

CONCEPT PAPER:

CULTURALLY COMPETENT CARE

Purpose: To provide input to the National Advisory Committee (NAC) for the design and definition of curriculum modules on culturally competent care based on the corresponding subset of National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS)

Overview and Introduction

Ethnic diversity and the diversity we demonstrate as people is broad: diverse populations include individuals with differences in race, culture, religion, mental or physical abilities, heritage, age, gender, sexual orientation and other characteristics. To communicate with and treat patients of varying backgrounds, preferences and cultures health care providers must have a solid understanding of and respect for patients' differing health beliefs and practices. In addition, physician's appreciation of his or her cultural beliefs and how they influence his/her behavior is critical to enhancing service delivery, medical education and the health workplace.

Current literature supports the need for specific, cultural competence curricula for physician training. (1, 2) The recently published National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards) further support and provide a useful framework to shape provider training. (3) The scope of the principles underlying cultural competence, the teaching approaches, and challenges to consider when implementing such curricula are applicable to all health professional training. Thus although this discussion centers on ways to structure and integrate cultural competence curricula into family medicine residency programs and clinical practice, the opportunities and challenges remaining for fully integrating culturally competence training into medical education and practice, generally, apply to all health professional training.

National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards)

The fourteen CLAS standards are all relevant for delivering culturally proficient health care services; however, the first four standards are most likely to directly impact the provision of health care and education of practicing family medicine residents and physicians. These four standards include:

- **Standard 1:** Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.
- **Standard 2:** Health care organizations should implement strategies to recruit, retain and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.
- **Standard 3:** Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- **Standard 4:** Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standards 1 and 3 form the basis for cultural competence training for providers in training and highlight the need for ongoing education and training, while standards 2 and 4 fundamentally challenge the current structure, recruitment and strategies used in health professional training and practice. This discussion begins with a discussion of the content area necessary to support CLAS

standards 1 and 3, and the teaching approaches that are likely to support cultural competence training. Remaining challenges and opportunities for medical education and practice are then reviewed, including issues related to Standard 2 and 4.

Core Content: Concepts, Knowledge and Skills

There continues to be a lack of comprehensive, formalized training in cultural competency in medical school and residency. (1) Accordingly, few providers have thought about biases they bring to patient encounters or about their own cultural/ethnic background, health beliefs, and practices. To begin to unravel the challenges inherent in cross-cultural encounters with patients and colleagues, physicians need to take steps towards becoming more culturally competent. Cultural competency has been defined by many (4), with the Terry Cross definition most frequently cited, and adapted in the CLAS Standard. (5)

Elaine Pinderhughes (6) has defined the perspectives, capacities, competencies and abilities that enable practitioners to focus successfully on culture in their work to become culturally competent: 1.) Becoming comfortable with differences; 2.) Acquiring the ability to control and change false beliefs and assumptions; 3.) Respecting and appreciating the values and beliefs of those who are different; 4.) Thinking flexibly and 5.) Behaving flexibly. Accordingly, achieving cultural competence requires a model of health care practice and instruction) that incorporates several domains of factors that are brought to an encounter by the doctor, the patient, and the context of the lives of each. This model argues for acquisition of knowledge about specific cultural groups, coupled with physicians' analysis and understanding of their own biases, racial and ethnic background; skill in utilizing this knowledge effectively in cross-cultural encounters, and an attitude that incorporates and validates other cultures, preferences, values and socioeconomic circumstances. This core knowledge, skills and attitudes are outlined in Table 1.

Teaching Framework

Curricula addressing culturally diverse populations are increasingly being refined in nursing, psychiatry, and more recently in medical school and residency programs. Traditional methods to teach physicians to care for diverse groups were based on the premise that mainstream approaches to the doctor-patient relationship would work for all patients, irrespective of cultural backgrounds or preferences. (7) This universalistic perspective suggested for example, that changing behaviors that fostered unhealthy lifestyles could work for all people. This approach ignored the cultural context of individual patient lives that could alter their health seeking or promoting behaviors, thus, limiting the ability to truly incorporate patient lifestyle preferences and values into the clinical encounter.

Other teaching focused on the culture-specific model. (8) Here physicians learned about different cultures, values and beliefs and compared them to the majority culture. This approach suffers from the tendency to have physician master a lengthy list of culture-specific characteristics that could lead to over or under generalizations about groups of people with little attention paid to the individual. It also forced the notion that one culture somehow ranked superior or inferior to another.

The many challenges presented in cross-cultural encounters with diverse individuals suggest that a multifaceted approach may be best suited to teach the skills to competently care for patients. (9) Evidence based evaluation, inductive models, narrative approaches and cultural flexibility, for example may be better suited to address the needs of diverse patients in the clinical encounter.

(10) Inductive methods of learning place the focus of learning, evaluation and assessment on the individual patient. Generalizations about a cultural group, therefore, are not ascribed without considering how applicable a given generalization may be for the individual patient. This method should, arguably, be central to all approaches. Narratives are wonderful ways of gaining information about our patients. Increasingly in diversity training, physicians are called upon to give narratives of their own lives to help them better understand the context of their cultural background, ethnicity and biases. (6) Accordingly, patients must be able to tell their stories, even if eliciting the story must occur over several visits. Evidence-based approaches are increasingly being used in all aspects of medicine. As cross-cultural work in medicine becomes more integrated into residency teaching programs and practices, more information is being written to give providers literature-based information that could support or refute generalizations about cultural groups. Providers can use this information as guidance, but must still ask questions of how a given patient fits or does not fit the observations ascribed to a cultural group he or she belongs to. Caution in insisting on absolute evidence of the impact of culture on a specific clinical outcome is warranted, as culture may be too complex to measure using standard statistical t tests and p values.

Cultural flexibility may seem like an obvious strategy to attempt in approaching the diverse patient. Yet many providers in training are limited in their ability to be culturally flexible; often they have not taken time to examine their own cultural background and biases. (11) Others (7,8) have suggested providers use a traditional/modern continuum to assess where a patient is in a given encounter; the provider would adapt her style to one or the other mode depending upon the patient. This approach works only if the traditional/modern paradigm is a starting place for assessment and treatment, with patients being allowed to deviate along this continuum. Psychiatry provides a comprehensive means of achieving culturally competent care through cultural formulations. (12, 13) This assessment and diagnosis of diverse individuals has been incorporated into the DSM-IV as an aid to the multi-axial diagnostic assessment. (14) It is also a very useful approach to adapt generally, allowing for the provider to describe the individual's cultural and social reference group and the cultural context of the patient's life. As summarized in Table 2, five key factors comprise a cultural formulation.

In all paradigms, the evaluation begins with the individual or family unit. To keep the individual central to the information used to make assessments about diagnosis and treatment, a series of questions might be further integrated into the patient interview (Table 3). These questions need not all be assessed in one visit, and can still encompass the domains identified by the cross-cultural formulation. These more recent approaches to evaluating diverse patients suggest that knowing that a patient was raised in Jamaica, believes in a *personalistic* health belief model and drinks tea to cure diarrhea complaints is as important as knowing the patient's race and gender. This approach also adds little extra time to clinical encounters, since the family history and patient background should be a routine part of clinical history taking. It does suggest that the importance given to these and related issues of individual habits and preferences be considered with more priority.

Teaching Strategies

The full curriculum and limited tenure of residency training may seem like a challenge to teaching residents the core content and skills necessary to encourage culturally competent health services. Yet, many opportunities exist to integrate and apply skills within the existing structure and flow of physician training and continuing education. As with the approach to the diverse patient, one

strategy is likely insufficient and certainly could not appeal to the different preferences of adult learners, nor to the necessary differences in technique to convey content knowledge, teach skills or influence behavior. With the patient or the family unit as the starting framework, therefore, the teaching strategies for cultural competence training should be shaped by whether the intent (goal) is to convey content knowledge, to teach skills, or to influence provider behavior (Table 4). Using this approach the most effective means of impacting behavior, teaching a skill and conveying content could be through the use of a video, while case studies may be more effective to challenge behaviors and attitudes (Table 5). Early intercultural training strategies and recent efforts to rapidly train academic faculty to successfully deliver cultural competence training have successfully applied this approach. (9, 15, 16) Use of the approach requires faculty trained to understand the relative advantages and disadvantages of various teaching strategies. Table 5 provides a brief summary of the advantages and limitations of each strategy.

Reaching cultural competence is a continuous process and suggests that training physicians in the core content and skills must also be continuous (that is throughout all years of training). Thus a single course may be insufficient to influence behavior and a single year of a practicum experience may be equally insufficient to understand the nuances of a specific cultural group. Early introduction into the training of residents address the reality that providers cannot be sheltered from the fact of diversity; however, early introduction must also be carefully structured to allow trainees to become accustomed to the new title and accountability afforded to being a physician. Once the “pinnacle” of becoming a physician is achieved, faculty status, the evolving nature of our diverse society and clinical settings warrant ongoing continuing education training for practicing physicians. The knowledge, skill and content areas remain the same, as does the teaching strategies, but with ample opportunity for newer (web-based training, chat-rooms,) and perhaps untested teaching methods.

Implications for General Medical Education and Practice

A number of challenges remain for including cultural competence training in family practice residency, and medical education in general. In addition to attempting agreement on the core concepts and teaching strategies, often cited issues include lack of time in already packed curricula, insufficient financial resources, lack of tools to teach, lack of faculty, lack of agreement on which groups of faculty should teach, the challenge of teaching a highly charged subject matter, a lack of comprehensive evaluation strategies and the endless controversy of whether training should be required or recommended. To move the field beyond the growing consensus that cultural competency training is necessary, addressing these issues is critical. Although only three are further discussed, all warrant ongoing discussion and resolution.

Faculty Expertise and Competence

Despite the pressing need to equip health professionals with the skills needed to provide care that is culturally appropriate and competent (1,2), many health professionals have had little to no prior training in these areas. There is an even greater paucity of information to guide teachers on approaches to introducing topics that address ethnic and cultural issues in medical curricula or clinical teaching (11) and to select appropriate content areas or recommendations for effectively structuring and facilitating cultural competency discussions. This has in part been attributed to a lack confidence or fear of eliciting, but not being able to effectively facilitate discussions on sensitive issues like race, discrimination and cultural preferences. (11) Recently, a training of trainer approach that emphasizes curricular content, teaching strategies and skills has been used to prepare multidisciplinary groups of health professionals to teach cultural competence. (16)

Evaluation

There continues to be a lack of comprehensive evaluation strategies to assess the effectiveness of cultural competence curricula. Efforts assessing whether curricular objectives are met through the use of Likert scales or written or verbal feedback at the end of course are routine and necessary. However, still lacking are proven strategies to measure whether core curricula in cultural competence impact behavior; the most difficult challenge here is that the likelihood of measuring any impact on behavior (i.e., whether cultural competence is changed in some way) requires measurements over time. Recent published guidelines are beginning to lay framework to guide educators and trainers on effective evaluation strategies (17, 18).

Required or Recommended Curriculum

The final report on the CLAS Standards (3) addressed the issue of whether standards needed to be required or recommended by grouping the standard into three types, CLAS mandates, guidelines and recommendations. Mandates are those CLAS standards that are current Federal requirements (i.e., language access services), guidelines are activities being recommended by the Office of Minority Health (OMH) for adoption as mandates by the federal government, and recommendations are suggested by OMH for voluntary adoption. Given the pervasive controversy over whether training programs should require or recommend cultural competence curricula (19), it may be reasonable to use the same strategy as outlined in the CLAS standards. More specifically, it may be prudent to have training programs adopt *guidelines* for core curricular content, leaving the challenge of ultimately having these guidelines be Federal mandates as a discussion for the national agenda. In this way, like CLAS Standard 4 relating to language assistance, organizations could avoid focusing on whether to include training in the core content areas, and focus more on the challenges inherent in meeting the mandate (financial resources, recruiting diverse staff, shaping a revised curriculum).

Diverse Leadership, Faculty and Staff

The agenda of increasing the number of diverse leadership, faculty and staff at all levels in the health care organization (CLAS Standard 2) is several decades old in the United States, and though some gains have been made, there remains a severe lack of ethnically and culturally diverse leadership and faculty in the majority of health care organizations. This is despite research demonstrating an increased likelihood that students from ethnically diverse or economically disadvantaged communities return to their communities to provide service. (20) Staff diversity is less often the challenge, though in some areas, staff too, may not reflect the demographic characteristics of the service area.

Training programs are making efforts to continue to push for the recruitment of more diverse, students, staff and faculty. (21, 22) Recruitment efforts must also include ethnically diverse and economically disadvantaged students from secondary and junior high schools who for a variety of reasons may not perceive health professional careers as options. Medical education and practice in a diverse society absent a broad diversity of teachers or a paucity of the same will remain disadvantaged. Achievement of faculty and student diversity are measures of the extent to which academic institutions and health care organizations can meet the same standards for cultural competency they desire for their trainees. (23, 24)

Table 1. Core Content Areas for Culturally Competent Care

Knowledge

- Awareness of difference
- Appreciation for diversity
- Concepts of race, culture, ethnicity and the role of power
- Differing communication styles
- Culture specific illness and behaviors, and influence on individuals and families
- Epidemiological principals of disease and impact on individuals and groups
- Family structure, function and roles, gender roles and preferences
- Religion, death, birth and other traditions
- Prevailing and historical psycho-social and political context of the group or individual's existence

Skills

Specific to each individual, group or culture:

- Effective communication skills
- Relationship building, including establishing empathy, trust, and respect
- Ability to illicit differing views of illness, healing and curing
- Ability to recognize culture related problems
- Cultural and non-cultural interpretation of individual behavior
- Language proficiency and effective use interpreters
- Application of epidemiological principles to common and uncommon illness

Attitudes and Behaviors

- Recognize and accept difference (avoid labeling and stereotypes)
- Self-Assessment and comfort with how personal bias influence behaviors
- Cultural and individual assessments made before drawing conclusions
- Willingness to integrate patient's beliefs into the management plan

Table 2. Outline for Cultural Formulation (14)

- The cultural identity of the individual is determined for reference. Immigrant status and the degree of involvement in the host or culture of origin are evaluated. Language abilities, and preferences are noted.
- Cultural explanation of the individual's illness is assessed to look for culturally interpreted illness, culture specific meanings of symptoms, and how the individual interprets disease, behaves toward health and healing within and outside of his cultural reference group.
- Cultural factors related to psycho social environment and level of functioning puts the family and social context of the patient's functioning into perspective and examines support networks and systems
- Cultural elements of the relationship between the individual and the clinician are determined. What are the differences in culture, social status between the patient and provider, and what challenges to assessment and management are presented because of these differences? Are there language or other communication barriers?
- Overall cultural assessment for diagnosis and care is formulated, along with consideration of how the identified factors may influence the patient's diagnosis, management and functioning.
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Table 3. Additional Questions to Consider In Assessing Diverse Patients

- Who is this person as an individual?
- How does she define her ethnic/cultural background?
- What is the context of her life?
- What experiences have shaped her interactions?
- How do her experiences impact her health and health care behavior?
- What is her health belief model?
- How does she explain illness, wellness, healing?

Table 4. Selected Cultural Competence Content and Teaching Methods

	Possible Content Area	Possible Objectives	Teaching Methods
Knowledge	<ul style="list-style-type: none"> • Perspectives of Illness and Healing • Appreciation for diversity • Concepts of race, culture, ethnicity and the role of power • Family structure, function and roles, gender roles and preferences 	<ul style="list-style-type: none"> • Learn differing views of illness and healing • Raise Personal Awareness • Define Terms • Learn differences in family structure and roles and impact on health behaviors 	<ul style="list-style-type: none"> • Discussion/ Lectures • Videos • Cultural Immersion or Patient Panels • Simulation or • Experiential Exercises • Family Genograms
Awareness	<ul style="list-style-type: none"> • Awareness of difference • Societal and Institutional discrimination • Stereotypes and Assumptions • Self-Awareness and Cultural Sensitivity 	<ul style="list-style-type: none"> • Identify Differing Health and Illness Beliefs • To Explore Personal Assumptions • To review the current health care environment and impact on patient care 	<ul style="list-style-type: none"> • Experiential Exercises • Video • Cultural Immersion or Patient Panels • Case Studies • Self-Assessment
Skills	<ul style="list-style-type: none"> • Social and language barriers in health • Use of interpreters in health care • Ability to elicit differing views of illness, healing and curing • Working in diverse teams 	<ul style="list-style-type: none"> • To assess and integrate the social lives of patient into their clinical management • To apply effective Communication Skills • Enhance Skills when using Interpreters • To take a patient history 	<ul style="list-style-type: none"> • Didactic discussions • Case Studies • Video of patient interactions • Skills-Building by simulated patients

Advantages and Disadvantages of Selected Teaching Techniques

TECHNIQUE	ADVANTAGES	DISADVANTGES	BEHAVIOR IMPACT
Lecture	Conveys a lot of information Structured Generates interest Addresses a large group Economical	One way communication Significant prep time is required May not reach all learners May lose audience if too long	Imparts Knowledge
Case Study	Real life application Elicits many views Easy to teach skills Engage participants Challenges attitudes and behaviors	May be too general or too specific Requires skilled trainer Poorly written cases can be confusing Limited to case themes	Teaches Skills Challenges Behaviors and Attitudes
Critical Incidents	Focused Applicable to real life Skill directed Easy to manage for trainers	Can be too specific to generalize Hostility and anger may arise from volatile incidents No one answer (multiple solutions)	Challenges Behaviors and Attitudes Teaches Skills
Role Play	Experiential Reveals hidden attitude Allows multiple role identification Good for retaining attention	Can be easily unrealistic Many trainees do not like acting Significant prep needed High risk Requires skilled trainer and significant trainer guidance	Excellent for Skills development Challenges Attitudes, values and opinions
Video	Addresses large group Multiple perspectives conveyed Demonstrates use of space and body language Elicits hidden issues A permanent record	Equipment may fail or be operator dependent Taped individuals may appear unrealistic Can be disruptive to group if poorly introduced May be too short or too lengthy if poorly planned	Imparts Knowledge Demonstrates Skills Raises Awareness

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Prepared by Melissa Welch, M.D., M.P.H. for National Advisory Committee Office of Minority Health/Office of Public Health and Sciences Department of Health and Human Services March 18-19, 2002

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