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Cultural Competence: Do We Agree on its meaning and Should It be Considered a Core Competency in Training Programs?

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Abstract

A literature review was undertaken to evaluate whether groups in American healthcare view cultural competence in the same way. It also explores learning opportunities in professional training programs. The review was specifically limited to the subject from the viewpoint of nurses, physicians, physician assistants, and healthcare executives.

Professional Web sites were reviewed for each group, The American Nursing Association, The American Medical Association, The American Academy of Physician Assistants, and the American College of Healthcare Executives. A journal search was performed utilizing Medline, CINAHL, EBSCO, and OhioLink for articles relating to cultural competence for each of the groups.

Each group conceptualized cultural competence in similarly, but each group provided unique insights and alternatives in achieving it. The methods included the addition of formal training in professional schools, of practicing professionals, and enhancing the diversity of the workforce. Conclusions were drawn from the literature to guide students and practicing professionals.

INTRODUCTION

There is a demographic imperative emerging in this country for those individuals in the dominant American culture to become familiar with other cultures in order to provide everyday services and conduct business. Nowhere in our society is that more important than in healthcare where communication and understanding form the basis for the delivery of competent and compassionate care. In 1998 approximately 28% of the population in the United States were cultural or ethnic minorities, by 2030 these minorities will account for 40% of the population.[1]

The concept of cultural competence may be described in different ways depending on the group providing the definition. A review of the literature was undertaken to determine if the definition and dominant focus of different groups within healthcare in the Unites States were the same. The major components of cultural competence may be defined or addressed differently, as a group, by physicians, nurses, allied health personnel, and health administrators.

The similarities and differences between these groups will be evaluated by reviewing the recent literature on cultural competence as well as group specific web sites that provide guidance to group members. In addition, from these sources, conclusions will be drawn to guide the practitioner in a rational approach to attaining cultural competence, if that is indeed possible.

REVIEW OF THE LITERATURE

OVERVIEW

In exploring the literature relating to cultural competence, it became apparent that the amount of writing related to the topic was quite different among these groups. The Nursing literature is quite vast on this topic. It would appear that the nursing community has taken a leadership role in this area. Physician focused literature was the next largest group, and the other two groups were less well represented in the literature on cultural competence. For that reason, I've chosen to discuss them in that order.

NURSING LITERATURE

The nursing literature is quite vast on the topic of cultural competence. It explores this topic in quite a comprehensive manner. Articles discussed cultural competence from a global perspective, a group specific viewpoint, and covered the lifespan from pre-term to end of life. The earliest literature using the phrase cultural competence and defining its meaning was provided by nurses just over a decade ago.[2]

The American Nurses Association provides a conceptual framework for cultural competence on their web site in the following way: "To meet the needs of culturally diverse groups, health care providers must engage in the process of becoming culturally competent. Cross, Bazron, Dennis, & Isaacs define cultural competence as 'a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations'[4] (p. iv). The word competence is used because it implies having the capacity to function effectively."[3]

Rosenjack-Burcham provides additional useful definitions of several attributes of cultural competence. These phrases often are used in place of cultural competence, but have greater meaning as components of cultural competence. Cultural awareness refers to "the developing consciousness of culture and the ways in which culture shapes values and beliefs".[2] Cultural knowledge refers to "the continued acquisition of information about different cultures".[2] Cultural understanding refers to "the ongoing development of insights related to the influence of culture on the beliefs, values, and behavior of diverse groups of people".[2] Cultural sensitivity develops as "one comes to appreciate, respect, and value cultural diversity".[2] Cultural interaction refers to the "personal contact, communication, and exchanges that occur between individuals of different cultures".[2] And finally, cultural skill begins "with the ability to communicate effectively... and to incorporate the client's beliefs, values, and practices into the provision and planning of care".[2] Each of the above terms are components of the concept, cultural competence.

An additional key concept in this area is one of ethnocentrism. It is "woven into the fabric of one's own cultural make-up".[5] Both health practitioner and patient must acknowledge the potential effect of ethnocentrism on their interactions with each other within a dominant culture.

Further, the concept of "trans-cultural communication" suggests that, "Accepting differences in people and displaying a nonjudgmental attitude are essential for the nurse to communicate successfully across different cultural groups".[6]

PHYSICIAN LITERATURE

The physician-oriented literature on cultural competence was also quite extensive. It seemed to be divided roughly along two lines. One was a body of literature that really was a discussion of health disparities among members of ethnic and cultural minorities. The other literature tended to discuss the need for cultural competence and how it might be achieved. Health disparities are important for clinicians to understand, and to factor into their decision-making process when caring for members of ethnic and cultural minorities.

The American Medical Association web site[7] includes a relevant quote from James S. Todd, M.D., a past executive vice-president of that organization. He offered the observation: "Give me standard patients and I'll practice standard medicine." This quote is relevant to the topic of cultural competence, in that the training of healthcare providers at all levels must reflect the population they will serve. Otherwise, their practice will reflect their training and not the needs of the populations they serve.

The AMA working definition of cultural competence is presented by first defining culture and then cultural competence as follows: "Our use of 'cultural competence' and 'culturally competent health care' reflects an inclusive definition of the word 'culture' – any group of people who share experiences, language, and values that permit them to communicate knowledge not shared by those outside the culture... To be culturally competent, ... physicians must be able to provide patient-centered care by adjusting their attitudes and behaviors to the needs and desires of different patients, including accounting for the impact of emotional, cultural, social and psychological issues on the main biomedical ailment. This in turn requires complex integration of knowledge (including knowledge of the effects of culture on others' beliefs and behavior and on one's own beliefs and behavior), attitudes (of the patient as well as the physician) and skills (with communication skills as important as technical skills)."[7]

Cultural competence is not yet a part of most medical school curricula. Carrillo, Green, and Betancourt[8] provide guidance for a cross-cultural curriculum. In particular, they caution a

need to avoid a "stereotypical" approach to cross-cultural care. They believe that the target audience for such a curriculum should be medical students as well as practicing physicians.

Rush Medical College in Chicago, Illinois developed a "Spanish Language and Cultural Competence Project" composed of three parts. First was Spanish language training, second was a didactic cultural competence component, and the third component was an 8-day international seminar. They spent the 8-days in both urban and rural Mexico in a variety of clinical and non-clinical areas to enhance their cultural understanding and improve their language skills.[9]

On a smaller scale, medical educators at Wake Forest University utilized a teaching method that created a "critical incident" to assist students readiness to learn cultural competence by moving them from "unconscious incompetence" to "conscious incompetence" in this area. They are thrust into a clinical scenario where they have medical comfort, but a culturally based incident occurs that affects their ability to diagnose a problem. This incident then makes them more receptive to the cultural competence training to follow.[10]

Chin and Humikowski make the case that there is a struggle to be culturally competent while avoiding racial stereotyping. They discuss cultural competence curricula and suggest that viewing "the patient within a wider cultural setting can help guide the initial clinical approach, but individualized care is mandatory."[11] They also suggest that cultural norms change over time, making "lifelong learning and flexibility" a necessity.

PHYSICIAN ASSISTANT LITERATURE

Physician Assistants (PAs) utilize the medical (physician) literature quite extensively in their training and on-going practice. However, they do have a smaller body of literature that explores the concept of cultural competence.

The American Academy of Physician Assistants[12] officially addresses cultural competence as a diversity issue as follows: "The AAPA is committed to a policy that respects the ethnic and cultural diversity of all people. The Academy's commitment to diversity is a belief in the value and worth of each individual, and a recognition that when differences in cultures and ethnic groups are understood and respected everyone in society benefits. Accepting diversity is not an attempt to eliminate or dilute the rich heritage that exists in all peoples. Accepting diversity does require an understanding and respect for the differences that exist among all physician assistants and the patients they serve."[12]

PA training programs have explored ways of incorporating cultural competence training. One method described in a paper by Miller and Morton-Rias[13] involved a component of the humanities course. They describe the utilization of a written and verbal requirement for PA students to examine their own cultural roots. They shared their "cultural portrait" with their classmates to include their racial and ethnic roots, socioeconomic profile, general values and beliefs, artifacts, and traditions regarding health care. This allowed the students to enhance their understanding of their own cultural background as well as improving the knowledge and understanding of their peers.

Another PA educator has created a model for small groups of PA's to confront their own cultural biases employing panel presentations, lectures, a field experience, and videotaped interviews.[14]

Yet another group of PA educators performed a study using a survey instrument testing their students "multicultural sensitivity" at four points during and immediately following a 30-month PA program. The greatest improvement in scores followed their clerkship rotations where they had encountered low-income patients of racial and ethnic backgrounds that were different from their own.[15] They suggested that increasing PA training in these settings would enhance multicultural sensitivity.

HEALTHCARE EXECUTIVE/ADMINISTRATOR LITERATURE

The literature representing healthcare administrators and executives is less extensive than that of the other groups. The importance of cultural competence to this vital group in the delivery of healthcare in America should be readily apparent. On reviewing the available literature, they seemed to focus on the skills needed to practice in a diverse environment, how to improve diversity among their ranks, and how diversity impacts the business of healthcare.

The American College of Healthcare Executives (ACHE) web site[16] was reviewed for references to cultural competence or diversity issues. A search of the site only revealed a need to encourage and promote minorities in the health management field. "Our country's increasingly

diverse communities result in a more diverse patient population. Studies suggest that diversity in healthcare management can enhance quality of care, quality of life in the workplace, community relations, and the ability to affect community health status. Achieving diversity in senior management will involve a commitment to awareness of diversity issues, hiring practices that attract diverse staff, development and mentoring in educational programs and organizations, and organization-wide diversity training." This group supports a newer group called the Association of Hispanic Healthcare Executives,[17] whose goals are to assist in the professional development of Hispanics in the U.S., promote public awareness of the healthcare needs of Hispanics, serve as a resource to improve access to care for Hispanics, and advocate for greater Hispanic representation in medical and health related academia. References to other minority advocacy groups were not made on the ACHE web site.

A project funded by the Robert Wood Johnson Foundation convened focus groups to determine how prepared public health administrators seemed to be. These groups identified forces that they believed influenced their competencies, determining that "recognition of the importance of cultural diversity" and acquiring skills in cultural competence were of primary importance. They also identified the barriers and incentives to acquiring these skills, citing limited time for training as a major barrier and improved effectiveness and pride in personal growth as important incentives.[18]

Brach and Fraser make a "business case for culturally competent health care".[19] They cite four interrelated financial incentives for providing culturally competent care: increasing their appeal to minority consumers, competing for private purchaser business, responding to public purchaser demands, and improving cost effectiveness. However, they acknowledge that while healthcare organizations may have some financial incentives to increase cultural competence, the incentives remain fairly weak and are often negated by cost constraints. It would appear, from their article, that the incentives would vary according to the market served. Interestingly, our course readings included a similar article making the case for physicians as small business men and women to embrace cultural competence as a means of practice building.

METHODOLOGY

A web search was conducted employing Google.com to access the relevant web sites for the groups evaluated in this paper. The sites were chosen for organizations that represent the interests of these groups: The American Medical Association, The American Academy of Physician Assistants, The American Nurses Association, and The American College of Healthcare Executives. A literature search for pertinent journal articles was undertaken employing, Medline, CINAHL, EBSCO, and OhioLink. The search terms utilized were cultural competence, and cultural sensitivity.

ASSUMPTIONS

For the purposes of this paper, the associations above were assumed to present the current prevailing views and interests of the represented groups. In addition, the individual papers cited were assumed to represent at least a portion of the group to which the authors belonged and not just represent the views of the authors alone.

LIMITATIONS

There is a vast literature on the topic of cultural competence or sensitivity. The scope of this paper does not allow an exhaustive review of that literature. While many viewpoints were represented in the literature, those presented here seemed to predominate. Also, the professions researched are not equally represented in the literature. The Nursing literature is vast on cultural sensitivity and competence. The numbers of articles were fewer for physicians, PA's, and fewest for healthcare executives and administrators.

DISCUSSION

Nursing has obviously led the way in discussions about cultural competence. They have a vast literature examining the issues that have an impact on cultural competence. The suggestion is that they developed the term "cultural competence". One of their greatest contributions may be in providing meaning to the various terms that are components of cultural competence. The terms referred to in the nursing literature include, cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, cultural interaction, and cultural skill. These components, it seems, are understandable and attainable, perhaps even measurable to some degree. Cross et. al.[4] rightly limits the definition of competence to "having the capacity to function effectively". A broader definition of the word competence in this context would be difficult or impossible to attain for most healthcare professionals and perhaps more difficult to measure. Nurses also freely acknowledge the impact of ethnocentrism[5] and the need for effective "trans-cultural communication".[6]

Physician oriented literature seemed to add a dimension to the discussion of cultural competence that was less prevalent in the nursing literature. That is the issue of health disparities in this country for members of ethnic and cultural minorities. While the root causes of these disparities are multifactorial, there is a suggestion that at least part of the disparity can be ameliorated by enhancing cultural competence among healthcare professionals.

The physician literature also acknowledged that cultural competence is not widely taught in medical schools. There were several articles that provided innovative means for providing that education. Rush Medical College utilized a language training program and a didactic training program, followed by a cultural immersion program in Mexico. This training could be tailored to other cultures, but it would be difficult to sustain if multiple cultures were included. It occurred to me that it might be more useful for many of us to be given training in cultural sensitivity and interviewing styles, followed by cultural immersion without the benefit of language skills. It might more closely approximate what providers are likely to face in their future training and practices.

A very appealing approach to this topic (for a health educator) was the Wake Forest teaching method. They created a "critical incident" to make students more receptive to cultural competence training after the event assisted them from "unconscious incompetence" to "conscious incompetence".[10]

Physician literature contained a recurring theme to remind us that there is a risk in cultural competence training that we might create cultural stereotypes. We are reminded that awareness and understanding are key, while "individualized care is mandatory".[11] They also remind us that cultural norms are constantly changing and require "lifelong learning and flexibility". Lifelong learning should be second nature to clinicians, as it is a requirement of medical practice in a modern world.

Not surprisingly, Physician Assistants rely heavily on the physician literature for their training and lifelong learning. However, the PA literature contained several references to novel means of incorporating cultural competence training into their programs. These included a requirement for students to develop their own "cultural portrait"[13], and small group work with students attempting to evoke biases via panel discussions, lectures, field experiences, and videotaped interviews.[14]

In another teaching program, educators were able to test their students multicultural sensitivity at four points during their training, thereby documenting their growth in this area after clinical experiences with patients whose cultures were different from their own.

Finally, healthcare executives and administrators addressed this issue from a business point of view. They suggested that cultural competence could be improved by improving the numbers of ethnic and cultural minorities in their ranks. Thereby making healthcare administration more reflective of the communities they serve. They also acknowledged a need for additional training and made a compelling "business case for culturally competent healthcare".[19]

The collective message from these articles and web sites is that it is imperative that we as healthcare professionals embrace the opportunity to become more competent culturally. That it is important that we develop the educational, economic, and political resources necessary to enable healthcare professionals to attain the skills necessary to provide competent and compassionate care to all members of our increasingly diverse society.

CONCLUSIONS

It is apparent that healthcare professionals seem to have a similar understanding of what cultural competence means, even if the approaches or focus is slightly different among the professions. While I do not think it is possible to be truly culturally competent in cultures where we spend relatively little time, the definition proposed by nurses for competence in this arena seems attainable. The development of a basic framework for cultural competence should be required of all healthcare professionals. It should be a high priority in all health profession training to incorporate didactic and clinical learning opportunities in this area.

For practicing professionals, I think we can enhance our skills in this area quite effectively. While it is impossible to know and understand all of the cultures one might encounter, it is reasonable to expect one to become adept at the two or three most prevalent ethnic or cultural groups in your community or practice. A rational approach might be as follows:

1. Know your community: there are ample resources to determine the prevalent cultures in your community and/or practice.

2. Seek out web or library resources to gain a basic understanding of the following about the prevalent cultures in your community: dietary differences, family structure, childrearing practices, religious practices, health beliefs, and death and dying beliefs.

3. Never assume that an individual holds the beliefs you have read or learned about, just because they identify with a particular group. Individuals have beliefs that are modified by many internal and external factors. Ask them what they believe.

4. Develop a dialogue with patients acknowledging that you are from a different culture, but that you are interested in their views and practices.

5. Ask probing questions during the interview, such as; what do you think caused this problem, how are you treating it currently, who else is assisting you with this problem, what do you think will help this, what can I do that would help you the most?

6. All patients should be asked (and have a record in the chart): what can I do that would help the most if you were to develop a serious medical condition, who will make or help you to make decisions if you are ever seriously ill, is there anyone who can legally make decisions for you if you were to become unable to make those decisions, and do you have any particular wishes if you were ever to become terminally ill?

These relatively simple actions would greatly enhance cross-cultural communication. In addition, they would indicate to the patient a genuine interest, whether or not you had a vast knowledge of their culture.

Incorporating cultural competence training into all health profession schools should be viewed as essential to a well-rounded health care education. Effective cross-cultural communication will improve the likelihood of providing compassionate and competent care to all patients. It appears to be well supported that increasing ethnic and cultural minority representation in the health professions would also improve the quality of care received by ethnic and cultural minorities in this country. There is little question that this training should be considered a core competency in the training of all health professionals.

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