**Episode 19 – Cultural Competence in Medicine**

**Intro music: 0:00**

**Podcast introduction: 0:10**
In December 2021 a small but significant change to CME rules for physicians and PAs took effect with a six-word amendment. The North Carolina Medical Board specified that it considers any course on the topic of cultural competence or implicit bias to be practice relevant continuing medical education. That means completed courses can be counted towards the dozens of hours of CME that physicians and PAs have to complete to keep their professional licenses in good standing. I'm Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. The rule change is a way to encourage medical professionals to seek out training in implicit bias and cultural competence. So why is this important? Well, our state and our nation is increasingly diverse by any definition of the word. And it is only going to become more so. According to US Census predictions, by the year 2050, that's 20 50, 20% of U.S. residents will be elderly. And as such, more prone to have one or more chronic health problems. And 35% of this over 65 population is expected to be from racial and ethnic minority groups. People, patients from diverse backgrounds typically have beliefs, customs and priorities that can create unique challenges when they navigate the health care system. Cultural competence attempts to better bridge these cultural divides. When efforts are successful, we can enhance communication, increase patient compliance with treatment recommendations, reduce costs, and improve quality of care. I didn't have to look far to find an expert to help me explore the many ways that developing greater cultural competence can positively impact in medicine. One of the North Carolina Medical Board sitting board members, Dr. Christine Khandelwal, has really embraced cultural competence in her own practice as a hospice and palliative care physician. And she's working to help other clinicians integrate it into their patient care. Dr. Khandelwal practices with Transitions Life Care in Raleigh and she's a faculty member at both the Campbell University School of Osteopathic Medicine and the UNC School of Medicine. She was first appointed to the medical board in 2018, and she currently serves as the Board's Secretary-Treasurer.

**Interview with Dr. Christine Khandelwal: 2:33**
JFB: Dr. Khandelwal, welcome. Thank you so much for joining me.

CK: Thank you so much for having me today. I'm really excited about this conversation.

JFB: Oh, it's a pleasure. Let's start with the basics. When did you first hear the term cultural competence?

CK: Yes, thanks Jean for that question. It would go remiss if I did not, first of all, thank my wonderful teachers and mentors that actually brought these words to my mind and it has been part of my practice ever since then. So, Dr. Varnell McDonald-Fletcher, she is a recent medical board member and colleague of mine and just finished and completed her last term here in the North Carolina Medical Board. And also, Dr. Karen Bullock, who's a professor and head at NC State Social Work, who, again, has spent 25 years of clinical practice in research in this field supporting older adults with serious illnesses and looking at health equity. So it’s really these two amazing strong educators and mentors for me that brought this information, especially the term cultural competency or cultural humility, which we'll talk about today. So, I want to thank them first of all, as we help the conversation today, Jean.

JFB: Right. So, do you recall sort of when you first started hearing the term cultural competence or maybe implicit bias or you know, how did you sort of tune in mentally to this conversation that was that's been going on in medicine for some time?

CK: So, my first year in 2018, I served on the Board, and I worked closely with Dr. McDonald-Fletcher, who helped mentor me as a new board member. And what I realized is part of our role and obligation to protect our public is also to ensure our licenses are providing quality of care. And what I have learned again is a lot of the quality care is because there's concerns about poor communication. Families or patients may submit a complaint to the medical board about, quote, poor communication from their doctor or their PA. But as I learned more about that, it was my understanding of, I used the word cultural competency meeting, trying to really learn more about an individual's culture and how to make decisions. But as Dr. McDonald-Fletcher, who corrected me and said, we will never be competent, it's more having cultural humility. And that was really the first time in 2018 I really heard that term, Jean and how to use that in my medical practice.

JFB: Can you define it for our listeners about what you mean when you say cultural humility?

CK: Yes. Cultural humility is the ability to see and authentically really accept another person, another individual who is different from ourselves. And it may include race and ethnicity, but it could certainly be other topics such as gender identity or national origins, religion, neurodiversity. People with physical, emotional, and spiritual differences. It could be that simple and really how they navigate the world. It plays a role in who they are. And certainly, in medicine, certainly as a physician, that all plays a role in how our patients and their families make decisions. So is really that cultural humility, which it defines itself, it's being humble and having awareness of other's differences. That I'm not an expert. I'm not going to I'm never going to achieve competence per se. I will always work towards that. But it's really been culturally humble and responsive, which requires actively growing and learning in that.

JFB: That really is an important distinction. You can improve cultural competence but in order to start down that path, you have to first have cultural humility.

CK: Dr. McDonald-Fletcher recommended some readings for me to learn more about this topic again, how it plays a role and be in a better physician, how to provide quality of care. The first book I read was entitled Medical Apartheid, and I recommend Licensee to read that book. It goes deep into the history of the African-American generations of medical abuse and why there's such a distrust and mistrust with the health care system. It's really important to understand that trauma so that we understand how we need to do better for our patients and their families in the communities that we serve.

JFB: Well, it's funny that you mention that, because I was going to ask that when you learned more about this concept of cultural humility and cultural competence what were some of the first steps that you took? So, you started by…by reading and by starting to educate yourself.

CK: That's right. And that's where I look more at Dr. Karen Bullock's work. As a palliative and hospice physician, Dr. Bullock is a leader in our field of research, and a lot of her work, again, has really been with serious illness, but more particularly health equity. And it was her mentorship that helped me better develop amongst my own practice how to do better care, how to provide more culturally

sensitive care to our diverse communities and population. So, I credit that…that learning from Dr. Bullock as well.

JFB: Right. You know, I wonder if we could pause and talk a little bit about your own clinical practice. So can you give some examples of situations where in retrospect, with your new knowledge of cultural humility, and cultural competence, where you looked back at care or looked back at certain situations with patients and families and realized that you may have missed some opportunities to improve or just really to connect better with patients in their families?

CK : You know, I think everyone always looks back at the pandemic 2020 the turning point for a lot of us. But I really have to focus on that time period, in the beginning of 2020, that really made me open my eyes to understand that I do hold some implicit biases. There's biases more toward prejudice against either persons or groups compared to others. But there's it's more than that. The implicit bias is we don't mean or we don't recognize or have awareness of these biases we have toward certain peoples or groups, whatever that may be. And I have to say, it was really my turning point to understand that was during the beginning of 2020, the COVID 19 pandemic, when I realized in my practice I served on the inpatient part of consult team at Wake med hospitals for palliative care and is where we take care of a patient or family as a team approach, I work with social workers and nurses and practitioners. All of us have come with different skill sets and expertise and provide care for our patients and families. But what I really recognized we did is really the disproportionate impact of COVID 19 on really the ethnic communities. And it really placed an overdue spotlight on these issues of racial inequity. And I say that because especially in a hospital system, we are no longer done with one or two patients and families with these inequities. By 2020 we had complete census. I mean there be 60 patients on our list. And all of them were facing some inequity at some point we're not well served. And it was only at this time where it really came to a head for us to really understand that and recognize it. I walked with shame I'll be honest with you, I felt shameful the first few months of really understanding this. But again, as because of great mentorship and teachers and support, that made me understand it's having the inside awareness. It's not shameful. It's part of a learning process. And we shouldn't be shameful to seek out and learn more about our implicit biases and the prejudice we have against certain maybe groups of people we didn’t realize. But it's moving forward and acknowledging it is what can change and we can be active in providing better care, quality of care for our patients and families. So it's really that was my turning point for me and making me understand also that the reason I was having difficult care plans with families and patients was because I didn't understand where they were coming from. I didn't understand the impact of their, for example, their personal beliefs. They could be in a spiritual or religious beliefs, their cultural background, how it really related to their decision making process. They used their belief systems as an approach to how they look at illness or pain, grief and dying, even bereavement. They all fall in their medical decisions and communicating to us the health care team. And so I realize if we don't recognize that, we will never provide equitable care to whomever we serve

JFB: Can you think of a specific interaction that would crystallize it for our listeners where you suggested something or didn't suggest something based on what was going on with the family and there was a cultural component to it?

CK: Yeah, great question. Wow, I have so many. And maybe it's because of the field of medicine I'm in, I recognize one of the skill sets is communicating difficult news. That's a part of it, just to be a palliative

and hospice care physician. And so perhaps maybe that's why it's so acute is because I have to have these hard conversations with patients and families.

JFB: Right.

CK: One that stood out to me and it was the aha moment was a patient I met one on one with and had to deliver some difficult news about diagnoses and prognoses. And she was very understandable. She knew what this meant. Where this was going. She was very clear to me, very honest in her own way, said, I hear you. I want to get home. I just want to be comfortable. Made her decision. Well, I realize I'd never engaged all of her families as part of the conversation. I'm a Caucasian woman and I have autonomy. I can make my own decisions. I don't necessarily have to have my brothers and sisters to be part of that goals a care conversation. But what I've really learned from this patient was just because she had an idea of mind, of her care plan to me one on one, I still had to involve all that she said were important people in her life, her family, including her cousins and including her, her religious leader as part of the care plan and goals of care conversation. And I could not make any decisions or implement a care plan, including a medication change Jean. It could be that simple new medicine, without involving the entire family that she named and also her religious leader and it taught me that we need to be understanding of that. And from that time forward, I had to make sure that other care teams, the surgery team, the ICU team, that any care plan that was going to be made for the patient had to involve the identified family members and the religious leader as part of that conversation. It didn't mean they were necessarily going to change or disagree with what the patient wanted to voice and say. It meant that was her, that those were her people that meant so much to her everyday life and how to play a role in her final decisions. She will defer to them sometimes to make sure they supported her, if there's ever misunderstandings or questions, we, as the health care providers, had to make sure we were all on the same page. But I'll never forget it because moving forward after that, I always would ask my patients, who else needs to be part of your care plan? What family members or are you part of a religious groups or our church community that I need to make sure they're included as part of these care plans and conversations? And that's just one example that I've used all the time now and again, it really made me think about that. On a personal note, I'm a caregiver. I take care of my mother-in-law. She lets me share these stories. My mother-in-law, she's actually hospitalized again right now. She does a lot of multiple morbidities. Chronic diseases. And she was born and raised her whole life in Calcutta, India. So when she's hospitalized, she's perfectly capable of making her own decisions. She certainly will tell you how things are. But again, she's a woman that we have to let the health care team know if we're not there, you need to include us because my mother-in-law wants our support, our feedback, and wants to make sure we all agree with what her decisions are. So I can tell you, even married into a wonderful Indian family, that's the same expectation on a personal side too. That we all going to be part of that conversation from my mother-in-law. She ultimately gets the decision, but we all make that decision with her where her support grew. So that's even from a personal side. That is how important that is to us.

JFB: Well, thank you so much for sharing that. So you mentioned that that was your aha moment and that you've since integrated that into your approach with patients. Just to ask, do you ask all patients the same question?

CK: Yes.

JFB: You know that because you just really don't know just from looking at someone what their reality is. So that's great. I want to ask a few more questions about how you started to incorporate these different techniques or these different questions. Into your approach with patients and families. You mentioned that you did some reading, but I assume you just didn't learn this through osmosis. I mean, did you do any training? You know, how did you get to the point where you knew what questions you needed to be asked, you know, that perhaps you hadn't asked before?

CK: That's a great question, Jean. Again, I'm fortunate in my field of medicine, we have modules. Again, Dr. Karen Bullock has done a lot of these free modules for any of us. I always have my learners, my residents and my students that rotate me, look at these modules. Something called Cap C, the Centers for Advanced Palliative Care, and they offer a really wonderful webinars, a lot of free resources on these specific topics. But particularly how to use, how to ask certain questions and make it part of your everyday practice. It can be that simple, Jean, whether you're an inpatient care, outpatient in an office setting, if you have a 15 minute visit with a patient, you can easily ask one or two questions to learn more about them, to engage more with your patient, to ensure you're improving your communication, really, so that you're providing the best quality of care to serve your patients and families. So those are the resources I've used on website. And also there's some really great TED talks on cultural humility and cultural competence. There's a lot of free resources for us to look at and to incorporate that as part of our practice.

JFB: Great. I wondered if you could give a few more examples of how you think your care has improved since you have been on this journey to develop better cultural competence, maybe a situation where you ask the right questions, or perhaps you picked up on a cultural cue and maybe changed your approach to better fit a patients and families needs?

CK: Yes. Again, I can think of a whole lot of examples. I think what has helped me is because of my lived experiences and sometimes doing things the wrong way and learning the hard way that I'm able to convey and teach not only my learners, but also my teams that I work with. Again, I'm very blessed to work with inner professional teams. I work with nurses, nurse practitioners, PA, social workers, and our spiritual care counselors. And because of kind of lessons learned for my own self, I've been able to try to embed some of these practices into our everyday practice. So one family that really, again, stands out to me was a family patient I met on the inpatient side that I saw as a palliative care consult. We were able to quickly bond immediately, and I was able to build a trusting partnership with them in the care of their elderly father who was being discharged back to home with hospice care. The plan was for this family to go back on home to allow a comfortable, dignified aging and ending of life care plan at home where family was going to take care of their father 24/7. I in my practice also help support our outpatient team. So our hospice team went to go see the family and patient. I get a frantic call one day. Jean, the family patient was supposed to sign on to hospice. That was the plan. We were all on the same page. I get a really upset call from the wife, very angry and upset. And when I was able to calm her down, she felt that the care plan we had that was supposed to continue back on home with hospice care was not matching what her care plan was. She wanted to see me immediately. So I went and did a home visit to understand what happened. Where was that disconnect from? When we met and had a plan together to when they went back on home and this is what again, my aha moment was, was just because again, I'm understanding and acknowledging the importance of the family's personal beliefs and who all had to be there for any changes of medicine again and involved their church leader how to be updates and involved with that the hospice team didn't know that. It was because the hospice team did not realize

how important and didn't ask the questions that I knew to ask that there was this distrust because this care completely changed when it actually didn't. It's just there was poor communication among the health care team signing off to each other and also a disconnect with what the family understood and what the new health care team taking over understood.

JFB: I see.

CK: So again, it made me realize we have to teach each other. Health care teams need to involve each other about what the personal beliefs are, other families and patients we take care of because it can't just be one care side. It has to continue on to wherever that patient or family, whether it's back to home, whether it's to a nursing home. If the patient gets hospitalized, we need to all ask the same question to continue that level and that trusting care plan that was already initiated. So that's when I realized I had to teach my care teams as well why poor communication leads to poor care, really. We have to hold ourselves responsible. Again, and that's where it made me realize I had to teach more cultural humility concepts, really, again, providing more culturally sensitive care so that we can serve our patients and families better.

JFB: That's great. And now, were you able to resolve that situation satisfactorily?

CK: Yes. So fortunately, I did a home visit, and when I was able to understand what happened, I was able to have the hospice team, the nurse, and social worker meet me back at home the next day, and we were able to all meet together, had to have an understanding of what happened. Again, being humble, that this was on us, that this was our fault, that we did not continue that understanding in working closely with the patient and family. And fortunately, they did sign on to hospice. But unfortunately, the patient died just really a few days later. But they were satisfied. They felt supported. And it was, again, a learning experience for all of us. But I am so grateful. I still think about that family, that patient because I always think about during their hardest time, the most difficult time, Jean, they were still teaching us a lesson. Again, sometimes I feel shame about it and it's hard not to, but I don't want us to have shame about this. We need to feel comfortable to really be honest in these conversations so that we can do better and provide quality of care.

JFB: I'd love to talk a little bit more about that feeling of shame, because I think it's fairly common for people when you're thinking critically, looking at what you're doing. I would imagine very few people set out doing their work and say, today I'm going to discriminate against people or who can I treat badly today? Most of it is, as you've referenced, unconscious, and it's acting on biases that you're not even aware you have. And I know you have studied the science on this. Could you sort of talk about how you can move past the shame and sort of what's going on in the human brain when you feel that shame and what you can do when you recognize, yes, I have biases.

CK: Yeah. Thanks, Jean. I think an approach I have done, I feel has been successful, and I can say that because when I teach this topic to learners or we provide new orientation for our new staff, we talk about this. I hope to create a safe space, so people feel open and honest. Of course, I share personal stories so that's always helpful. But there's really a science to it. And I when I break it down to that, then it kind of helps minimize the shame. So, for example, I kind of walk through a what unconscious bias or implicit bias really is. Well, the reality is we really have two major systems in our brain. And I can tell you there are system one, which is our older system. That's the majority of our brain. And then we have

system two, which is more our frontal cortex. The system one is older. It's our…the limbic system, but that's where our emotions are learning is. And it operates fast and quick. I mean, it has to. It's very energy efficient. We have no control of it. These are automatic. And then there's system two. It's slower…requires a lot more energy…is our decision-making process. But sadly, it's system two is overpowered by system one. System one takes over 95% of our everyday thinking process. So when we think about implicit biases, implicit bias is really again is that automatic shortcuts for processing information and that's where the problem is and understanding there's really three tenets to unconscious bias. Again, it's unconscious. We lack awareness of it, so we don't know we have them. There's a lack of intention. So for example, of course I'm not biased, Jean. But is contrary to what our conscious beliefs are. That's where unconscious bias is. It's contrary to what we think and how we consciously, believe and things. And finally, unconscious bias. It's automatic mental shortcuts of processing information. So I say that so that people don't feel shameful. Everyone has them. It's our human nature. And I don't want people to feel like, well, I have no control of it. Actually, we do have control of it, and that's where we can focus on that system number two. We need to start taking a pause and actually putting a little bit more effort in the information that we have in front of us before we make such a quick decision. And we can do that. We have control of that. We can, again, train ourselves to kind of take a pause and really look at system two to help us make better decisions, to make more of an effort so that we can have more reliable information and better decision making. So I try to put my learners through an activity to understand that. So we're not being shamed. Every single one of us have implicit or unconscious bias. That's our human nature. However, we all control of it, we all can do better. And that's where I want people to walk away from.

JFB: Yeah. No, I think that's really important to confront that head on because I think it's a very, very common response. When you mention your learners, who are you talking about exactly?

CK: So I'm fortunate. We have Campbell fourth year med students rotate the Wake Med Hospital System. I also have had the pleasure of working with UNC Med students, fourth years who do an elective rotation. We have our family medicine again, UNC residents rotate with us and now Wake Med has an internal medicine residency program, so they'll be rotating to spend some time with us as well.

JFB: Okay.

CK: The medical professions I also love to teach community. I do a lot of community teaching. I work with Wake AHEC, a great team. So I can really not just focus on medical students or residents, but it's really all of us. So Inter-professional education is really what I try to focus on.

JFB: Okay, great. And I wanted to mention, I know you have actually gone above and beyond what most clinicians who are interested in developing greater cultural competence might do, and you're actually enrolled in a graduate program to study this. Can you talk just a little bit about that?

CK: Yeah, sure. So I'm fortunate that I'm going through Campbell's program. It's their Master's in Professional Healthcare Education. It's a wonderful program for those of us who really love education, but to build our skill set. And fortunately, part of that program is developing a quality improvement or our pilot program. And what I was able to have support last year with mentorship was to develop a more culturally competent or an education curriculum to help improve health care providers, again, to provide more culturally sensitive care. And it's through that first year and now my second year that I

continue on with that process, with the mentorship and skills and resources to continue to provide this kind of teaching and education for health care professionals.
JFB: That's fantastic. And what moved you to take that step? I mean, this is you know, for some people, I imagine it would be sort of a personal revelation and they might be moved to make changes to their own clinical practice. But it sounds like you really are trying to change the system.

CK: I hope so.

JFB: Yeah.

CK: I know it's a big undertaking, but I think a lot of us as teachers and educators…I mean, I think back even when I was a medical student, there was moments that you were with a preceptor or a teacher that stood out and you'll never forget it and you took a message or a teaching moment with you. And I hope even if I can engage one learner of thinking about their practice better by including, again, having more cultural humility be more culturally humble, that we can do better and provide better quality of care, particularly improving our communication with our patients. I hope at least that's my goal is I can at least touch one learner, just like my mentors have taught me. I hope to do that for others. So I think that's really where the drive comes from and why I love to do it so much. It's really that mission.

JFB: Yeah. One thing that I think is important, you've inferred it in a lot of your comments, but I want to be clear for our listeners that cultural competence is not just about race or ethnicity. And could you just say a few more words? Because I think it really and again, you've touched on this, but I think just to underscore that this is just not a Black-White issue, it's not a religion issue. It's kind of everything that forms somebody's identity. Would you just offer a few more thoughts in that area? Just to make that clear for our listeners.

CK: You absolutely said it very well, Jean. It is not. Yes, I know. We keep talking about race and ethnicity but you're absolutely right. There's patients we see with a really think about gender identity, religion. I always joke, I'm from New York. My family is Catholic New Yorkers and I always laugh and joke. I'm part of a Catholic church here in North Carolina and it's very different. So I always laugh at just because you're from the same religion it still can be different. And so even a physician in the office, you're chatting with your patients and family. You still need to understand what their beliefs are, even if they follow the same religion as you, for example, because it's not necessarily going to be the same as how you practice it. You know, we're having to understand more about patients of sexual orientation neurodiversity, again, physical and emotional differences. And what we call when I go back to neurodiversity, understanding that and understanding that our patients again, we need to ask more inquisitive questions to learn more about them. And that helps us again with our decision making. And that's right.

JFB: Yeah.

CK: The way I look at it, is if you ask more about your patient that's in front of you, first of all, they're the expert in themselves. So in order to do well for them, you need to learn more about them and just be more respectful towards how to do better care for your patient. So that's more about thinking about not just about race and ethnicity all these other are, like you said, all these other things that make us who we are individually.

JFB: And I think bottom line, it's kind of about not making assumptions. Don't assume you know, ask.

CK: Absolutely.

JFB: Okay. Now pivoting a little bit to sort of practical advice for clinicians who may be listening and saying, how can I get some of this, you know, going on in my own practice? Let's talk about the types of medical professionals who can benefit, you know, who is cultural competence and implicit bias for? Are there particular types of clinicians who need this or is it everybody?

CK: Well, I'm biased as a medical board member, probably, but anybody that interacts with patients every day, they really need to think about this extra education. I mean, prescribing a medicine sounds something very simple, but why is your patient maybe not taking that medication what is their beliefs or thoughts about it? How about our patients? A lot of patients now love to take over-the-counter, perhaps homeopathic herbal supplements. I know my mother law does. I just was there yesterday and she showed me what she's using for her arthritic pain. We need to understand. And so any of us have to take care of patients to be sure they're going to follow up with the care plan. It's a partnership. We need to acknowledge that they may or may not take that medication depending on what their beliefs are about it or their thoughts about it or the side effects about it. So anybody who takes care of patients need to think about incorporating these more cultural humility and working towards cultural competence in their everyday practice. It's just a quality care measure. That's how I see it, Jean.

JFB: Okay. And is there research? Is there evidence that backs this up that if you improve your cultural competence, that you also improve quality?

CK: Yes, absolutely. And again, I can certainly defer more to the field of palliative care. In hospice, we see differences that patients are more compliant in regards to follow up with the care plans. That patients will more likely follow through with even what's been communicated to them. If the provider spends more time in acknowledging more about their personal belief system, for example. There is even a study there was a systematic review in 2015 by Hollettall, that showed implicit bias was actually significantly related to patient provider interactions, as to treatment adherence and actually patient outcomes, which are very important for us to understand.

JFB: Oh, absolutely. Yeah.

CK: I mean, even in my medicine, I know there's a lot of different topics but certainly there's a lot of literature now to support that and that we need to again acknowledge that.

JFB: To me, I think that's a really important fact and really persuasive that it truly is a way of improving quality. Now what steps would you recommend for a colleague who is just learning about cultural competence? Where is a good place to start?

CK: That's a great question. So obviously, as the medical board, we're looking at how to provide more resources and educational support. We're fortunate in North Carolina. We have AHEC who provides a lot of wonderful webinars and educational resources and didactic, some lectures. I know WakeAHEC ourselves there's a series on this specific topic, so I'd recommend even locally, what are some options? There's a website I always refer. I actually learned from a medical board lecture that was provided to us

a few years ago. It was called Project Implicit, and it's a website by Harvard, and it's a free test you can take your own personal assessment Jean, and there's all these different topics, but any of us can just log on and you can take a test and it really helps look at different implicit biases you may have never known about yourself. It is eye opening. That's something to my learners, too. It's online, it's free, and it really gives you your own personal insight. And then from there, they have resources as well as Where do I go from here? So there's a lot of options for that, too.

JFB: Em, and we have developed a resource page on cultural competence that we're going to be promoting. So certainly any listeners of this podcast can go to our show page and find all sorts of information, reading, CME opportunities. So we definitely want to support licensees who are interested in learning more. I always like to ask my guest, you know, if there is anything I haven't asked that you want to add before we end our conversation.

CK: Thank you so much. First of all, I want to thank you again for this opportunity. I'll just end kind of how I like my learners to walk away when we have these conversations is we will never be an expert in our patients and our families they don't expect us to be an expert on everything about them. But it's more about being humble and inquisitive. And don't be afraid to ask. Patients love to share their stories and talk about themselves and share things about themselves. So on one hand, you want to learn from your patients, but also it is on us to learn how to do better and to teach ourselves and to continuously be proactive in our own personal education and growth to do better care for our patients and our families. I always say just practice medicine with empathy, curiosity, and respect. That's always what I always want my learners to walk away from.

JFB: Right. Well, Dr. Khandelwal, thank you again. This has been really interesting conversation, and I thank you for your time.

CK: Thank you so much.

**Podcast Closing: 34:57**

Well, that brings us to the end of this episode of MedBoard Matters. I hope you find this topic as interesting and eye opening as I do. If you would like to learn more about cultural competence or if you're ready to sign up for some training, visit the North Carolina Medical Board's new Cultural Competence page at www.ncmedboard.ord/diversity. You can find additional resources on our show page, which is www.ncmedboard.org/podcast. Remember, sharing is caring. Tell your friends and colleagues to listen and subscribe to MedBoard Matters and if you have thoughts, suggestions, or constructive criticism for us, send it to podcast@ncmedboard.org. This is Jean Fisher Brinkley signing off. Thank you for listening. I hope you'll join me again.