Cultural Competency in the Trenches

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A core mission of health professions schools is to educate and train a workforce that will be optimally prepared to provide health care and public health services for the diverse communities that they serve. It is important to create and develop a health care workforce who can understand and assist in the battle against health care disparities. For health care workers and health profession schools, cultural competence education and training has been identified as one solution to the problem. However to educate and properly train a culturally competent health care workforce is not an easy task. The literature on cultural competency is growing, with numerous studies that have focused on specific traits of cultural competency but unfortunately, a consensus on the best approach to achieve the desired outcomes has not been reached. A review of the literature on cultural competency reveals some common concerns regarding cultural competency, especially about how cultural competence education is incorporated in the classroom/clinical setting. What training and preparation does the instructor possess to qualify him or her to teach cultural competency? Was the instructor chosen because of gender or because he/she is from a racial or ethnic minority group which somehow makes him/her an expert? How much time should be devoted to cultural competency training in health professions? How do we accurately assess student learning of cultural competency? And finally, how do we as faculty committed to cultural competency get our colleagues to also participate in cultural training/education? These are key questions, concerns, and problems that many who teach cultural competency training have encountered. Therefore, a variety of approaches to cultural competency education and training have been developed within our schools.

Earlier this year, a joint expert panel convened by the Association of American Medical Colleges and the Association of Schools of Public Health released a report with recommendations for Schools of medicine and public health defining a set of

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appropriate competencies for learners in both disciplines to prepare culturally competent practitioners.[1] Unfortunately, these recommendations are not well known and furthermore only provide a general framework for the incorporation of cultural competency education. Similarly the American Dental Association's Commission on Dental Accreditation requires all dental and dental hygiene schools to incorporate diversity and cultural competency standards and evaluation methods into the school's program according to new accreditation standards.[2]

We would like to share our experiences as four African American health professions educators (a physician, a nurse, a dental hygienist, and a non-physician medical educator) who develop, teach, and assess cultural competency education and training to health professions students in our institution. We are all faculty members working in a predominately White university in the medical, dental and nursing school in the state of Kentucky with a health sciences campus located in a predominately urban African American area of the city. Although we are located in a downtown urban area, many of our students come from rural areas of Kentucky. Some come with very limited exposure or interactions with people of diverse backgrounds and beliefs.

Kentucky as a state is less diverse than the nation as a whole, with 89% of the population identified as White not Hispanic, 8% Black, 2% Hispanic, 1.2% Asian, two or more races 1.6. One in four residents of Kentucky live in a rural area (24%) compared with only 6% in U.S. Between the years 2000 and 2010, 63 counties in Kentucky saw a decrease in the number of Blacks.[3] Kentucky has a higher rate of hate-crime incidents than the nation. Of all the Kentucky hate crimes, 92% were against African Americans.[4]

Regarding health outcomes and health factors, Kentucky typically ranks near the bottom of all 50 states. Kentucky is ranked 43rd in overall health status when assessing the determinants and outcomes of health. Kentucky ranks 22nd for deaths secondary to HIV/AIDS, but HIV/AIDS is the 11th leading cause among African Americans (http://www.americashealthrankings.org/ky). The state of Kentucky ranks third in the nation for adults 65 years and older who are edentulous.(http://www.richmondinstitute.com/rankings-u-s-states-by-trends-in-oral-health) The racial and ethnic composition of the health care workforce in Kentucky is not diverse for medicine and dentistry. The percentage of African American dentists is 0.9% and 2.0% for physicians practicing in the state.[5] African American nurses constitute 5% of practicing nurses in the U.S. with a lower percentage in Kentucky.[6]

In our experiences of teaching and offering cultural competency programs, we have encountered learners who span the spectrum in relation to their willingness to engage in such learning. Some will enthusiastically participate in educational programs and courses and want to learn more about being a culturally competent practitioner. However, some see no need for formal learning and are reluctant to participate in cultural competency training while a segment of students appear to be downright hostile to the concept or presentations focused on culture in professional education. We find this surprising because this generation of learners have grown up in the era of multiculturalism where diversity awareness has been part of the public discourse from the time they were in elementary school through their college years. However, with such early exposure to diversity, learners sometimes feel they already know all about cultural competency and therefore fail to recognize cultural competency as being

different from diversity awareness. Yes, awareness of diversity is part of cultural competency, but cultural competency encompasses significantly more than that. It is about how cultures interact with the health care system. It is about the systemic biases and policies of health care institutions and workers that often create unnecessary barriers for people from different cultures and backgrounds seeking health care.

To further the goal of cultural competency education, it may be important to begin the conversation by realigning our educational activities with a direct discussion of content based on concepts of cultural awareness and cultural accommodation and then make the case for intercultural collaboration as a strategy to support and transform health for our diverse communities. This perspective is somewhat different from "competency" which might imply that just being knowledgeable is all that is needed—many students have this misconception when they say they are culturally competent. In reality, we should include the concepts of appreciation and valuing which requires the practitioner to understand that they are guests in the world of those who are culturally different and as a result must accommodate that culture as well as introduce ONLY those things that improve or support the individual's or group's health status.

This approach is supplemented by focusing on the context of those who are culturally (and/or socially) different from the provider. The learner should strive to experientially immerse himself/herself in the cultural and social environment. This method requires the faculty member's attention and processing of the experience with a focus on not only the primary educational objective (clinical practice) but also on the cultural and contextual issues that are experienced by both the student and the community. Many times it means moving the learner out of the clinical setting (MD office/hospital) into the community itself. Students have an opportunity to see how people live, what their challenges are and, most importantly, what their strengths are within the context of their daily lives. Those cultural strengths are a critical part of the building blocks for provider-patient interaction and culturally competent care.

As stated earlier, the four of us have come into the role of educating and training students in cultural competency from different viewpoints and backgrounds. One author's view was through the lens of a family member who was transported from a rural community to our academic medical center for more intensive treatment after a motor vehicle accident. Although he received excellent medical care, it was troubling to see the medical staff interact with the family dismissively. Only when the author identified herself as a physician did this change. The change took place in an instant, with the medical team constantly providing information, even bringing X-rays and other tests to the room to discuss with the family. Why did it take this intervention of identifying the author as "one of them" to achieve the simple right of actively engaging in the health care decisions? The author felt like they saw a young Black male from a rural community in a university hospital and thought he was poor and uneducated, therefore, they didn't really have to explain anything about his treatment except in the simplest of terms despite family members asking repeatedly for more information. This was a lesson learned and initiated a life-long desire to transform our educational system into one that focuses on patient-centered care.

Another author is the only Black female faculty in her program. She recalls at the beginning of her teaching career how alone she felt. She would seek solace by turning

to the main campus for support through an inclusive teaching circle. There she could express her fears in a safe place. She also recalls a negative incident that happened at her health professional school, which later ignited mandated sensitivity training for everyone. As she sat on the school's diversity committee, she noted many people did not like being forced to do sensitivity training. A diversity expert provided training to the students in a safe environment. One activity called for one White male student to stand up and one Black male student. The Black student asked the White student, "How often during the day do you think about being White?" The student said none. The White student asked the Black student the same question and he said "All the time."

Our nurse educator was influenced by several factors that served as the foundation for her emphasis on the ongoing process of cultural competence. As a native of Kentucky, she was raised in a large family with two parents in public housing. She had first-hand experience with segregated housing, low income, and health care disparities. She is old enough to have experienced a time in nursing education when all of the texts focused primarily on care of patients who were White and when questions were raised in class about similar care for African Americans, faculty could not adequately respond. This lack of knowledge to support culturally appropriate nursing care in clinical settings frequently resulted in others asking her how to do things such as assessing those with dark skin, identifying strategies for hair care and problem-solving when milk-based tube feeding resulted in diarrhea in African American adult patients. There were few resources for that information and it resulted in less than optimal care for those who depended on nurses. She spent the remainder of her career incorporating cultural, ethnic/racial, and socioeconomic factors in health and health care into a resource base and using that knowledge in her teaching, publication, and experiential activities for students and other educators.[7]

The non-physician medical educator of our group grew up in the era of busing and realized from an early age that people of different races often do not naturally work or learn together well. It became a routine occurrence to experience racial riots and being chased out of the White part of town and being beaten up and seeing friends physically harmed because of the color of their skin. There were a few well-meaning adults who tried to intervene in our predominately White high school to draw attention to the meaning of diversity (long before Rodney King) to help us all just get along. This work of just getting along with others set in motion a lifetime of work in diversity training and later in cultural competency for this educator. However, now this work is not just about race, but about issues of class, gender, sexual orientation, and national origin, which often marginalize one group and propel one group to think they are superior. When these groups collide in the health care arena the results can be disastrous.

As educators we have found many excellent resources to gather information about the perspectives of people of diverse identities. Some of the best sources for information and educational strategies regarding cultural and linguistic competence can be found at the National Center for Cultural Competency Web site at http://nccc.georgetown.edu/resources/assessments.html. Another outstanding resource we use in promoting cultural competency in our courses each year is the video series, "Unnatural Causes" (http://www.unnaturalcauses.org/episode_descriptions.php). The two that we use are *Bad Sugar* and *Place Matters*. Still, these are not enough.

Each year our health sciences campus sponsors a one day cultural competency workshop for all entering health professions students. This was our 7th year of providing the workshops. The workshops are developed and planned by upper-class students from the health professions schools who have gained experience working with a variety of patients from groups with whom many had no previous contact. Numerous speakers and experts are invited to assist students in learning about different cultures, such as members from the Amish/Mennonite community, learning about Islamic health practices, lesbian, gay, bisexual and transgender health issues and concerns, issues such as child abuse, complementary and alternative medicines, and substance abuse in the health professions. This workshop is designed to make students aware of the diversity of people and situations they may encounter as a health care professional.

Cultural competency should be a concept that is embedded all through the curriculum in our schools. It should easily flow through every component of teaching, patient care and research like blood flows in the human body. We will continue to enhance our skills and build the resources necessary to achieve the ultimate goal-improving health outcomes of all individuals we encounter.

Notes

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2. American Dental Association. Accreditation standards for dental education programs. Chicago, IL: American Dental Association, 2007.
3. Price ML. Kentucky Population growth: what did the 2010 census tell us? Louisville, KY: Kentucky State Data Center Research Report, 2010.
4. Kentucky Commission on Human Rights. Status of African Americans in Kentucky. Louisville, KY: Kentucky Commission on Human Rights, 2009.
5. Kentucky Institute of Medicine. Comprehensive statewide physician workforce study. Lexington, KY: Kentucky Institute of Medicine, 2007.
6. Sullivan Commission. Missing persons: minorities in the health professions—a report of the Sullivan Commission on diversity in the healthcare workforce. Washington, DC: Sullivan Commission, 2004.
7. Georgetown University. Foundations for cultural and linguistic competence. Washington, DC: Georgetown University, 2012.