**RESOLUTION 38-18**

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| Title: | Peer-Facilitated Intergroup Dialogue |
| Introduced by: | Nabiha Hashmi for the Medical Student Section |
| Original Authors: | Salma Aljamal, Sameen Ansari, BreeOna Ebrecht, Michelle Fedorowicz, and Nabiha Hashmi |
| Referred to: | Reference Committee E |
| House Action: | **APPROVED AS AMENDED** |

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Whereas, the current Association of American Medical Colleges' guidelines emphasize promotion of cultural competence in medical education; however, cultural competence fails to account for the intricacies of cultural humility which posits that one cannot ever fully be competent in another's culture[1,2], and

Whereas, cultural humility is a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one starts with an examination of his or her own beliefs and cultural identities[3], and

Whereas, learning cultural humility is vital for physicians because poor health communication between a physician and patient of a different cultural background can lead to poor health outcomes[4], and

Whereas, cultural competence is primarily taught in a didactic setting in medical schools; however, studies have found that didactic instruction alone was not sufficient in achieving cultural proficiency, yet a combination of didactic instruction and cross-cultural activities proved more effective in improving comprehensive cultural competence[5,6], and

Whereas, peer-facilitated intergroup dialogue is a facilitated group experience that may occur once or may be sustained over time and is designed to give individuals and groups a safe and structured opportunity to explore attitudes about polarizing societal issues[7], and

Whereas, peer-facilitated and structured interactions of intergroup dialogue are important for creating engagement across differences which would lend to better communication between physicians and patients of diverse backgrounds[8], and

Whereas, studies have shown clear evidence of dialogue leading to increased intergroup understanding and attitude change[9], and

Whereas, a few medical schools such as Georgetown and New York University have already adopted intergroup dialogue into their curriculum[10,11], and

Whereas, the American Medical Association has previously resolved to support efforts designed to integrate training in cultural competence across the undergraduate medical school curriculum[12]; therefore be it

RESOLVED: That MSMS encourages the inclusion of peer-facilitated intergroup dialogue in clinical medical education in Michigan, including but not limited to, medical schools and residency programs; and be it further

RESOLVED: That the Michigan Delegation to the American Medical Association (AMA) ask our AMA to work with the AMA Council on Medical Education and Academic Physician Section to encourage the Accreditation Council for Graduate Medical Education, Liaison Committee on Medical Education, Commission on Osteopathic Accreditation, Association of American Medical Colleges, and Accreditation Council for Continuing Medical Education to encourage the inclusion of peer-facilitated intergroup dialogue in medical education programs nationwide.

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WAYS AND MEANS COMMITTEE FISCAL NOTE: NONE

**Relevant MSMS Policy:** None

**Relevant AMA Policy:**

**Educating Medical Students in the Social Determinants of Health and Cultural Competence H-295.874**
Our AMA: (1) Supports efforts designed to integrate training in social determinants of health and cultural competence across the undergraduate medical school curriculum to assure that graduating medical students are well prepared to provide their patients safe, high quality and patient-centered care. (2) Supports faculty development, particularly clinical faculty development, by medical schools to assure that faculty provide medical students' appropriate learning experiences to assure their cultural competence and knowledge of social determinants of health. (3) Supports medical schools in their efforts to evaluate the effectiveness of their social determinants of health and cultural competence teaching of medical students, for example by the AMA serving as a convener of a consortium of interested medical schools to develop Objective Standardized Clinical Exams for use in evaluating medical students' cultural competence. (4) Will conduct ongoing data gathering, including interviews with medical students, to gain their perspective on the integration of social determinants of health and cultural competence in the undergraduate medical school curriculum. (5) Recommends studying the integration of social determinants of health and cultural competence training in graduate and continuing medical education and publicizing successful models.

**Enhancing the Cultural Competence of Physicians H-295.897**
1. Our AMA continues to inform medical schools and residency program directors about activities and resources related to assisting physicians in providing culturally competent care to patients throughout their life span and encourage them to include the topic of culturally effective health care in their curricula.
2. Our AMA continues to support research into the need for and effectiveness of training in cultural competence, using existing mechanisms such as the annual medical education surveys.
3. Our AMA will assist physicians in obtaining information about and/or training in culturally effective health care through dissemination of currently available resources from the AMA and other relevant organizations.
4. Our AMA encourages training opportunities for students and residents, as members of the physician-led team, to learn cultural competency from community health workers, when this exposure can be integrated into existing rotation and service assignments.
5. Our AMA supports initiatives for medical schools to incorporate diversity in their Standardized Patient programs as a means of combining knowledge of health disparities and practice of cultural competence with clinical skills.

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[12] AMA Resolution H-295.874. "Educating Medical Students in the Social Determinants of Health and Cultural Competence". Approved 2006, Reaffirmed 2011, Modified 2014, Reaffirmed 2015.