A Guide to Incorporating Cultural Competency into Health Professionals' Education and Training

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Part I: Need for Cultural Competency

Currently, racial and ethnic minorities make up at least 30 percent of the U.S. population. Steady changes in the demographics of the U.S. highlight the demand for cultural awareness and sensitivity in the clinical environment as the percentage of minorities in America is projected to exceed 50 percent by 2056, with a far less proportionate rise in the number of minority physicians and medical students.[1]

Racial and ethnic disparities in health and health care access have been recognized in the United States for 30 years.[2] Despite an improved life-expectancy for all races and ethnicities, minorities continue to account for a disproportionate share of the national morbidity and mortality rates and continue to utilize less preventative and necessary health care services.[3] As the United States' population becomes increasingly diverse, health care professionals are becoming progressively more responsible for the health care management of people from various races, ethnicities, languages and cultures. Providing culturally and linguistically competent health care to these patients has the potential to reduce racial and ethnic disparities in health and health care services and to improve the nation's overall health outcomes.[4]

Unfortunately, a lack of consensus about the education, training and evaluation of health care professionals in the provision of culturally competent health care exists. In the following guide, the need for cultural competency education and training for health care professionals will be explored, and a checklist for a model cultural competency curriculum, specifically for the field of medicine, is developed. To do this, we provide an overview of federal guidelines and state legislative initiatives, along with examples of the activities of various professional organizations, foundations, and medical schools related to the provision of cultural competency training.

Part II: Federal Guidelines

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs and activities receiving federal financial assistance with the following statement:

> No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.[5]

The obligations of Title VI extend to all programs or agencies receiving any federal funding; thus, it is applicable to nearly every health care provider in the United States as well as many schools educating health professionals. In the late 1990s, attention to the racial and ethnic disparities in health and health care in the United States increased. However, many health care providers and organizations reported a lack of guidance about providing culturally and linguistically appropriate health care services. Instead of having a national set of guidelines, numerous ideas of what constituted culturally competent care existed.[6] While Title VI provides a legislative foundation for the notion of cultural competency in health care, it does not provide discrete guidance on what it means to provide culturally competent care.

Responding to the increasing need for a national consensus on what cultural and linguistic competence means in health care, the Office of Minority Health (OMH), under the United States Department of Health and Human Services (HHS), began to focus on policy and research concerning the practice of culturally competent care.[7,8] With the assistance of Resources for Cross Cultural Health Care (RCCHC) and the Center for the Advancement of Health, a two-part report was generated concerning the systematic analysis of key laws, regulations, contracts and standards currently in use by government agencies and other organizations. In 1999, draft standards for ensuring culturally competent care were prepared using input from policymakers, health care organizations and researchers. After the release of these standards, a four-month public comment period was allotted to allow various stakeholder groups, including health care organizations, health care professionals, consumers, unions, government agencies and health care accrediting agencies, to review the recommendations. Using these comments, the draft standards were reviewed by an expert advisory committee, which made further revisions based on the public comments.[8]

In December 2000, the OMH presented the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), which are a "collective set of mandates, guidelines, and recommendations intended to inform, guide, and facilitate required and recommended practices related to culturally and linguistically appropriate health services."[8] These standards outline the basic activities required for the provision of culturally and linguistically competent health care in the United States and serve to enhance a common understanding of the definitions of cultural and linguistic competence.[7] The standard definition of cultural and linguistic competence is as follows:

> Cultural and linguistic competence is 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. 'Culture' refers to integrated patterns of human behavior that include the language, thoughts, communication, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. 'Competence' implies having the capacity to function effectively as an individual and an organization within the context of

the cultural beliefs, behaviors, and needs presented by consumers and their communities.[8,9]

In addition, the final report emphasizes the importance of pursuing the development of innovative activities that help implement and assess cultural and linguistic competence in health care organizations and among health care professionals. Recommended activities include developing core cultural competencies for health care professionals at all levels of education, supporting efforts to diversify the professional workforce, developing curricula standards and evaluative tools for cultural competency training for health care professionals, and raising awareness of and promoting adoption of the CLAS Standards.[8] For this reason, the development of a model core curriculum of cultural competency for medical education at all levels of training is essential to the success of the CLAS Standards initiative in health care.

The 14 CLAS Standards can be divided both in terms of stringency and themes. There are *mandates*, which are governmentally required activities for all agencies receiving federal funds; *guidelines*, which are activities that are recommended by the OMH to the Federal government to become mandated; and *recommendations*, which are suggested activities by the OMH for voluntary adoption. The three themes are Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7) and Organizational Supports for Cultural Competence (Standards 8-14). Standards 1-7 have the most direct impact on clinical care, while Standards 8-14 deal more directly with organizational activities.[8] All 14 of the standards are necessary for the successful provision of culturally competent health care, but the first three standards are particularly relevant to supporting the incorporation of cultural competency curricula into health professionals' education and training. The following sections will provide a brief overview of these three standards and their implications for health care; the full OMH report is available online.

Standard 1: CULTURALLY COMPETENT HEALTH CARE (Guideline)

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 in their preferred language.[8]

This standard embodies the main issue that the CLAS Standards are aimed at alleviating by emphasizing the importance that all health care consumers should experience culturally and linguistically appropriate health care when interacting with professionals in the health care system.[8] Thus, patients and consumers from diverse backgrounds should feel comfortable in interacting within a health care organization. 'Effective' care denotes care that results in positive outcomes for the patient. 'Understandable' care means providing care in the patients' preferred languages and ensuring that all information is comprehensible. 'Respectful' care means considering the values, beliefs, preferences and needs of each individual patient and incorporating them into each health care consumer's care. [8]

Providing culturally competent care includes the ability to identify and respond to diverse health beliefs, cultural values regarding care and disease incidence and prevalence, as well as treatment efficacy in diverse populations. In implementing this standard, professional education must include curricula on cross-cultural education and training and ongoing assessments of health care providers' abilities to provide culturally competent care. In general, this standard indicates that providers need to work toward the development of culturally tolerant and open-minded attitudes, respectful interpersonal behaviors, skills to effectively communicate with culturally diverse patients, and motivation to continue enhancing the development of knowledge development regarding culturally competent health care.[8]

Standard 2: STAFF DIVERSITY (Guideline)

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.[8]

According to Standard 2, a diverse organization is a necessary ingredient in the provision of culturally competent services. A "diverse staff" is defined as being demographically representative of the served community. Building staff diversity can play an important role in how the organization responds to the needs of diverse patients or consumers. Implementing this standard means operating on a good faith mission to diversify staff at all levels of the organization.

Currently, the demographic diversity of health care professionals is not congruent with the increasingly diverse population they serve, and racial and ethnic minority students in health care professions are underrepresented. For example, studies indicate that in order to reflect the demographic nature of the population, the number of White physicians would need to be reduced by two-thirds, number of Asian/Pacific Islanders would need to be reduced by two-fifths, the number of Hispanic and Black physicians would need to be doubled, and the number of Native American physicians would need to be tripled.[10] In addition, medical school enrollment for Blacks, Hispanics and American Indians has long been underrepresented.[11] The significance of this data is enhanced by recent studies finding that patients prefer to be cared for by people of similar appearances and cultural backgrounds.[10, 12, 13] For example, Black patients are more likely than Whites to visit Black physicians.[12, 14]

In addition, patients who are treated by providers of the same race and ethnicity as themselves report higher satisfaction with their provider as compared to those patients who are treated by someone who is racially or ethnically different.[14] Therefore, efforts to recruit and retain minority professionals are needed in order to reach demographic equity between patients and providers. Also, this standard supports the recommendation to solidify relationships between academic settings and health care organizations that can provide community-based experiences focused on cultural diversity and connect younger students with cultural learning experiences.

Standard 3: STAFF EDUCATION AND TRAINING (Guideline)

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.[8]

This standard, which emphasizes the importance of staff education and training, is perhaps the most important constituent for the provision of culturally competent health care. Standard 3 stresses that simply maintaining a diverse staff is not sufficient in the provision of culturally competent care. Ongoing education and training that is based on the needs of the organizational staff at all levels and relevant to the needs of the community are essential for ensuring CLAS delivery. Health care organizations are responsible for assuring that staff at all levels and in all disciplines participate in ongoing training in accredited education programs and/or must provide such training and education.[8]

The recommended training objectives embrace the following topics: the effects of cultural differences on clinical encounters and outcomes, the strategies to resolve racial and ethnic disparities, the elements of effective communication among diverse populations, the application of Title VI of the Civil

Rights Act and the differences in clinical management of chronic illnesses as varied by different cultural groups. The educational content should emphasize the development of skills that allow health care professionals to effectively ask questions, especially regarding medical care, of individuals with culturally diverse backgrounds. Thus, the presentation of general knowledge regarding various races and ethnicities is not adequate and may actually facilitate stereotypes.[8]

Standard 3 also addresses the need to normalize the curricula and training of health care professionals. Currently no uniformity for the training and education of cultural competency exists, which complicates the ability to implement, replicate and evaluate educational programs. The inadequacy of the curricula and training recommendation was highlighted by public commentators, who proposed that education should be ongoing and that training programs should be CME- or CMU- accredited. To address these concerns, this standard supports the development of conferences and workshops that offer innovative activities related to the provision of culturally competent health care. A needs assessment of students and health care professionals, and the development of standardized, reliable and valid performance improvement tools are also supported under this standard. Finally, Standard 3 addresses the development of a measure for cultural competency trainers who are qualified to lead the education and training of health care professionals.[8]

In conclusion, the CLAS Standards provide a blueprint for the incorporation of cultural competency curricula into all levels of health care education. The Culturally Competent Care Standards are primarily concerned with assuring that all patients and consumers of health care receive culturally competent care. These standards support the diversification of health professionals as a step in providing appropriate care and emphasize the importance of ongoing education and training across all professional levels. However, Standards 1-3 are only guidelines set forth by the OMH and are not yet governmentally mandated standards. Therefore, creative approaches to encourage the incorporation of culturally competent education into curricula are necessary to ensure widespread adoption and dissemination.

Part III: State Initiatives

Several states have taken major steps to address the issue of cultural competency in their states. Some states, such as New Jersey, California, and Washington have taken action at a policy level by enacting bills that set standards and expectations for providers, clinics, and other health related services. Other states, such as Illinois, New York and Arizona are approaching the issue by funding programs and initiatives to provide cultural competency training in addition to considering policy level actions.

In March 2005, New Jersey became the first state to directly address the issue of equity in health care and cultural competency training of physicians through law with the enactment of Senate Bill 144.[15] Under this law, medical professionals are required to receive cultural competency training in order receive licensure or re-licensure in this state. Completion of cultural competency instruction is mandated for the following:[15]

1. Receipt of a diploma from a college of medicine in this state.
2. A condition of re-licensure for physicians who graduated prior to this act, in addition to other continuing medical education requirements.
3. Within 3 years for physicians licensed to practice in New Jersey.

To facilitate this training, the State requires that each medical school in New Jersey provide cultural competency instruction focused on "race and gender-based disparities in medical treatment decisions" through classroom instruction or other educational programs, and include continuing education credit.[15]

California has taken multiple steps to address the issue of providing culturally competent care to its residents through the legislation that focuses on physician training and provision of interpreters. The Medical Practice Act placed regulation of physician licensure under the duties of the Medical Board of California and set the requirements for continuing education. Initially, this Act created "a voluntary program for providers to learn foreign languages and cultural beliefs and practices that may impact patient health care practices."[16] In September 2005, Assembly Bill 1195 was amended this law with the "intent to encourage physicians and surgeons to meet the cultural and linguistic concerns of a diverse population."[16] The curriculum of continuing medical education courses was mandated to include topics related to cultural and linguistic issues in the practice of medicine, unless the courses are "solely for research or topics that do not include direct patient care."[16] These curricula must address a minimum of one of the following guiding principles:[16]

1. Cultural competency through applying linguistic skills, using cultural information to establish therapeutic relationship, or using pertinent cultural data in diagnosis and treatment.
2. Linguistic competency, which refers to providing direct communication in the patient's primary language.
3. A review or explanation of relevant federal and state laws/regulations regarding linguistic access.

In California, physicians and surgeons are required to take 100 hours of continuing education courses every four years.[17]

Additionally, California enacted Senate Bill 853 , which requires the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI), to adopt regulations establishing standards

for providing enrollees of health care service plans with access to language assistance in obtaining health care services.[18] The legislation requires plans to assess the linguistic needs of the enrollee population, to provide oral interpretation for enrollees in commercial health plans, and to provide translation of vital documents to enrollees.[18] It also requires health plans to report to DMHC and DOI on the plans' internal policies and procedures related to cultural appropriateness and the ways they are moving to improve the cultural competency of their services.[18]

California also requires health plans that cover Medi-Cal (the name for Medicaid in California) services to incorporate structural cultural competence through training programs and additional staff hiring.[19] Similar to the Medicaid contracts in other states, California has defined requirements for the provision of language services by contractors in the Medi-Cal plan. California requires the provision of 24-hour oral interpreter services at all key points of contact in medical and non-medical care settings to all monolingual, non-English speaking, or limited English proficient Medi-Cal beneficiaries.[20] Oral interpreters, fully translated written materials, referrals to culturally and linguistically appropriate community service programs and telephone language services are the minimum services required.[20] Written translation services must be provided to populations of mandatory Medi-Cal beneficiaries where the number indicating a primary language as other than English meets a numeric threshold of 3,000 or meets the concentration standard of 1,000 in a single zip code or 1,500 in two contiguous zip codes.[20]

Additionally, Los Angeles County has developed cultural and linguistic competency standards.[19] Some of these standards include promoting incentives to reward culturally competent practices, providing staff with the skills and knowledge to support culturally competent practices, and promoting recruitment and retention of bilingual staff.[19] However, implementation of this program was limited by budgetary issues.

In March of 2006, Washington enacted Senate Bill 6194 that establishes "an ongoing multicultural health awareness and education program as an integral part of its health profession regulation."[21] The stated purpose of this education program is to "to raise awareness and educate health care professionals regarding the knowledge, attitudes, and practice skills necessary to care for diverse populations to achieve a greater understanding the relationship between culture and health."[21] Under this bill, each education program with a curriculum to train health professionals for employment will be required to integrate instruction in multicultural health as a part of its basic education preparation curriculum by July 1, 2008.[21]

New York is considering two pieces of legislation. One policy "would require medical schools to include at least one course in cultural competency in the curricula."[23] Another would require already licensed physicians to complete 16 hours of culturally competency training for re-licensure.[24]

Illinois is also considering legislation to have the "state's local medical societies oversee a voluntary education program" focusing on cultural competency training.[24] However, various programs within the state have already focused their efforts on cultural competency issues. In 2001, the Asian Health Coalition of Illinois (AHCI) developed the Open Doors Cultural competency training program with the goal of "instilling health care providers with the awareness, knowledge, and skills to provide quality health care services to patients of different cultural backgrounds.[25] Although the amount of participation in this program and other similar programs in the State is unknown, the presence of such programs is an indication of "response to the need for culturally competent services in the Chicago area."[25]

Similarly, Arizona is addressing the issue of cultural competency through policy and programs. The state government is considering legislation to "require medical schools to make cultural competency

courses available to licensed physicians and students."[24] Already in place is the "Bridging the Gap and Enhancing Care" program developed by the Arizona Health Care Cost Containment System (AHCCS), the State's Medicaid program.[26] Their cultural competency provider-education initiative includes cultural competency workshops and guidelines for reporting quality improvements in the cultural competency, with the intent of "reducing redundancy in activities and developing new outreach resources to supplement existing programs."[26] Additionally, this program produces a "cultural competency pocket guide" that is distributed to all providers practicing under AHCCS health plans, and is a consortium of issues relating to cultural competent practice.[26]

Overall, states are beginning to address the issues of disparities in health care for minority and underserved populations by focusing on cultural competency training. Currently three states, New Jersey, California and Washington specifically address the topic through legislative mandates.[15, 16, 18-21] Other states, such as New York, Illinois, and Arizona, are considering implementing similar policies and regulations and are attending to these issues through support of local programs and initiatives.[23-26]

Part IV: Suggestions from Physician Associations

Numerous professional associations support cultural competence education, and many specialty-driven organizations have created relevant policy statements. To achieve congruent competence, efforts must target professionals at all levels of training. The following examples from the American Medical Association, Association of American Medical Colleges, American Academy of Pediatrics and American Academy of Family Physicians illustrate programs directed at each tier of medical education: medical students, residents in training, and physicians in practice.

Example I: American Medical Association (AMA)[27]

The AMA policy statement regarding cultural competence, *Enhancing the Cultural Competency of Physicians* (H-295.897), sets forth five objectives:

1. To continue efforts to inform medical schools & residency programs about cultural competency resources and encourage them to include culturally effective health care in their curricula;
2. To continue research into the need for and effectiveness of cultural competence training;
3. To form an expert national advisory panel of consultants who will also develop a list of resources;
4. To help physicians obtain information and/or training through an online resource database;
5. To seek external funding for a 5-year program for promoting cultural competence in collaboration with a number of national health-related organizations – the goal being to restructure medical education and staff /faculty development programs to deliberately emphasize cultural competence as part of professional practice.[27]

Example II: Association of American Medical Colleges (AAMC)[28]

In 2000, the Liaison Committee on Medical Education (LCME) of the AAMC introduced their standard for cultural competence: "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. Medical students should learn to recognize and appropriately address gender and cultural biases in health care delivery, while considering first the health of the patient."[28]

The AAMC has accepted this charge in designing five institutional requirements for an effective cultural competence curriculum: 1) support of the leadership, faculty, and students; 2) commitment of institutional and community resources; 3) involvement of community leaders in curriculum design and evaluation; 4) provision of integrated educational interventions appropriate to the level of the leaner; and 5) a clearly defined evaluation process including accountability and evaluation.[28] The latter requirement is the focus of the AAMC's Tool for Assessing Cultural Competence Training (TAACT). This tool is designed to help medical schools integrate cultural competence content into their curricula and meet LCME objectives. Self-administered, the TAACT can be used to inspect multiple aspects of a given medical school's total curriculum. The first part (Domains) facilitates monitoring of *where* teaching is occurring, and the second part (Specific Components) allows identification of *which* learning objectives are being met. It is important to note that the TAACT may not permit analysis of teaching strategies (i.e.: lecture vs. discussion) or achievement of learning outcomes (see Part VI for the TAACT).

Example III: American Academy of Pediatrics (AAP)[29]

The AAP (in conjunction with the AMA Committee on Minority Physicians) defines culturally effective pediatric health care as "the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions. Such understanding should take into account the beliefs, values, actions, customs, and unique health care needs of distinct population groups. Providers will thus enhance interpersonal and communication skills, thereby strengthening the physician-patient relationship and maximizing the health status of patients."[29]

Acquisition of this culturally effective health care can be achieved through educational courses with the singular objective of addressing cultural competence and/or cultural sensitivity and specific didactic components in the curriculum of medical schools, residency programs, and continuing medical education programs. The following figure represents examples of cultural competence curricula resources at each level of pediatric training:

Figure 1: Cultural Competence Curricula Resources in Pediatric Training[29]

General Pediatric Clerkship Curriculum and Resource Manual

→ Developed by: the Council on Medical Student Education in Pediatrics and the Ambulatory Pediatric Association (APA).

→ Target audience: medical students

Training Residents to Serve the Underserved: A Resident Education Curriculum

→ Developed by: the APA

→ Target audience: pediatric residents and their medical educators

Culturally Competent Health Care for Adolescents: A Guide for Primary Health Care Providers

→ Developed by: the AMA

→ Target audience: practicing primary care physicians who treat adolescents

Example IV: American Academy of Family Physicians (AAFP)

The AAFP has also developed cultural proficiency guidelines. The Academy has developed a list of issues to consider in preparing informational or continuing medical education programs which include attention to: the practice setting from both the patient and physician perspective, research-based information on cultural proficiency, cultural differences, and cultural expectations or beliefs. In addition, the AAFP has featured Cross-Cultural Medicine in the December 1, 2005 edition of its publication *American Family Physician.* Authored by Dr. Gregory Juckett, the article describes the cross-cultural interview, highlights Latino and Asian cultures, and provides listings of web-based resources for cross-cultural medicine.[32]

Part V: Suggestions from Nursing and Public Health

American Nurses Association (ANA)

The American Nurses Association has addressed cultural competency since it issued a position statement on cultural diversity in nursing practice in 1991. The ANA noted that knowledge of other cultures could provide nurses with "alternatives in services, delivery systems, conceptualization of illness, and treatment modalities."[33] Nurses are encouraged to do a cultural evaluation of each patient because interactions will occur between the culture of the nurse, the patient, and the environment. As patient advocates, nurses need to understand how each cultural group understands life processes, defines health and illness, maintains wellness, identifies causes of illnesses, and accepts the role of healers. The position statement asked that all nursing curricula provide information about health care beliefs, values, and practices of the diverse cultures seen in the US health care system. In addition, nursing administrators need to be aware of the cultural diversity of providers and patients alike, making sure that cross-cultural resources are available and accessible. Lastly, ethnocentric beliefs have no place in the health care environment, as they can negatively impact the interaction between patients and providers.[33]

The importance of multicultural education in nursing schools cannot be underemphasized. Cultural and linguistic sensitivity are essential to the patient-provider relationship, as misunderstandings and miscommunication can hinder the delivery of high quality care. For example, before entering nursing school, students may not understand the different criteria for diagnosing cyanosis in African Americans, why a Vietnamese mother does not want anyone touching her child's head, or why Asians may be scared of people in white uniforms. A nurse that understands the nuances of different ethnicities, races, and cultures is better prepared to deal with these situations. With cultural competency, a nurse is more likely to know that African Americans' skin turns dusky instead of blue when they are cyanotic; some Vietnamese mothers believe evil spirits will haunt the child if a stranger touches the head; and some Asian cultures associate death with the color white.

Although CLAS standards apply to health care organizations and providers, there are no federal guidelines mandating cultural competency in nursing school curricula. Regardless, nursing programs around the country are addressing the challenge of cultural competency.[34] An example is provided by a collaborative project between Washington State University College of Nursing Vancouver and Southwest Washington Health District, now known as Clark County Health Department. The "Cultural Competence in Public Health Practice" project sought to partner registered nurses (RNs) pursuing a Bachelor of Science in Nursing (BSN) degree with public health professionals in order to improve the students' cultural competency.[35] The project used three clinical tools in the project: the Campinha-Bacote model of cultural competence, the Minnesota Department of Public Health's nursing intervention "wheel," and Christine Tanner's model of clinical judgment.[36]

Campinha-Bacote's model has 5 components: "1) cultural awareness, which refers to awareness of one's own cultural values and biases as well as awareness of the other's; 2) cultural skill, which refers to conducting a cultural assessment or getting the story; 3) cultural knowledge, which refers to patterns of belief, practice, and behavior; 4) cultural encounters, which refers to direct interaction with culture members, and 5) cultural desire, which refers to motivation, intention, and the spirit of the encounter."[36] Before and after the 16-week training period, students completed the California Critical Thinking Dispositions Inventory (CCTDI) and the Inventory to Assess the Process of Cultural Competence Among

Health Professionals (IAPCC). The CCTDI assesses critical thinking dispositions and the IAPCC measures the process towards cultural competency.[36]

The entire goal of the project was to develop culturally competent and population-focused nurses. The public health mentors emphasized the importance of expanding the student's ideas about the scope of nursing practice, as RN-BSN students are often trained in acute care settings. Working with patients outside of a hospital gave students a more sincere understanding of the roles of culture and community in healthy living. Students were instructed in identifying culturally related patterns of movement, speech, and behavior. Sometimes they even took a cultural assessment form to the patient's home to assist in the evaluation. Students were also asked to challenge these assumptions with individuals, because the students needed to know the difference between cultural generalities and cultural stereotypes.[36]

Oncology Nursing Society

The ANA is not the only nursing organization concerned with cultural competence, as the Oncology Nursing Society issued guidelines for cultural competence interventions in 1999. The four components of this intervention were promoting cultural self-awareness, disseminating cultural knowledge, developing cultural skills building, and facilitating cultural encounters. In one field test of these guidelines, the nursing staff of a cancer center used multiple interventions over several years to teach cultural competency, leading to a system-wide institutional initiative. The nurses at this Virginia hospital reviewed cancer cases from 1992-1995 and found that 12% of their patients were an ethnic minority. This patient base included African-Americans, Hispanics, Koreans, Vietnamese, Filipino, East Indian, and Chinese patients, in decreasing order of frequency.[35] The staff began to participate in community activities to reach these populations, such as participating in an African American health fair, and providing educational materials about breast cancer to Korean and Hispanic women, which were translated specifically for these audiences. Also, they started a lunch series to educate staff about communication styles, family relationships, expectations of staff, and death rituals of various cultures encountered in the hospital. They even started a diversity education web site, which included such things as ANA position statements on cultural diversity education, a cultural snapshot of Virginia to reinforce the importance of diversity understanding, important questions to ask patients, and resources available to patients (i.e. advance directive brochures translated into different languages).[35]

Society for Public Health Education

The Society for Public Health Education's (SOPHE) mission is to promote individual, family, organizational, and community health by acknowledging the importance of cultural diversity education among health educations.[37] Their code of ethics focuses on several core principles in the health care profession: respect for autonomy, promotion of social justice, active promotion of good, and avoidance of harm. These principles are further delineated to provide guidelines related to a health educator's responsibility to the public, the delivery of health education, employers, the profession, professional preparation, research and evaluation. The following guidelines (Figure II) are from SOPHE's Code of Ethics and have direct relevance to cultural competency training.[37]

Figure II: SOPHE'S Code of Ethics[37]

Article I: Responsibility to the Public

- Health Educators support the right of individuals to make informed decisions regarding health, as long as such decisions pose no threat to the health of others.
- Health Educators encourage actions and social policies that support and facilitate the best balance of benefits over harm for all affected parties.
- Health Educators accurately communicate the potential benefits and consequences of the services and programs with which they are associated.
- Health Educators protect the privacy and dignity of individuals.
- Health Educators actively involve individuals, groups, and communities in the entire educational process so that all aspects of the process are clearly understood by those who may be affected.
- Health Educators respect and acknowledge the rights of others to hold diverse values, attitudes, and opinions.
- Health Educators provide services equitably to all people.

Article IV: Responsibility in the Delivery of Health Education

- Health Educators are sensitive to social and cultural diversity and are in accord with the law, when planning and implementing programs.

- Health Educators empower individuals to adopt healthy lifestyles through informed choice rather than by coercion or intimidation. Health Educators communicate the potential outcomes of proposed services, strategies, and pending decisions to all individuals who will be affected.

Part VI: Foundation Efforts

Example I: The California Endowment [30]

In April 2001, J. Gilbert and J. Puebla-Fortier received funding from the California Endowment to gather national input for the development of the standards for cultural competence education of health care professionals. Their consensus publication sets forth criteria by which to plan or evaluate courses in cultural competence and provides guidance for the following: health care professionals, educators, consultants, administrators, licensing and accreditation organizations, policy makers and advocates. Select guideline standards are detailed below in Figure III:

Figure III: Select Guideline Standards for Cultural Competence[30]

Content of Cultural Competence Education:

→ Institutions may start out simply in their inclusion of cultural competency training, but are expected to build in more complex, integrated and in-depth attention to cultural issues in later stages of professional education.

→ Cultural competence training is best integrated into numerous course, symposia…and practicum activities as they occur throughout an educational curriculum.

→ Wherever possible, diverse patients, community representatives, consumers and advocates should participate as resources.

Training Methods and Modalities:

→ Cultural competence education is best achieved through a diverse set of training strategies, such as lectures, in-depth, interactive exercises and discussions, case study analysis, genograms.

→ Ideally, cultural competence education should not be confined to one course or workshop but should be integrated into many curricular offerings…such as case discussions, grand rounds, symposia, clinical rotations, preceptorships, and continuing education courses and conferences.

Evaluating Cultural Competence Learning:

→ Evaluation of students' mastery of cultural competence attitudes, knowledge and skills should rely on a variety of techniques both qualitative and quantitative. Students should be given the opportunity to self-assess their application of cultural competence knowledge and skills at various points along their educational trajectory.

→ The ultimate test of knowledge and application of cultural competence attitudes, content and skills is in increased patient satisfaction with clinical encounters and improved health status

The Commonwealth Fund has supported a range of activities to improve understanding and delivery of culturally competent care, including the Association of American Medical Colleges' project, *Medical Education and Cultural Competence: A Strategy to Eliminate Racial and Ethnic Disparities in Health* Care (www.cmwf.org). The Kaiser Foundation published a 2003 *Compendium of Cultural*

Competence Initiatives in Health Care, which lists private and public sector efforts in the realm of cultural competence (www.kff.org).[31]

Part VII: Training in Medical and Dental Schools

In response to the demand for greater cultural awareness, medical and dental schools have taken two broad strategies to address the issue. The first approach entails cultural immersion programs whereby students take part in an international elective or serve part of a clinical rotation in a more localized native community.[39] Compared to a mere 8 percent of medical students taking part in international electives in 1982, 38 percent of U.S. medical students in 2002 reported participation in abroad rotations.[40]

The second strategy to address ever changing cultural issues involves the integration of cultural competency curriculum into existing school courses often through case-based, small-group sessions touching on subjects, such as core cultural beliefs of various ethnic groups, complementary and alternative medicine, language barriers, substance abuse, racism, and cross-cultural interviewing skills.[39] Although 87 percent of medical schools in the United States had some sort of cultural competency training curricula in 2000, content was often limited to three or fewer courses during the preclinical years, with only 8 percent of medical schools offering separate courses.[41] However, such statistics are encouraging in light of only 13 percent of medical schools offering any content regarding cultural competency in 1991.[42]

Cultural Competency Curricula in Medical and Dental Schools

Cross-cultural curricula have been developed to address issues involving how a patient's socio-cultural background affects their interaction with the current health care infrastructure as well as alter their health beliefs and behavior. However, despite national requirements from the Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical Education (ACGME) that medical schools and residency training programs integrate cultural competency education within their programs, the slow uptake and varied quality of such programs have often produced less than desirable results.[43,44] The issue of cultural competency and the push for integration of such material into medical school curricula dates back to the 1960's. However, among the 122 medical schools in the United States, only 8 percent have devoted separate courses addressing cultural competence, while the majority (87%) has opted to integrate such knowledge into existing courses/electives.[41]

A number of professional medical organizations have led the charge for cultural competency training of U.S. medical students. Through a grant from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, Division of Medicine and Dentistry, the American Medical Student Association (AMSA) began pilot testing their Achieving Diversity in Dentistry and Medicine (ADDM) program in September 2003. The ADDM project provides technical support and limited funding to medical and dental schools in the development and evaluation of cultural competency programs by offering the following: [45]

1. Strategies for preparing medical school faculty to teach cultural competency through integration;
2. A suggested curriculum outline for cultural competency that can be tailored to any school;
3. A look at ways to evaluate the efficacy of a culturally competent medical education and student/faculty performance within it;
4. Detailed methods for student instruction in cultural competency, based on existing curriculum type;
5. A blueprint for making cultural competency an integrated part of an institution.

Currently at least five medical schools (Brown Medical School, Eastern Virginia Medical School, Midwestern University College of Osteopathic Medicine, University of Illinois College of Medicine at Chicago, University of North Carolina at Chapel Hill School of Medicine) and three dentistry schools (University of Nebraska College of Dentistry, University of Nevada, Las Vegas School of Dental Medicine, University of Texas Dental Branch at Houston) are developing cultural competency curricula through the ADDM project.[45] AMSA also supports cultural competency projects through their Promoting, Reinforcing, and Improving Medical Education (PRIME) program. Through a five-year contract awarded through the U.S. Public Health Service Bureau of Health Professions, Division of Medicine, PRIME addresses issues in medical education, such as, diversity training and trials of service-based learning targeted at students with career interests in primary care to meet the unique needs of underserved populations.[46]

Additional medical school programs have chosen an approach of service learning to address cultural competence training, looking to teach students about various localized cultures through projects that seek to improve the health of the surrounding community. For example, the University of Iowa through a student-directed two-year elective entitled "Community Health Outreach," addresses the issue of medically underserved populations in Iowa City by partnering the local community with the academic medical school.[47] The first year of the program involves students learning about various community service organizations and how they address the health care needs of their target populations. The second year involves the application of attained skills through self-directed projects that focus on areas such as substance abuse, mental health, and other underserved populations. The goals of the project are for students to gain skills in communication, teamwork, assessing community needs, and the design and implementation of community projects.[47] Similar programs are being conducted at the University of Kentucky College of Medicine and Wright State University at various levels of implementation and success.[48,49]

Evaluation of Cultural Competency Programs

As new courses are being developed and institutions experiment with integrating cultural competency skills and knowledge into their existing infrastructure of medical education, the need for assessing program success and outcomes becomes paramount. Limited data exist in evaluating the effectiveness of such programs and more research is needed to make decisions about the future direction of cultural competency training. The truth is that we cannot manage what we do not measure, and efforts to improve our ability to characterize this poorly understood and inadequately addressed problem will help shape future policies to close gaps in our knowledge and understanding of an ever changing patient population.

In order to assess the current levels of cultural competency knowledge, all third year medical students at a single medical institution were surveyed during their medicine clerkship between November 2001 and February 2004.[50] The survey instrument consisted of a 40-item, multiple choice, single correct answer questionnaire that measured several areas of cultural competence, such as health disparities, stereotyping, exploring culture, communication, language and perceptions of health and illness. Results included a mean and median overall knowledge score of 55 percent, with no student scoring above 80 percent. Examining specific content areas, students had decent mean scores for exploring culture (76%), communication and language (63%), and knowledge of health disparities (65%) but faired worse in the areas of stereotyping (27%) and perceptions of health and illness (45%). Although the results are limited in their generalizability to other student populations, they are an indicator of the limited knowledge of cultural competence among medical students and the need for cultural diversity training.[50]

The outcomes of a course entitled Elective Course in Culture and Diversity at Wake Forest University were analyzed and recently published. Post-course surveys indicated a self-reported increase in students' cross-cultural skills and a greater awareness of issues, such as cultural sensitivity, alternative therapies, and cultural cues during a patient interview.[51] However, methodological problems such as a small study size, potential selection bias of motivated student volunteers, and possible measurement bias through lack of objective measures and use of self-reported data limit the conclusions and interpretations of the results.[51] Another study at Dalhousie University in Canada evaluated the attitudes of medical students entering their clinical years after being exposed to a new course entitled "Physicians, Patients & Society" (PPS) that addressed cultural and social issues in medicine, such as medical ethics, health policy, and public health. Overall, students stated that learning about social and cultural issues during the two-year course made little or no difference in their behaviors during clinical rotations.[52]

Many medical schools have recognized the need to incorporate cultural competency training into their curricula, but the content and methodologies are inconsistent and varied. Thus far, evaluation of such strategies for the promotion of cultural competence has been un-impressive or nonexistent. The lack of a model curriculum for which to base teaching methods, topics and evaluations may hinder the ability of medical leaders and program administrators to improve the cultural competency training of medical students.

Part VIII: Checklist for Model Curriculum

The need for a model curriculum for cultural competency in health care education and training became evident in the previous sections. The CLAS Standards emphasize the need to provide continued training to culturally diverse students, and many professional medical and health care organizations are beginning to incorporate this type of education and training into their policy statements. In addition, many states are beginning to mandate cultural competency training for health care professionals into legislation, even though no standard curriculum exists.

The previously mentioned Tool for Assessing Cultural Competence Training (TACCT) is designed to assist schools in their efforts to integrate cultural competence content into their curricula. While this tool is comprehensive in content, ongoing training, education and evaluation that captures new evidence, skill refreshers and promotion of the provision of culturally competent care is also highly recommended. The following figure, based on the TACCT, provides a checklist for assessing proposed curricula on cultural competency.[53]

Figure IV: Cultural Competency Checklist[53]

Domain I: Cultural Competence—Rationale, Context, and Definition

- Definition and understanding of the importance of cultural competence; how cultural issues affect health and health-care quality and cost; and, the consequences of cultural issues
- Definitions of race, ethnicity, and culture, including the culture of medicine
- Clinicians' self-assessment, reflection, and self-awareness of own culture, assumptions, stereotypes, biases

Domain II: Key Aspects of Cultural Competence

- Epidemiology of population health
- Patient/family-centered vs. physician-centered care: emphasis on patients'/families' healing traditions and beliefs [for example, ethno-medical healers]
- Institutional cultural issues
- Information on the history of the patient and his/her community of people

Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making

- History of stereotyping, including limited access to health care and education
- Bias, stereotyping, discrimination, and racism
- Effects of stereotyping on medical decision-making

Domain IV: Health Disparities and Factors Influencing Health

- History of health-care design and discrimination
- Epidemiology of specific health and health-care disparities
- Factors underlying health and health-care disparities—access, socioeconomic, environment, institutional, racial/ethnic
- Demographic patterns of health-care disparities, both local and national
- Collaborating with communities to eliminate disparities—through community experiences

Domain V: Cross-Cultural Clinical Skills

- Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class
- Dealing with hostility/discomfort as a result of cultural discord
- Eliciting a culturally valid social and medical history
- Communication, interaction, and interviewing skills
- Understanding language barriers and working with interpreters
- Negotiating and problem-solving skills
- Diagnosis, management, and patient-adherence skills leading to patient compliance

Conclusion

As the population of the United States becomes rapidly more diverse, there is increasing need and demand for cultural awareness in health care settings. Cultural competency is more frequently an aspect of health professionals' initial and continuing education. Efforts range from the federal CLAS to state policies and a range of activities underway in the nations medical, dental, nursing, and public heath schools. Despite the lack of national standards, these activities have shared characteristics and all of them seek to achieve understanding during the health care encounter and, thus, to improve patient satisfaction with care givers and health outcomes.

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