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Culturally Competent Care Pedagogy

What Works?

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Abstract
Background In its 2002 publication *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine reported American racial and ethnic minorities receive lower-quality health care than white Americans. Because caregiver bias may contribute to disparate health care, the Liaison Committee on Medical Education and the Accreditation Council for Graduate Medical Education have issued specific directives to address culturally competent care education.
Questions/purposes We discuss the general approaches to culturally competent care education, the tools used in evaluating such endeavors, and the impact of such endeavors on caregivers and/or the outcomes of therapeutic interventions from three perspectives: (1) Where are we now? (2) Where do we need to go? (3) How do we get there?
Methods We summarized information from (1) articles identified in a PubMed search of relevant terms and (2) the authors' experience in delivering, evaluating, and promoting culturally competent care education.
Where are we now? Considerable variation exists in approaches to culturally competent care education; specific guidelines and valid evaluation methods are lacking; and while existing education programs may promote changes in providers' knowledge and attitudes, there is little empirical evidence that such efforts reduce indicators of disparate care.
Where do we need to go? We must develop evidence-based educational strategies that produce changes in caregiver attitudes and behaviors and, ultimately, reduction in healthcare disparities.
How do we get there? We must have ongoing dialog about, development in, and focused research on specific educational and evaluation methodologies, while simultaneously addressing the economic, political, practical, and social barriers to the delivery of culturally competent care education.

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Introduction

The development of a 21st century healthcare system that is safe, effective, patient-centered, timely, efficient, and equitable emerged as a major aim of the Institute of Medicine in its 2001 report *Crossing the Quality Chasm: A New Health System for the 21st Century* [4]. However, in its 2002 report *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* [11], the Institute of Medicine reported American racial and ethnic minorities receive lower-quality healthcare services and have worse health status indicators than white

Americans. While the Accreditation Council on Graduate Medical Education (ACGME) had previously described six competencies required for resident education, including "[p]rofessionalism, as manifested through a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population" [9], *Unequal Treatment* suggests health disparities may be caused in part by limited "cultural competence." Cultural competence is defined by the Association of American Medical Colleges (AAMC) [1] as "…a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations, where 'culture' refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups, and 'competence' implies having the capacity to function effectively as an individual or an organization within the context of the cultural beliefs, behaviors, and needs presented by patients and their communities." *Unequal Treatment* also reported deficiencies in cultural competence in health care may be in part due to conscious or unconscious bias on the part of the caregiver. Recognizing the importance of education in reducing healthcare disparities, the Liaison Committee on Medical Education (LCME) issued the following directives to address culturally competent care education (CCCE) in medical school curricula [6]: (1) The faculty and students must demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments; and (2) medical students should learn to recognize and appropriately address sex and cultural biases in healthcare delivery, while considering first the health of the patient. Moreover, LCME Educational Objective Number 21 states, to demonstrate compliance with this standard, "…the medical education program should be able to document objectives relating to the development of skills in cultural competence, indicate the location in the curriculum where medical students are exposed to such material, and demonstrate the extent to which the objectives are being achieved" [6].

In this paper, we explore the questions: (1) where are we now? (current approaches to CCCE, methodologies for evaluation of such approaches, the impact of CCCE on the attitudes and behavior of caregivers, and the reduction of disparate care); (2) where do we need to go? (opportunities to improve CCCE); and (3) how do we get there? (strategies for improving the delivery and evaluation of CCCE as one mechanism to reduce and ultimately eliminate disparities in health care).

Search Strategies and Criteria

To identify relevant information in the published literature, we searched the PubMed (National Library of Medicine) database of English-language articles published over the last three decades (1980–2010) using the following terms: "culturally competent care education," "cultural sensitivity," "healthcare disparities," "healthcare quality," and "medical education." Of the more than 200,000 articles identified in the initial search, the search terms were then combined to produce 5181 articles with potential relevance to the study question. We then scanned the titles and key words of the remaining articles and excluded those that were not relevant to minority health, did not have a full article available for review, or did not apply to the topic of CCCE methodology or evaluation. Ultimately, the full text and reference lists of 67 articles (including two systematic reviews of the literature) were combined with review of the AAMC, ACGME, and LCME Web sites (www.aamc.org, www.acgme.org, and www.lcme.org, respectively) and the authors' personal experiences delivering, researching, and promoting CCCE. From these 67 sources, 10 [1–10] provided information relevant to the delivery and/or evaluation of CCC education.

Methodologies for CCCE

While a detailed review of CCCE is beyond the scope of this review, we have found it useful to consider the approaches in four broad categories that we refer to as role modeling, immersion approaches, anthropologic approaches, and template approaches. For example, role modeling, through either real or simulated situations, demonstrates culturally competent care on the part of caregivers for students. Through immersion approaches, students are immersed into a particular culture, such as a Native American Indian Reservation or a distinctly ethnic neighborhood, wherein they learn, with support and guidance, the care of a number of patients in that particular environment. Anthropologic approaches emphasize the learning of prevailing cultural characteristics of a variety of patient groups that tend to surface in the patient-doctor relationship. Finally, patient-centered generic template approaches provide the individual caregiver with the general skills, knowledge, and attitude to approach any patient in patient-centered care without having to actually be involved with specific knowledge of the patients' culture. Each approach appears to have particular strengths and weaknesses [7], and the various approaches are often combined in various proportions in individual CCCE programs. In a 2003 study of curricular materials from 19 US medical schools, Pena Dolhun et al. [7] revealed

considerable variation in both the approaches to teaching and the content of crosscultural education across the schools.

Methodologies for Evaluating CCCE

The ACGME and LCME have provided both qualitative and quantitative examples of how the impact of such efforts might be evaluated, but specific program guidelines or evaluation methods have not been provided. However, several methods for evaluating CCCE endeavors have emerged. Probably the best known and most utilized of these is the Tool for the Assessment of Cultural Competence Training (TACCT) developed by the AAMC [1]. TACCT is a self-administered assessment tool that can be used by medical schools employing either traditional or problem-based curricula. This tool allows medical educators to examine cultural competence training across all aspects of the medical school curriculum, to identify gaps and redundancies in the curriculum, and to use the information to make the best use of opportunities and resources. While TACCT has limitations, including little analysis of learning outcomes, teaching strategies, or informal learning that occurs outside of structured settings, this tool has the unique advantage of gathering data about cultural competence training across the entire curriculum and informs the creation of comprehensive and developmentally appropriate educational programs [3].

In a comprehensive review of the literature, Kumas-Tan et al. [5] identified the 10 most commonly used measures in their evaluation of 54 cultural competence measures identified in the literature. These measures included the Multicultural Counseling Inventory; Cultural Self-Efficiency Scale; Inventory for Assessing the Process of Cultural Competence Among Health Professionals; Cross-Cultural Adaptability Inventory; Quick Discrimination Index; Cultural Attitude Scale; Multicultural Awareness, Knowledge, and Skills Survey; Cultural Competence Self-Assessment Questionnaire; Cross-Cultural Counseling Inventory; and Multicultural Counseling, Knowledge, and Awareness Survey. While many of the measures demonstrated utility and represented progress with respect to earlier measures, these authors found most of the measures were limited by their primary focus on race and ethnicity rather than a broader definition of "culture" and concluded we still lack valid methods for measuring skills or competent practice across a wide range of patients' social differences.

In a 2005 effort to measure the success of interventions to improve cultural competence among healthcare professionals, Beach et al. [2] published their results of a systematic review of such studies published between 1980 and 2003. This study and a subsequent study by the same group [8] revealed a substantial lack of methodologic rigor in many of the works. Their analysis revealed excellent evidence that cultural competence training improves the knowledge of health professionals, good evidence that such training improves the attitudes and skills of health professionals, and good evidence that cultural competence training of healthcare providers improves patient satisfaction in clinical encounters. However, these authors found little to no evidence that cultural competence training influences patient health status outcomes or patient adherence to treatment regimens. In fact, review of the literature actually reveals few, if any, evidence-based documentation of cultural competency curricula that actually reduce, reverse, or otherwise change the indicators of disparate care. For example, in 2010, Sequist et al. [10] showed, with an appropriate educational program, attitudes and knowledge of trainees were changed, but the monitored health outcomes in African American diabetic patients treated by the culturally competent educated doctors did not change.

Discussion

In its 2002 publication, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine reported American racial and ethnic minorities receive lower-quality health care than white Americans. Because caregiver bias may contribute to disparate health care, the LCME and the ACGME have issued specific directives to address CCCE. In this review, we discussed the general approaches to CCCE, the tools used in evaluating such endeavors, and the impact of such endeavors on caregivers and/or the outcomes of therapeutic interventions from three perspectives: (1) Where are we now? (2) Where do we need to go? (3) How do we get there?

We recognize limitations of our review. First, it was a selective review. We searched only one database (PubMed) using selected review terms. While we also searched the Web sites of the AAMC, ACGME, and LCME, using other databases and other terms would undoubtedly provide a wider range of information and data. Second, the information we provide on methods for promoting CCCE is limited and rather we chose to outline the approaches. Third, the literature evaluating these approaches is limited, so we do not have a clear idea of whether or how these approaches are effective. Fourth, we introduced information from our own experience, which might not reflect that of other individuals.

Where are we now? Considerable evidence exists that, despite similarities in age, socioeconomic status, insurance coverage, and other relevant demographic factors, many minority group patients receive disparate health care

compared to white patients. Because conscious and unconscious bias on the part of the caregiver is reportedly a major factor in the persistence of healthcare disparities [11], there has been growing acknowledgment of the importance of cultural considerations in medical education. Cultural competence fits substantially under the rubric of professionalism as noted by the AAMC guidelines. While myriad philosophies have emerged regarding CCCE, considerable variation exists both with respect to the approaches to teaching and the content of such educational programs in US medical schools [7]. Despite similar goals, there are no standard guidelines to help educators effectively design, evaluate, or report cultural competence interventions [7]. Moreover, while good assessments may be qualitative and quantitative, a lack of methodologic rigor seems to limit the evidence for the impact of cultural competence training on minority healthcare quality.

In addition to the objective difficulties of CCCE curricular design and evaluation identified in the literature, it is the authors' experience that several major tangential barriers have persisted in the pedagogy of culturally competent care, including substantial current doctor stressors; the need for organizational behavior change to effect culturally competent care; the difficulty of educating the unconscious mind; the interconnectedness of diversity and cultural competence; limited time and money resources; the paucity of faculty who have been taught culturally competent care; the fact that some might find culturally competent care is not necessarily fun to teach; the fact that there may be disinterest in the subject; the reality of the impact of white privilege on healthcare disparities; and the political, ethical, and economic issues at the core of CCCE, among myriad other potential roadblocks.

Where do we need to go? While it would be nice to change the hearts and minds of caregivers for the purposes of cultural competency in health care, that might be more challenging than finding ways to change behavior. Ultimately, caregivers must make actual use of cultural competency skills, like other clinical skills, in their interactions with patients, such that healthcare disparities are reduced.

How do we get there? Behavioral changes to reduce healthcare disparities might be best advanced by education. There is a need for education across three important groups: medical students, residents and fellows, and the faculty; and we need to make more progress in the design of educational programs for caregivers at all levels. Synthesis of the available data suggests the concept of becoming a "cultural anthropologist" for many cultures may be less favorable than developing and using template skills that allow one to respect all patients, to view them in the environmental or social contexts that they exist, and to explore with them their views and thoughts about their health care. The successful development and integration of CCCE programs will, in turn, require further attention to the development of standardized, comprehensive, reliable, and methodologically rigorous methods to qualitatively and quantitatively assess the efficacy of the various educational efforts.

Finally, we must continue to identify and remove tangential barriers that may interfere with CCCE initiatives. To end on a positive note, we must remind ourselves that in the development of evidence-based educational methodologies for diminishing healthcare disparities lay tremendous opportunities to make monumental contributions to patient care.

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