

An Innovative Approach to Developing a Cultural Competency Curriculum; Efforts at the John A. Burns School of Medicine, Department of Native Hawaiian Health

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Abstract

Introduction: Initial efforts to teach cultural competency at the University of Hawai'i John A. Burns School of Medicine began in the late 1990s through the Native Hawaiian Center of Excellence. With the formation of the Department of Native Hawaiian Health in 2003, cultural competency training was added as a key area of focus for the department. A multidisciplinary team was formed to do the ground work. Physicians (Family Medicine and Internal Medicine) and an administrator (MBA now at Queens Medical Center) from the Department of Native Hawaiian Health were joined by a cultural anthropologist (Department of Family Medicine and Community Health), a social worker (UH Myron B. Thompson School of Social Work), and a retired DrPH/Registered Dietician from the State Department of Health to form the cultural competency curriculum team. All but one of the team members is Native Hawaiian.

Discussion: As cultural competency training is a relatively new, rapidly developing field, there is no consensus on how to teach it. The department decided early on to focus on a variety of methodologies using Native Hawaiian health as the curriculum's foundation. Many different paths were taken toward the development of the present curriculum which utilized different components within the medical school's curriculum. This paper describes the process and development of a cultural competency training curriculum at the University of Hawai'i medical school. Recent literature recommendations by experts in the field reinforce the current curricular content that resulted from this developmental process.

Introduction

There has been a national compendium of standards around the topic of using cultural competency training as a way to address the health disparities confronting our nation's minority populations. In addition, health related regulatory agencies are now requiring cultural competency training for healthcare providers. This has also resulted in efforts to develop cultural competency training in medical schools.

There are a multitude of definitions of "cultural competency" developed over the past decade or so. A definition used by the federal Health Resources and Services Administration centers on a process that adapts according to the needs of individuals and organizations. It includes, as originally defined by Cross and colleagues, "a set of congruent values, behaviors, attitudes and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations."^{1,2} Most definitions assume an understanding of the diversity of patient populations.

Herein are included a few examples of the myriad of standards and recommendations related to the requirement for, and content of, cultural competency training. The National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS standards), issued by the US Department of Health and Human Services, Office of Minority Health in March 2001, were established to ensure that all people entering the health care system receive equitable and effective treatment in a culturally and linguistically appropriate manner. These standards were proposed as a means to

correct inequities and to be inclusive of all cultures.³ The Institute of Medicine (IOM) in 2002 concluded that "(al)though myriad sources contribute to these disparities, some evidence suggests that bias, prejudice, and stereotyping on the part of healthcare providers may contribute to differences in care." Consequently, they recommend "integrate cross-cultural education into the training of all current and future health professionals."⁴ The Liaison Committee on Medical Education (LCME) requires the inclusion of cultural components of care in medical education.⁵ Organizations such as the California Endowment published recommended standards for the content of cultural competence education in the areas of attitudes, knowledge, and skills.⁶ Jordan J. Cohen, the President of the Association of American Medical Colleges (AAMC), summed it up in 2003:

"One of the most difficult challenges facing medical education is how to inculcate the knowledge and skills required for culturally competent patient care. Given the rapidity of demographic changes in our society, virtually every future physician will have responsibility for caring for a more diverse group of patients than is the case today. The needed competencies cannot be adequately acquired from books and lectures alone; what's required is emersion (sic) in learning environments in which sufficient numbers of students (and faculty) from diverse racial and ethnic backgrounds interact on a continuous basis."⁷

A concern is raised that cultural competence tends to focus on the "other" at the expense of what the practitioner brings to the patient-physician relationship. A better option may be the recently-coined term, "cultural humility," which focuses instead on the development of a respectful partnership with the patient. In order to be culturally humble, the practitioner must commit to be self reflective, self critical and culturally inquisitive in the service of establishing non-paternalistic clinical relationships with patients, their families and communities.^{8,9} While the authors support the philosophical shift in the term "cultural humility," this paper will use the more commonly known term, "cultural competence/competency." This is also the term originally used for the project.

The Need for Cultural Competency Training in Hawai'i

Cultural competency training is also needed in Hawai'i, with its ethnically diverse population.¹⁰ Many of these diverse populations suffer from health disparities.^{11,12} Native Hawaiians, the host culture, have some of the worst health statistics of all ethnic groups in the state of Hawai'i. They have the highest mortality rates for heart disease, cancer, stroke, accidents and diabetes.^{13,14} Life expectancy for Native Hawaiians continues to be the lowest of all groups and has even plateaued in contrast with longevity gains being made by other ethnic groups.¹⁵

Initial efforts to address Native Hawaiian health and health disparities through cultural competency training for physicians and medical students began in the late 1990's with the establishment of the Native Hawaiian Center of Excellence (NHCOE) at the University of Hawai'i (UH) John A. Burns School of Medicine (JABSOM). The

NHCOE, under the guidance of Dr. Benjamin Young, discovered that many faculty and community physicians were unaware of Native Hawaiian health disparities. NHCOE addressed this knowledge gap by sponsoring continuing medical education (CME) conferences with cultural competency training. Topics included Native Hawaiian health disparities, social determinants of health, teaching, research, and traditional healing.

In 2001, in collaboration with the 'Ahahui o nā Kauka (Association of Native Hawaiian physicians) and Protect Kaho'olawe 'Ohana, the NHCOE organized the first Kaho'olawe island cultural immersion experience for Native Hawaiian and other interested physicians. This was in response to requests from Native Hawaiian physicians for the opportunity to learn about their own culture.^{16,17} The structure of the weekend allowed physicians to immerse themselves in land-based activities that promoted indigenous healing. The concept of the 'āina (land) as a healing agent was very moving, and the participants continue to talk about that experience today.

Discussion/Description of Project

Formation of the Department of Native Hawaiian Health, 2003

In October 2003, the Department of Native Hawaiian Health (DNHH) was established within JABSOM as the only medical school department solely dedicated to indigenous health in the United States. In February 2004, a community strategic planning meeting was held to establish the vision, mission and objectives for this newly established department. In keeping with traditional Hawaiian values that honor the wisdom of the elders and community leaders, invited participants included *kupuna* (elders), traditional healers, other health care professionals, and community representatives. Participants strongly recommended that all JABSOM medical students undergo cultural competency training.

Formation of the Cultural Competency Development Project, 2004

As a result of this meeting and with the encouragement of then Dean Cadman, the DNHH began the process of developing a cultural competency curriculum for JABSOM and thus, the Cultural Competency Curriculum Development Project ("C3") was born. By this time, the NHCOE had also been absorbed into the DNHH which allowed for increased collaborative work in the area of cultural competency. While much was being published about cultural competency in healthcare during this period, a literature search of national medical training programs acknowledged that cultural competence was not being widely taught in medical schools.¹⁸

Formation of the Cultural Competency Curriculum ("C3") Development Team

The cultural competency curriculum development team ("C3") was purposely multi-disciplinary; guided by the Native Hawaiian 'Ōlelo no'eau (proverb) that instructs, "'A'ohē pau ka 'ike i ka hālau ho'okāhi" (all knowledge is not taught in the same school).¹⁹ The original members of this committee were comprised of a diverse and experienced group of healthcare professionals, some of whom were also cultural practitioners: two primary care physicians and an administrator from the DNHH, a social worker from both the JABSOM Department of Psychiatry and UH School Social Work,

a retired DrPH and dietician from the State of Hawai'i Department of Health, and a cultural anthropologist and researcher from the JABSOM Department of Family Medicine and Community Health. A *kupuna* physician and another primary care physician are recent additions.

Development of the Curriculum

Early discussions centered on curricular objectives. The team recognized that there were many diverse ethnic populations in Hawai'i, such as the recent immigrant population of Micronesians, also suffering from significant health disparities.^{11,12} However, the consensus of the group was to focus on addressing the health and health disparities of Native Hawaiians, the host culture. Specifically, the curriculum would do this by enhanced training of students and physicians who interact with Native Hawaiian patients. Should the curriculum prove successful, it could then be broadened to include other ethnic and social groups.

The first step in the development of the curriculum was to look at strengthening the "culture" in cultural competency training. Hawaiian issues relating to well-being, cultural practices, and spirituality needed to be an integral part of the training. To address this, the team knew it needed to go back to the culture for guidance. They asked for advice from Native Hawaiian *kupuna* and community members, medical students and physicians (the latter participated in at least one of three Kaho'olawe immersions) in the form of focus groups. The results helped guide the formation of the curriculum.²⁰

Initially, C3 focused on faculty training, as faculty behavior is frequently modeled by medical students. It would be ideal if both faculty and medical students could be trained concurrently, but there were limited resources available at that time. Various teaching and assessment strategies for the faculty were proposed including web based teaching, small group discussions, and role playing, self-reflections, self-assessments, pre and post tests, and CME courses. We initially partnered with the Hawai'i State Department of Health, Office of Health Equity as they were also developing cultural competency training. This proved challenging due to timeline differences.

There was no budget allocated for any of these proposed initiatives. Serendipitously, the Project Director received monies from the UH Kualii Council (Native Hawaiian faculty and staff and representatives of Native Hawaiian serving programs) for culturally competent initiatives for medical students. As a result, the team's focus changed from faculty to medical student training. Faculty development would have to wait.

As with all under-funded innovative projects of this type, progress depends on the passion and commitment of those tasked with making it happen. Many members of the C3 team initially volunteered their time in the development and implementation of the curriculum, including spending entire weekends in project activities.

Cultural Immersion

Cultural immersion programs have great potential as a method of consciousness-raising among medical students to counter the effects of non-conscious inherited racism and biases, and the impact of these beliefs on health care.²¹ Cultural immersion is based on the principle that immersion in another's culture, practices, and language is an effective means of learning about oneself "in" another culture. The team studied the week long immersion experience of 3rd year medical

students from the University of Otago in Aotearoa (New Zealand) to different remote predominantly Maori rural communities.²² Because of its potential as a great learning experience, the C3 team chose to start with a medical student immersion. The model, though not the venue, was the cultural immersion programming conducted a few years earlier for physicians on Kaho‘olawe island. In attempting to duplicate the essence of the Kaho‘olawe experience, the Wai‘anae Coast on the island of O‘ahu was chosen as the immersion site. Its population is predominantly Native Hawaiian and the community is rich in cultural resources. Since 2006, six medical student immersions have been conducted. Approximately 25% of each first year JABSOM class participated after a random selection process. Immersions focus on (1) increasing students’ capacity for empathy by exposing them to a different worldview, (2) developing critical self reflection/self awareness, (3) experiencing traditional Hawaiian cultural practices, and (4) exploring traditional and contemporary Native Hawaiian values and beliefs, focusing on the culture’s strengths. Cultural immersion programming is guided by the Hawaiian ‘*Ōlelo no‘eau*, “*Ma ka hana ka ‘ike*” (In the doing, one learns).¹⁹

Colloquia

In 2006, after discussions with, and support from, JABSOM’s Office of Medical Education, a 4-hour mandatory cultural colloquium (lecture) was incorporated into the Community and Populational Health Colloquial Series for first year medical students. This provided the opportunity to address Native Hawaiian cultural issues with the entire class. With slight variation over the years, core topics continue to include Native Hawaiian health disparities with emphasis on its relationship to the history of Hawai‘i, cultural historical trauma and indigenous healing, patient-physician relationship, culture of western medicine, experiential exercises that promote self-awareness, and Native Hawaiian traditional healing practices.

Lectures and Problem Based Learning (PBL)

Further expansion of cultural competency training curriculum included an introduction to Native Hawaiian health lecture, patient-physician panels and traditional healing practices. In 2007, the team revised a problem-based learning (PBL) case that highlighted cultural learning issues. By 2008, further colloquia time allowed for richer content that included social justice issues, more traditional healing practices, and role-playing exercises. As of the 2010-2011 academic year, first year medical students complete 9.5 hours of mandatory cultural competency training. However, the two and a half day cultural immersion program, while a voluntary experience for students, remains the heart of the C3 curriculum.

Elective

In early 2009, an elective in Native Hawaiian health focusing on traditional healing practices was initiated. The following school year, this elective combined with another DNHH elective in research methodology to become a year-long “selective” course in Community Health Course, “Native Hawaiian Health, Past, Present and Future.” The course features traditional Native Hawaiian concepts and practices around health and healing, addresses Native Hawaiian health disparities through research and community initiatives, and encourages students to develop a research project benefiting Native Hawaiian health.

Other Initiatives

The positive effects of the cultural immersion program resulted in the institutionalization of the immersion weekend by the Family Medicine Residency Program. It has funded cultural immersion weekends for all of their interns over the last four years. These were especially important, as many of the interns are not from Hawai‘i and have no experience with Native Hawaiian patients. Due to intern request, the team also provided seminars on topics such as traditional Native Hawaiian healing practices, traditional diet, cultural historical trauma, and indigenous healing. The C3 team has also piloted cultural standardized patient cases with the Family Medicine residents. The Family Medicine residency had already implemented standardized patient cases utilizing other ethnic groups such as the Filipino and Micronesian population.

The C3 Project has engaged in collaborative activities with the indigenous health programs of the University of Otago in Christchurch, New Zealand and University of Melbourne, Australia, since an international medical conference in 2006. Faculty attended each other’s immersions in 2009. Discussions and feedback have positively enriched all programs. Furthermore, in Spring 2011, the C3 team joined the UH Myron B. Thompson School of Social Work Hawaiian Learning Program faculty and students on their weekend cultural immersion, paving the way for future partnerships.

In 2010, the Department of Surgery, in collaboration with the Department of Native Hawaiian Health and other University partners initiated an annual Cross-Cultural Health Care Conference. See Table 1 for the chronological development of the cultural competency curriculum.

Initial C3 efforts in training faculty have begun and include faculty immersions and culturally based activities. New initiatives were started utilizing culturally-based standardized patient cases for medical students. Opportunities for additional multi-disciplinary collaborative efforts with international colleagues continue. Planning is underway for curricular involvement in the second and fourth year of medical school and focus groups of senior students to reflect on our past efforts.

Assessment of the Curriculum

The C3 team is assessing the effectiveness of its efforts utilizing multiple evaluation strategies. Assessment tools include pre- and post-tests for the immersion, post-curricular qualitative and quantitative evaluations for workshops, immersions and electives, and a JABSOM standardized patient assessment tool. Data collection is ongoing and preliminary results are being evaluated. However, more data is needed to achieve statistical strength. On-going evaluation of the curriculum is challenging as much of the curriculum is guided by indigenous world views and processes, many of which don’t lend themselves to a western evaluative framework. Finally, funding constraints has impacted the evaluation process.

Funding

Funding for the C3 curricular initiatives was piecemeal in the beginning. The initial funding from the UH Kualii Council, was stretched out over three and a half years. Smaller grants were obtained from the UH SEED (Student Equity, Excellence & Diversity) program and the JABSOM Office of Medical Education. The Family Medicine Residency is continuing to fund the intern immersions. In 2009,

Table 1. Chronological Development of Department of Native Hawaiian Health (DNHH) Cultural Competency Curriculum (C3) at JABSOM

Academic year	Initiatives
1990's	NHCOE grant begins at JABSOM Dr. Ben Young starts as NHCOE grant PI (1998) Faculty/cultural competency development conferences begin (1999)
2003-2004	DNHH established, JABSOM NHCOE became part of DNHH DNHH tasked with starting a Cultural Competency Curriculum (C3)
2004-2005	Multi-disciplinary C3 team organized
2005-2006	Focus groups begin
2006-2007	Medical Student Initiatives (1st year medical students at JABSOM) <ul style="list-style-type: none"> • Cultural immersions • Four Hour Colloquium
2007-2008	Medical Student Initiatives <ul style="list-style-type: none"> • Cultural Immersion • Four-hour Colloquium • Introduction to Native Hawaiian Health Lecture • Problem-based Learning (PBL) case revised Family Medicine Residency Initiatives <ul style="list-style-type: none"> • Cultural Immersion started • Seminars started • Cultural Standardized patient case piloted
2008-2009	Medical Student Initiatives <ul style="list-style-type: none"> • Cultural Immersion • Four-hour colloquia • Introduction to Native Hawaiian Health Lecture • PBL Case • Elective in Native Hawaiian Health Family Medicine Residency initiatives <ul style="list-style-type: none"> • Cultural Immersion • Seminars • Cultural Standardized (new) patient case piloted
2009-2010	Medical Student Initiatives <ul style="list-style-type: none"> • Cultural Immersion • Four-hour colloquia x2 • Introduction to Native Hawaiian Health Lecture • PBL Case • Selective in Native Hawaiian health within Community Medicine course Family Medicine Residency Initiatives <ul style="list-style-type: none"> • Cultural Immersion Other Initiatives <ul style="list-style-type: none"> • International collaboration on immersion program (New Zealand) • Dept. of Surgery's Cross Cultural Health Care Conference collaboration
2010-2011	Medical Student Initiatives <ul style="list-style-type: none"> • Cultural Immersion • Four-hour colloquia x2 • Introduction to Native Hawaiian Health Lecture • PBL Case • Selective in Native Hawaiian Health • Cultural Standardized patient pilot Family Medicine Residency Initiatives <ul style="list-style-type: none"> • Cultural Immersion Other Initiatives <ul style="list-style-type: none"> • Faculty Immersion • Cultural activities for faculty • School of Social Work's Hawaiian Learning Program collaboration • Dept. of Surgery's Cross Cultural Health Care Conference collaboration

the team was very fortunate to secure monies from a newly funded NHCOE to support current programs and new initiatives. As many of the efforts have been dependent on grants, future funding will continue to be a challenge.

Conclusion

In 2004, there was limited cultural competency training taking place in JABSOM and no real infrastructure to support its development. As with most

unfunded, but critical initiatives, this project depended on the passion and resourcefulness of those tasked with implementing them, as well as the goodwill of the community, whose members have contributed time, resources, and expertise in order for this project to succeed. This cultural competency initiative has been strongly influenced by: C3 team availability for teaching and planning, limited instruction time within the overall JABSOM curriculum, budgetary challenges, and serendipity. The C3 team was influenced by the national cultural competency standards of the time, but also relied heavily on focus group data to inform curricular development. Many aspects regarding the process of teaching the curriculum came from the culture itself. In addition, all curricular initiatives were subjected to evaluation, which also influenced curricular development.

A 2010 article by Betancourt and Green discussed the evolution of cultural competence. The DNHH current and proposed cultural competency curriculum is congruent with many of the key principles and recommendations proposed in their article. The article describes that the “categorical approach” has evolved to “an approach focusing on the development of a set of skills and a framework that allow the clinician to assess—for an individual patient—what sociocultural factors might affect that patient’s care.” Many of these skills are taught throughout our curriculum, including: eliciting a patient’s understanding of his/her illness, skills for assessing decision-making preferences and the role of family, techniques for ascertaining the patient’s perception of biomedicine, and his/her use of complementary and alternative medicine, and bringing an awareness of issues of mistrust and prejudice of the provider and of the impact of race and ethnicity on clinical decision making. These skills are needed if clinicians are to deliver the highest-quality care to all patients.²³

It’s been a fascinating journey developing this cultural competency curriculum. There is still much to do. The team will do its part to decrease Native Hawaiian health disparities through physician training by continuing to address national standards and guidelines while honoring the Native Hawaiian voice. Although still called the “cultural competency curriculum,” the team uses the term “cultural humility” in its teaching. It is the belief of the C3 team that many of the lessons from the curriculum are generalizable to other populations. For example, lessons around “cultural humility” apply to all patient-physician interactions. The team believes that many of the basic processes and themes utilized by the C3 curriculum at JABSOM can be adapted for other medical schools.

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