populations course are then paired with the Household-centered care course, in which students make visits to a household facing complex health challenges to learn about the social determinants of health (SDOH) and how to make identify appropriate support services (*TJFFCOM MD Program*, n.d). The Household-centered care course is a required aspect of the curriculum, taken throughout all four years of medical school. UHCOM takes the initiative to educate its future physicians on the various social and behavioral components influencing patient health; however, there is no linguistic component integrated within

the curriculum to supplement the cultural competency education. Combining Spanish education and understanding the impacts of SDOH would help bridge cultural gaps between physicians and patients.

Baylor College of Medicine

The Baylor College of Medicine (BCM) MD program is divided between its Houston and Temple campuses. The MD program does not have a separate DEI office, but it does promote the Race in Medicine Task Force (RMTF) (Morgan, 2023). This program was created with the purpose of incorporating anti-racism curriculum content into all levels of education of medical schools and to implement diversity recruitment and retention strategies (Morgan, 2023). The Office of Institutional Diversity, Equity, and Inclusion directs most of the DEI initiatives across all the schools. Initiatives vary from microaggression workshops, collaborations with the BCM Center of Excellence in Health Equity, and the inclusion and excellence council (Morgan, 2023). In my review of the BCM core competency graduation goals (CCGG) that are based on LCME standards, there are no goals that directly reference cultural competency education. However, the curriculum has been updated recently to better fulfill the LCME cultural competency standard. As of 2023, the new subpoints under interpersonal and cross-cultural communication skills required graduates to employ active listening during patient-centered interviewing and employing effective communication to advocate for individual patients (CCGG, 2023). The updated CCGG also implements a brand-new goal of health systems and social context of care, which is meant to demonstrate awareness and responsiveness to the larger context and systems that illness is experienced and care is

delivered (CCGG, 2023). Under the new goal, graduates are required to recognize the cultural, community, societal, and system-level factors that impact individual and population health (CCGG, 2023). Considering how recent the new core competency goals are, the current curriculum might not be the best reflection of the goals in place. The current required courses barely address aspects of cultural competency. Courses like Patient Safety and Practice of Medicine provide the bare minimum in creating culturally competent physicians. The courses teach the key principles of patient safety in delivery of healthcare and teaching communication skills while facilitating positive and professional identity formation (*Foundational Sciences Curriculum*, n.d). While the BCM MD program provides electives for pre-clerkships, there are no language courses provided to supplement the cultural components in the new CCGGs. BCM is trying to renovate its program to produce culturally competent physicians, however, the language component must not be overlooked. Updating the core competency goals must come with changes within the curriculum as well, providing education on the historical, social, behavioral, and linguistic factors impacting Hispanic patients' healthcare decisions.

Texas Christian University Burnett School of Medicine

The last medical school on the list, the Texas Christian University (TCU) Burnett School of Medicine located in Fort Worth opened its doors in 2019 (Morgan, 2023). There are various DEI-related programming and training opportunities for students and faculty to learn about health disparities, unconscious bias training, and important topics affecting healthcare (Morgan, 2023). Along with its DEI efforts, the TCU School of Medicine has a mission to transform healthcare through the newly coined term of

“Empathetic Scholars.” Empathetic scholars develop the skills to be life-long learners and are highly valued as physicians, colleagues, leaders, and citizens in their community (*Empathetic Scholar*, n.d). The empathetic scholar curriculum is composed of several elements like medical knowledge, practice-based learning, interpersonal and communication, patient care, systems-based practice, and professionalism (*Empathetic Scholar*, n.d). Each element comprises required courses, community involvement, and other components necessary to eventually develop an empathetic scholar outlined by the curriculum. The interpersonal and communication element has a four-year communication course meant to provide the tools for better communication with patients and families. The patient care element is composed of a four-year longitudinal integrated clerkship and social determinants of health course. The professionalism element within the curriculum is used to address and teach about DEI, cultural competency, and humanism (*Empathetic Scholar*, n.d). The complex Empathetic Scholar curriculum is based on the twenty-four educational program objectives. The medical knowledge EPO is used to address the psychosocial-cultural influences on health and disease, reflected within the patient care element of the curriculum (*TCU School of Medicine Educational Program Objectives*, 2022). The TCU school of medicine has the potential to create a new curriculum that directly addresses the lacking standards of cultural competency training. While the curriculum states that cultural competency will be taught, the existing courses do not explain how it will be taught. There is no specific course that teaches the various components of cultural competency, let alone the linguistic aspect necessary to produce culturally competent care. As the school waits for full accreditation from the LCME, it

would be a beneficial to develop courses to include every aspect of cultural competency, including language.

In summary, there is little standardization among medical school curricula. Every Texas medical school utilizes a different program and curriculum to fulfill the LCME requirement of cultural competency. The table below condenses the key objectives presented by Texas medical schools to fulfill cultural competency requirements.

Table 9

Summary of Texas Medical school programs

School	Is cultural competency incorporated within the educational program objectives?	Are components of culture (e.g., social, behavior, beliefs, habits, etc.) taught in the curriculum?	Does the program have a medical Spanish course to supplement cultural competency training?	Are there mandatory clinical experiences to reinforce cultural competency skills?	Are DEI resources offered to students, faculty and staff?
Baylor College of Medicine	Yes	Yes, through required courses of Patient Safety and Practice of Medicine	No	No	Yes
Texas A&M Health Science Center College of Medicine	Yes, however lacks clarity on implementation	No	Yes, offered as an elective	No	Yes
Texas Tech University Health Sciences Center in Lubbock	Yes	Yes, through the required patients, physicians, and populations (PPP) 1 course	Yes, a required online course covering basic medical terminology	No	Yes
The Joe R. and Teresa Lozano Long University of Texas School of Medicine at San Antonio	Yes	Yes, through a required two-year module called Medicine, Behavior, and Society (MBS)	No	No	Yes
The University of Texas at Austin-Dell Medical School	Yes	No, as the curriculum covers health inequities and social determinants but does not teach specific clinical skills.	No	No	Yes
The University of Texas Health Science Center at Houston McGovern Medical School	Yes	Yes, however the Culture Conversations course is an optional elective	Yes, an optional medical Spanish class consisting of language and culture-focused classes	No	Yes

The University of Texas Medical Branch at Galveston	Yes	Yes, the cultural competency course is mandatory for students on the Bilingual Health Scholarly Concentration (BHSC) track and optional for other students.	Yes, a mandatory class on clinical conversational Spanish for students on the BHSC track. Optional for other students.	Yes, mandatory for students on the BHSC track. Not a requirement for other students.	Yes
The University of Texas Rio Grande Valley School of Medicine	Yes	Yes, through the MBS longitudinal course	No	No	Yes
The University of Texas Southwestern Medical Center	No	Yes, however it is through the optional Community Action Research Track (CART)	Yes, there is an optional medical Spanish course, but it is classified as a noncredit elective	Yes, but through CART. There is no mandatory clinical volunteering in minority communities for students not on CART	Yes
University of Houston College of Medicine	Yes	Yes, through the mandatory clinical focus sessions and PPP course	No	Yes, the Household-centered care course is required throughout all four-years of medical school	No
Texas Tech University Health Sciences Center Paul L. Foster School of Medicine at El Paso	Yes	Yes, through the required Society, Community, and Individual (PSCI 5221) class	Yes, the Spanish program is a required two-year program for all medical and dental students	Yes, the PSCI 5221 teaches skills that are applied to mandatory field experiences within the border community	No
TCU Burnett School of Medicine	Yes	No, there is a course that teaching on the social determinants of health in patient care however no specific curriculum on culture	No, there is no medical Spanish course offered but there is a required four-year communication course to improve patient and family communication	Yes, there is a four-year longitudinal integrated clerkship	Yes, but not clearly stated

Some schools try to fulfill the requirement through optional workshops and seminars; however, learning to be culturally competent requires long-term education to result in long-term behavior changes. Cultural competency training specifically culture and language “should be included into students’ clinical education to enhance culturally appropriate knowledge and abilities” (Rukadikar et al., 2022). Certain schools incorporate aspects of cultural education into their curriculum but do not require or do not offer medical Spanish courses. Language is a major component to cultural competency since language barriers between physicians and patients hinder effective communication and later produce negative healthcare outcomes (Magaña, 2020). The varying standards of cultural competency training between schools leads to the question of where cultural competency is being implemented in the healthcare system.

Cultural competency training needs to begin at the start of medical education training and must be standardized among all schools. Although medical schools are striving to reduce health disparities through their cultural competence programs, schools differ in their content, emphasis, setting, and duration (Kripalani et al., 2006). In addition to lack of cultural preparation, students are not receiving cross-cultural medical training that can impact their interactions with patients.

Previous chapters have indicated the dangers when physicians are not culturally competent in cases like that of Willie Ramirez. Healthcare providers need to develop a multifaceted understanding of culture and language to deliver culturally sensitive care and bridge the cultural gaps implicated in negative healthcare outcomes. However, having a meaningful understanding of a culture does not mean that physicians can “predict the behaviors and attitudes of their patients simply based on their cultural

backgrounds” (*How to Improve Cultural Competence in Health Care*, 2021). Considering that behavior and beliefs associated with culture are not “one size fits all,” healthcare professionals must build cultural competence and recognize the limits of their knowledge about other cultures, a construct known as cultural humility (*How to Improve Cultural Competence in Health Care*, 2021). Since culture is a multilayered concept, medical schools need to better integrate various forms of cultural competency training throughout the four years of medical education. Better cultural competency training can pave a way for formal medical integration, where both traditional and biomedical healers can work in conjunction with one another and help circumvent the risks that stem from informal medical pluralism (Kennedy and Olsson, 1996). This chapter discussed the standard of cultural competency training through the AAMC and analyzed Texas medical schools on their efforts to teach cultural competency. To address the current cultural competency programs, I will present my formal recommendation of a cultural competency program for Texas medical schools in the next chapter.

CHAPTER 7

A Formal Recommendation for Cultural Competency Programs in Texas Medical Schools

Introduction

No cultural competency program is the same, just as not every medical school is built the same. Reviewing Texas medical school educational program objectives, curriculum, and DEI resources in the previous chapter demonstrated the fluctuating criteria for cultural competency programs and their fulfillment of the LCME standard. Considering the lack of regulation and uniformity for cultural competency programs, I will present my formal recommendation to improve current programs in order to produce culturally competent physicians as a step to formally integrate traditional and biomedical science within the U.S. healthcare system.

I will begin my recommendation by identifying obstacles to effective cultural competency programs. First, I will analyze positive aspects of Texas medical school programs and their role in fulfilling the cultural competency components. I will then review different types of educational and communication models, including their implementation and teaching styles. Considering how culture and language are intertwined, I will delve into the importance of cultural humility and recognizing how language proficiency is not the same as cultural awareness. Understanding culture can be a hindrance if physicians do not address cross-cultural communication barriers with their patients because it can lead to reinforcement of stereotypes against patients based on their ethnicity. Outside of medical education, the use of cultural brokers will be discussed as a

supplement to physician training on culture and language. The chapter concludes with my recommendation for a new cultural competency program.

Cultural Competency Education Obstacles

Research on cultural competency education has found that training improves provider knowledge and attitudes while also reducing provider bias towards racial/ethnic minority patients. The question therefore arises as to why cultural competency training is not being implemented across medical schools (Jernigan et al., 2016). Culture itself is a multi-faceted and complex topic to cover as it encompasses more than just nationality, race, or ethnicity (Vaughn et al., 2009). Culture is constantly developing, making cultural competency a life-long endeavor. With such a complex and fluid topic, teaching and measuring cultural competency training is challenging, lacks standardization, and comprises diverse programs/methods (Jernigan et al., 2016). Aside from difficulties measuring program outcomes, there is resistance among faculty and students against cultural competence training. Resistance against training has stemmed from the “time- and labor-intensive nature of the training in already busy schedules, lack of institutional commitment, lack of full-time funding to support training, and the lack of culturally competent role models” (Jernigan et al., 2016, p.8). Another barrier to cultural competency programs is its lack of integration into biomedical models because students and faculty are forced to examine their own beliefs about how medicine is taught and practiced around culture. Since medicine is firmly grounded in biomedical practice, it is difficult to completely reimagine a medical model that incorporates culture and language. Outside of higher education, physicians face various obstacles, such as time constraints,

that aggravate the cultural barriers between doctors and their patients (Magaña, 2020).

Cultural competency has the potential to address many healthcare disparities today, and it is imperative that medical schools take the initiative to overcome the obstacles preventing effective cultural competency training.

Medical Spanish Courses

Nevertheless, some Texas medical schools offer courses, programs, and resources to enrich students' cultural education. Schools like UT Southwestern, UT McGovern, UTMB, and TAMU-COM offer optional medical Spanish courses to supplement their education. Only two of the thirteen Texas medical schools mandate a medical Spanish course. For example, the Spanish program under PLFSOM is unique as it requires all medical and dental students to take the course throughout the first two years of medical school and incorporates various components of cultural competency. Aside from language, the course known as "Society, Community, and Individuals" teaches population health, culture, and other aspects of health impacting border residents. Students also are required to participate in field experiences to apply the lessons and gain exposure to the border community. The requirement is meant to address the primarily Spanish-speaking patients in El Paso and teach students how to interact and treat communities with different backgrounds. PLFSOM structures the class to include linguistic, cultural, and field experience and makes it a mandatory course for every student to gain the invaluable skill of cultural competency. A second program, TTUHSC in Lubbock, has a similar requirement of its students, only differing in the curricular structure. TTUSHC divides the linguistic and cultural courses into the year-long patients,

physicians, and populations (PPP 1) course and an online basic medical terminology course. The PPP1 course is used to provide the framework for students to gain skills like cultural competency, teamwork, and collaboration (*4 Year Curriculum Overview*, n.d). In addition, the PPP1 course introduces topics like health systems, health policy, and social/cultural issues impacting health. It addresses the cultural history and context necessary to understand a patient's culturally-informed decision. Although the online medical terminology Spanish course is a step in the right direction to promote communication between physicians and patients, basic Spanish terminology does not replace the ability to hold a conversation with patients.

Elective Courses in Cultural Competency

While cultural competency should be a required course, specific Texas medical schools offer structured and well-rounded electives on cultural competency. An example is McGovern medical school, offering electives in cultural conversations and medical Spanish. The cultural conversations elective teaches cross-cultural implications in medicine and how to incorporate this knowledge when treating patients with different cultural backgrounds. The course addresses a wide range of topics from language barriers, mental health in minority populations, and complementary medicine. The medical Spanish elective incorporates both language (eight courses) and culture (two courses). The linguistic component of the medical Spanish elective emphasizes a foundation to communicate with Spanish-speaking patients in a medical setting, gain skills to accurately obtain a patient's medical history and provide feedback on a patient's health conditions (A.P. Gomez, personal communication, November 1, 2023). The

cultural aspect of the course is taught through guest speakers and aims to instill cultural competencies to understand and manage the cross-cultural barriers between a patient and physician. The structure of the elective courses provides a well-rounded education to introduce cultural competency skills for students. Unfortunately, courses are electives, and students do not have to participate unless they have personal goals to become culturally competent. Nevertheless, all Texas medical schools accredited by the LCME contain some semblance of cultural competency in their educational program objectives to fulfill the LCME requirement. While technically Texas medical schools are meeting the LCME requirements, there should be a standardized cultural competence curriculum among all schools to ensure Texas physicians are actually prepared to treat patients of different cultural backgrounds.

Current Education and Communication Models

Before a standardized curriculum can be proposed, the current educational and communication models used to teach cultural competency must be reviewed. Educational models for teaching culture vary on multiple factors like implementation, teaching styles, time frames, and evaluation of participants. (Examples of educational models and their descriptions are listed in Chapter 6, Table 1.) Not every model is used to specifically address cultural competency, which makes one question whether the models are actually addressing the issue at hand. On the same note, cross-cultural communication models are utilized to teach students how to interact with patients of different cultural backgrounds (Hobgood et al., 2006). Examples of communication models are listed in Chapter 6, Table 2. It is important to recognize that educational and communication models need to

be used together to ensure a well-rounded foundation in cultural competency. Teaching aspects of culture is not sufficient to address the communication barriers within the physician-patient relationship, and teaching communication skills will not be effective without cultural knowledge.

A review of educational models illustrates various methods of teaching cultural competency. The Culture and Diversity Course model is a year-long training program for second-year medical students based on the twenty-seven core competencies from the American Medical Student Association's Promoting, Reinforcing, and Improving Medical Education (AMSA PRIME) project (Hobgood et al., 2006). The model includes interactive lectures, videos, role play, workshops, community-based service learning, and patient interviews to establish an educational model grounded in specific competencies and a framework allowing for skill acquisition to be assessed (Hobgood et al., 2006). The diverse teaching formats account for different components of cultural competence like historical context, social determinants, behavior, health practices, spiritual beliefs, and language. The community-based service aspect of the culture and diversity course model provides students an opportunity to solidify their knowledge while gaining experience and practice of multicultural communication skills (Kripalani et al., 2006).

Another model found outside of the U.S. is the immersion model from New Zealand, which promotes learning about other cultures and "principles associated with cultural safety to address the issue of unconscious inherited racism in medical training" (Hobgood et al., 2006, p.1291). Participants train to be open-minded and non-blaming toward patients from different cultural backgrounds so that the patient population will view providers as culturally safe (Hobgood et al., 2006). The model is a one-week

immersion program for third-year medical students where “they are placed in a remote region with one of the New Zealand tribes to learn about the culture and to assess health needs” (Hobgood et al., 2006, p.1292). The immersion model can provide an in-depth experience with culture that is not often replicated within a traditional hospital setting but should be carefully structured to ensure the utmost respect for the community being studied.

Understanding culture is not enough to bridge the cultural barrier between a physician and patient. This fact highlights the importance of effective communication and negotiation models in cultural competency training. Communication models vary in framework; some models guide the student on how to approach a patient and interact with them, while other models provide questions to address a patient’s cultural health beliefs. An example of a guiding framework is the LEARN model:

- Listen with sympathy and understanding to the patient’s perception of the problem
- Explain your perceptions of the problem
- Acknowledge and discuss the differences and similarities
- Recommend treatment
- Negotiate treatment

The LEARN model offers more than just questions since it helps the physician build on cultural values like *respeto* (respect) and *personalismo* (friendliness) by listening and giving the patient an opportunity to participate in their own healthcare treatment.

A similar model to LEARN is the ETHNIC model, which takes a further step to directly address a patient’s cultural health practices. The ETHNIC model stands for

explanation, treatment, healers, negotiate, intervention, and collaboration. The first three components ask the patient to explain their illness, the treatments they have tried, and if they sought any advice from folk healers (AAMC, 2005). The last three components involve communication between the physician and patient as they negotiate acceptable treatment options, agree on a treatment, and collaborate with patients and their families for treatment adherence (AAMC, 2005). By directly addressing possible cultural health practices and collaborating with the patient on treatments, a physician demonstrates cultural values like *respeto* (respect), *personalismo* (personalism), and *familismo* (family-orientation). Observance of cultural values decreases patient distress and increases treatment effectiveness (Magaña, 2020).

The LEARN and ETHNIC models provide a behavioral framework to build social interaction skills; however, other models effective if presented in an appropriate way. In particular, Kleinman's Explanatory Model of Illness presents eight questions to elicit a patient's explanation of their condition by asking:

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Will it have a short or long course?
5. What kind of treatment do you think you should receive?;
6. What are the most important results you hope to receive from this treatment?
7. What are the chief problems your sickness has caused for you?

8. What do you fear most about your sickness? (Kleinman et al., 1978)

Patients are often hesitant to disclose their cultural health beliefs to their provider for various reasons, so clinicians need to be persistent in demonstrating genuine interest in the patient's cultural practice (Kleinman et al., 1978). Kleinman's last three questions model allow patients to explain their therapeutic goals and the psychosocial and cultural meaning of their illness (Kleinman et al., 1978). Having patients explain their goals actively incorporates them in their treatment and allows physicians to learn about the cultural meaning of that illness.

Biomedical models provide practicing physicians a guideline for patient interactions to enhance the skills and knowledge needed to address cultural barriers. A biomedical model that outlines the essential components of culturally competent healthcare is CRASH – Culture, show Respect, Assess/Affirm differences, show Sensitivity and Self-awareness, and do it with Humility (Rust et al., 2006). The CRASH-course in cultural competency emphasizes uses interactive teaching methods like “didactic presentations, self-awareness instruments, video-vignettes, case studies, and group discussions” (Rust et al., 2006, p.31) The model combines the importance of understanding culture and how to interact with a patient with a different background. The six basic components of the CRASH-course model can be taught in formats ranging from a one-hour introductory session to a full-day workshop, which makes it an easily adaptable model for programs to implement.

Similar to the CRASH model, the Awareness-Assessment-Negotiation (A-A-N) model requires participants to be culturally informed and gauge a patient's cultural beliefs without stereotyping according to ethnicity. Used by practicing physicians, the awareness aspect of the A-A-N model requires the clinician to be culturally informed and become aware of commonly held beliefs and practices within their community (Pachter et al., 2016). The next step of the A-A-N model leads the clinician to "assess the likelihood that an individual patient subscribes to and acts upon these beliefs during a particular illness episode" (Pachter et al., 2016, p.1073). By taking the step to assess whether patients participate in certain cultural beliefs, physicians can circumvent the issue of stereotyping members of a group as having the same practices. Once an assessment is done by obtaining a patient's health belief history, the negotiation portion of the model is utilized if non-biomedical beliefs are being used by the patient. Non-biomedical beliefs refer to traditional medicine and spiritual healing (detailed in Chapters Two and Three). After cultural treatments are identified, physicians negotiate a plan to "safely combine the ethnomedical and biomedical beliefs and practices in order to increase adherence to biomedical therapies" (Pachter et al., 2016, p.1073). To ensure patient safety, physicians need to also assess if the traditional medicine practice is benign and develop a plan to integrate both forms of treatment. Taking the time to incorporate safe non-biomedical treatments that fit within a patient's beliefs demonstrates to the patient that the clinician is respectful of their practices and strengthens the physician-patient relationship.

Cultural Competency Versus Cultural Humility

There are dozens of cultural competency training models; however, cultural competency is a “commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves” (Tervalon & Murray-García, 1998, p.118). Culture has a major impact in a patient’s life, more than just their healthcare decisions. Undergoing the journey to become culturally competent is life-long, requiring healthcare professionals to practice humility as they self-reflect and self-critique themselves as learners of a culture (Tervalon & Murray-García, 1998). The term “cultural humility” best illustrates the process when physicians understand the power imbalance in the physician-patient relationship through communication and actively counter it using patient-focused interviewing and care (Tervalon & Murray-García, 1998). Culture is a complex concept composed of beliefs, behavior, customs, social constructs, and language that will never be fully understood by those who aim to learn it. Even individuals who participate in their respective cultures will not always be able to translate their beliefs to other cultures. It is important to recognize that learning aspects of culture like health beliefs or language through educational models and trainings is *not* enough to bridge cultural gaps. It is easy for one to gain a false sense of security on their cultural knowledge which can result inadequate and potentially harmful outcomes (Tervalon & Murray-García, 1998). They describe a case exemplifying such potentially harmful outcomes:

An African American nurse caring for a middle-aged Latina woman several hours after the patient had undergone surgery. A Latino physician on a consult service approached the bedside and, noting the moaning patient, commented to the nurse that the patient appeared to be in a great deal of postoperative pain. The nurse summarily dismissed his perception, informing him that she took a course in nursing school in cross-cultural medicine and ‘knew’ that Hispanic patients over-express ‘the pain they are feeling.’ The Latino physician had a difficult time influencing the

perspective of this nurse, who focused on her self-proclaimed cultural expertise. (p.118-119).

Learning cultural behaviors is a vital component of cultural competency, but it does not equate to expertise. Similarly, being proficient in a language does not necessarily fulfill cultural competence. While it is important that healthcare professionals address language barriers by learning Spanish (or other languages), there is still risk of miscommunication caused by lack of cultural competence. Medical interpreters are obvious examples where language proficiency may not substitute for cultural competency training. Magaña (2020) points out that “the law does not require interpreters to be certified, and bilingual staff or health care workers often assume interpreting roles even if they have had little formal training” (p.2). Without formal training in cultural competency or medical interpretation, interpreters can hinder the doctor-patient relationship by editing or deleting pieces of the conversation and acting as co-diagnosticians through selective interpretation (Magaña, 2020). While interpreters are meant to help bridge the language gap, they can essentially sow more mistrust of the healthcare system in Hispanic patients.

Vaughn et al. (2009) proposes a solution using intermediaries known as cultural brokers or lay health workers. Cultural brokers in healthcare are patient advocates who act as “liaisons, bridging, linking, or mediating between the healthcare provider and the patient whose cultural background differ in order to negotiate and facilitate a successful health outcome” (Vaughn et al., 2009, p.70). Lay health workers, such as *promotores* “healthcare promoters”, provide public health services to individuals who do not have access to equitable and adequate healthcare (Vaughn et al., 2009). They usually have lived in the communities they serve, providing health education and service delivery within a limited scope of practice. Using their cultural knowledge and social networks

within the community, they provide insight for physicians and provide tools to spread health information. Individuals like cultural brokers and lay health workers have the potential to supplement healthcare professionals during the journey of learning cultural competency.

Recommendations and Components of Cultural Competency Training

My formal recommendation for cultural competency training incorporates a combination of educational and communication models with an outline of key ideas that should be required. The recommendation is based on cultural competence education being clearly interwoven throughout clinical education. As previously mentioned, becoming culturally competent is a complex and life-long process (Kripalani et al., 2006). Most Texas medical schools offer only optional electives to teach cultural competency; therefore a program must be implemented through all four years of medical school and be a requirement to graduate. A requirement may seem like an additional hurdle for already stressed medical students, but culturally-relevant knowledge and skills need to be reinforced throughout their pre-clinical and clinical years. The cultural competency education should be broken into three parts: culture, language, and awareness.

Cultural Competency

The first aspect of the program would take a knowledge-based approach to teach cultural aspects like history, the use of herbal medicine, spiritual healing, social determinants that impact health, environmental impacts on health, and other cultural

barriers in medicine. The information for the culture component of the program is addressed in the first five chapters of this thesis is intended to help provide context to Hispanic cultural beliefs and their influence on behavior. In a knowledge-based approach, the information can be taught using the Culture and Diversity Course model. Through interactive lectures, videos, workshops and other teaching formats, students can develop the knowledge needed for skill acquisition later in the program. Effective knowledge-based culture education is highlighted in the culture conversations elective at the UT McGovern school of medicine. By addressing topics like language barriers, mental health in minority populations, and complementary medicine, students can learn cross-cultural implications of medicine and how to incorporate the information into treating patients with different cultural backgrounds.

Language

The language component of the recommendation is a simple requirement, which has students learn medical Spanish in the first two years of their medical school education. This component is closely modeled by the curriculum at the Paul L. Foster School of Medicine in El Paso. Students are required to participate in field experiences to learn medical Spanish and apply skills in the individual course, community, and society at large. Another school to model for the language component would be the University of Texas McGovern Medical School, specifically their medical Spanish elective. The course emphasizes a foundation to communication with Spanish-speaking patients in medical setting, gain skills to accurately obtain a patient's medical history, and provide feedback on a patient's health conditions (A.P. Gomez, personal communication, November 1,

2023). By producing more Spanish-speaking providers, communication issues can be improved and can help build the cultural value of *confianza* (trust) in the healthcare system (Magaña, 2020).

Awareness

The final component is awareness, which specifically focuses on cultural humility and addressing the student's implicit biases. Learning other cultures is a lifelong commitment that requires more of individuals than just taking courses, which is why cultural humility should be integrated. Taking the time to self-evaluate and self-critique, equalize the power in the physician-patient dynamic, and develop beneficial partnerships with the community allows healthcare providers to provide culturally competent care to their patients (Tervalon & Murray-García, 1998). Since health practitioners are influenced by culture in unconscious ways, self-awareness can foster “strong professional perspectives, allowing healthcare workers to connect with others while maintaining personal integrity and respecting the individuality and diversity of each client” (Rukadikar et al., 2022, p.4322). The awareness aspect of the program would be evaluated through narrative writing or self-reflective journal assignments. By having students participate in self-reflective writing, they “openly reflect on their values, beliefs, and biases, and encourages them to consider their personal experiences with prejudice, discrimination, challenging patient encounters and prior mistakes” (Kripalani et al., 2022, p.1117). The awareness component emphasizes the importance of cultural humility in regard to other cultures and reflection on the students' personal beliefs that could impact patient interactions.

Potential Models

The three components of culture, language, and awareness should be implemented together to gain practical skills. Programs could select from the following models based on their individual needs. First, to prevent the overgeneralization of culture across a population, students participate in interactive educational methods like standardized patient encounters and role-play to help develop the communication skills needed while still receiving feedback from the trained actor (Kripalani et al., 2006). After developing the necessary skills within the pre-clinical years, students would be encouraged to participate in community service activities within the Hispanic community to reinforce and apply the skills. By applying the information from the cultural competency training into practice, the issue of reinforcing stereotyping behavior is avoided since students are applying knowledge of socio-cultural issues at an individual level (Kripalani et al., 2006). In addition, students learn first-hand that a Hispanic patient may exhibit different behavioral patterns and health beliefs based on factors like individual experience (Kripalani et al., 2006).

To help foster effective communication skills, there are various models that could be utilized based on preference. The five models recommended would be LEARN, ETHNIC, CRASH, A-A-N, or the Kleinman explanatory model of illness. The LEARN and ETHNIC models guide the student on how to interact with a patient by developing cultural values and encouraging patient involvement. The models can be supplemented with Kleinman's questions to address a patient's mistrust of the healthcare system through

genuine interest in the patient's cultural practices and actively including the patient in their treatment.

The CRASH or A-A-N model would be a better framework to incorporate all three components of the cultural competency training since they both compel students to be culturally informed to effectively utilize them. The A-A-N model, in particular, guides the student to gauge a patient's cultural beliefs and "safely combine the ethnomedical and biomedical beliefs and practices in order to increase adherence to biomedical therapies" (Pachter et al., 2016, p.1073). By incorporating safe non-biomedical treatments that align with a patient's cultural beliefs, the healthcare provider practices *respeto* which strengthens the physician-patient relationship. The CRASH model better exemplifies the awareness component of cultural competency training since it guides students on how to interact with patients of different cultures.

As students apply the educational models to standardized patient encounters or role-play scenarios, they would be observed and receive feedback from their professors. To receive effective and useful feedback, faculty members should already demonstrate cultural competence and humility as well. Educators have a major influence on their students which can "inadvertently foster and perpetuate rigid stereotypes of the risk factors for members of a particular group" if not educated on cultural competency (Hobgood et al., 2006, p.1290). Having faculty who model cultural awareness and value culture from a patient's perspective can serve as strong professional role models for students learning cultural competency. Employing a more culturally diverse faculty who are sensitive to multicultural approaches to medicine can address the difficulty in recruiting strong cultural role models for students. Hiring a more diverse faculty also

fulfills DEI initiatives that may apply towards cultural competency as well. The issue of having culturally aware models within healthcare is larger than medical education, as residency programs must also consider the behaviors being reinforced. As Hobgood et al. (2006) states,

In a typical clinical-training environment, the trainees' efforts often are focused on providing patient care that will impress and gain the approval of senior members of the team ... if the attending or senior residents do not place value on enhanced cultural awareness ... [it] may lead to the modeling and reinforcement of negative traits at the expense of understanding the cultural components of the patient (pg.1289-1290).

Cultural competency must be incorporated in medical school, medical residency, and continuing medical education to ensure reinforcement of important knowledge and skills to provide culturally competent care. Residency programs need to reflect on their current education model and adjust their priorities towards cultural humility training and hiring culturally aware role models. Nonetheless, the evaluation of residency programs and cultural competency is beyond the scope of this particular thesis.

Fulfillment of National Standards for Cultural Competency

The current recommendation for cultural competency programs in Texas medical schools can be utilized to fulfill the LCME and AAMC cultural competency standards. Using the TACCT domains listed in the previous chapter, the outline provided fulfills each domain on cultural competence. The first required domain includes a definition and understanding the importance of cultural competency, which would be fulfilled throughout classes and clinical interactions. The second domain requires key aspects of cultural competency be incorporated such as understanding a patient's healing traditions and beliefs, institutional cultural issues, and information on the history of the patient and

their community of people (AAMC, 2005). The culture component of the recommended program would cover every aspect in the second domain by teaching students the various aspects of culture. The third domain discusses the history of stereotyping, bias, discrimination, and the effects of stereotyping on medical decision-making which would be fulfilled through the culture and awareness sections outlined (AAMC, 2005). Teaching historical background on health disparities affecting the Hispanic culture in the culture class and identifying one's own biases in the awareness class would satisfy both the third and fourth domain in TACCT. The final required domain covers cross-cultural clinical skills. The program would instill cross-cultural clinical skills by teaching medical Spanish to bridge the language barrier and patient interactions using various biomedical models to teach communication skills. The cultural competency training program would combine culture, language and awareness, thereby, developing important clinical and communication skills to provide culturally competent care and also satisfy each TACCT domain.

Conclusion

Culture is larger than a lecture on cultural history or a single patient interaction. Culture permeates every aspect of an individual's life: behavior, knowledge, beliefs, customs, habits, language, values, rituals, relationships and much more. While this thesis covers Hispanic culture, every single patient and culture deserves consideration and respect. To learn the history of a culture and its unique beliefs and practices, each component cumulates to a complex construct that physicians should acknowledge when treating a patient. Understanding culturally-informed medical decisions of herbal

medicine, spiritual healing, and pharmaceutical abuse can potentially save someone's life. The risks associated with informal medical integration between biomedicine and complementary medicine is too high, as drug interactions can range from mild side effects to death. Many physicians are unaware of complementary medicine use, so we need to improve insufficient communication skills to avoid their negative impact on patients. Cases like that of Willie Ramirez highlight the dangers of inadequate communication and lack of cultural competency within the health care system. To address the risks stemming from inadequate cultural competency skills, Texas medical schools need to reflect on their current curricula and objectives to ensure they are preparing physicians to provide culturally competent care. The multifaceted program recommended above can achieve the goal of producing culturally competent physicians with the goal of improving the healthcare system for minority patients.

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