



**Student National Medical Association  
CULTURAL COMPETENCY POSITION STATEMENT**

**Author:**

**Ana Sofia Lopes, Multicultural Affairs Committee Chairperson**

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# **THE STUDENT NATIONAL MEDICAL ASSOCIATION CULTURAL COMPETENCY POSITION STATEMENT**

## **I. SCOPE OF PROBLEM**

According to the U.S. Census Bureau the ethnic diversity in our country has increased dramatically. Our demographics are changing due to the aging of the population, the growing majority of women, and the nation's increasing ethnic heterogeneity. Immigration continues to contribute largely to the growing diversity of our country. However, our country has begun to see a new emergence of Hispanic immigrants. In 1940, 70% of immigrants were from Europe. By 1992, the pool of immigrants had changed such that 15% came from Europe, 37% came from Asia and 44% came from Latin America and the Caribbean.<sup>1</sup>

The increasing presence of the Hispanic population in California alone warrants a closer look at the challenges that lie ahead in health care delivery. In 20 years, California's population will be 42% Hispanic, 18% Asian, 33% White non-Hispanic. By the year 2020 there will be more people who speak Spanish than those who speak English in the state of California.<sup>2</sup> Minorities and women from all ethnic groups will comprise 51% and 62% respectively of the new entrants into the national workforce between 1994-2005.<sup>3</sup> Yet, minority health status is substantially worse than that of the majority citizens.

As cultural, ethnic, and racial diversity increase within the United States, health care practitioners face increased challenges of recognizing patients' culturally defined expectations of the health care system. Although underrepresented minorities are the fastest growing segment of the U.S. population, our national demographics are not reflected in the medical school classrooms. Currently in the U.S., racial and ethnic minorities comprise 28% of the population and are expected to increase 40% by the year 2030. Conversely, underrepresented minorities comprise only 7% of the current physician workforce.<sup>4</sup> In 1996, the number of minorities applying to medical school decreased by 19% in California and 22% in Texas, Louisiana, and Missouri. Overall, minority applicants decreased nationwide by 12%.<sup>5</sup> This decrease in numbers is "bad news" especially when populations are growing in numbers and in their diversity.<sup>6</sup> A shortage of minority or culturally diverse physicians creates a problem. Therefore, it will be imperative that all clinicians be prepared to care for a diverse population since illness and disease vary by culture. Diverse belief systems exist on health, healing, and wellness. Once clinicians understand the heritage, beliefs and values that shape our communities, we will be better able to develop effective health practices for the most vulnerable segment of our society.

Our increasing diversity and the need for culturally competent providers are further compounded by the health disparities that exist in minority communities. Communities with large numbers of African American and Hispanic residents are four times more likely than other areas to have a shortage of physicians regardless of community income. African American physicians care for nearly six times as many African American patients as do non-black physicians. Hispanic physicians care for more than twice as many Hispanic patients as do non-Hispanic physicians. In addition,

Medicaid recipients compose approximately 45% of African American physicians' patients while they make up only 18% of the patients seen by white physicians. Similarly Hispanic physicians see 50% more uninsured patients than do their non-Hispanic white colleagues.<sup>7</sup> Furthermore, minority physicians are twice as likely as their white peers to take on leadership roles in community service or social activities. Other studies have found that minority physicians are twice as likely to work in underserved areas.

Research has shown that cultural attitudes affect relationships with physicians and other providers. "Patients seeing physicians of their own race rate their physicians' decision-making style as more participatory." Clearly, improving cross-cultural communication between doctors and patients and providing patients with access to a diverse group of doctors may improve adherence, satisfaction and health outcomes.<sup>8</sup> These alarming facts are a reminder to the nation's medical schools to meet their societal obligations to support diversity and to educate a culturally competent physician workforce.

## **II. DEFINITION OF CULTURAL COMPETENCE**

Cultural competence is defined as a "set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations."<sup>9</sup> Operationally defined, "cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes."<sup>10</sup>

There is not a single definition of culture. The word culture implies the integrated patterns of human behavior that includes thoughts, communications, actions, customs, beliefs, values, as well as institutions of racial, ethnic, religious, or social groups. Culture is the medium of human social relationships that must be shared because it is a predominant force in shaping behaviors, values and institutions.

Cultural differences exist and have an impact in health care delivery.<sup>11</sup> We learn from our own culture how to be healthy, how to recognize illness, and how to be ill. One culture may believe for example, that people should starve a cold and feed a fever. Another culture may believe the opposite. It is also important to recognize that as health care providers we are ethnocentric. We are socialized into the culture of laboratory samples, departmental paperwork, medical jargon, and the omnipotence of technology. It is not uncommon to hear patients say things like "I have no idea what the doctors and nurses are saying." In light of the health care culture, we must be aware of our biases to use only medications that have been proven by scientific means and recognize only healers that have been certified according to our requirements. It is time that health care coincided with the needs of the client.

The word competence implies having the capacity to function within the context of culturally integrated patterns of human behavior defined by a group. Cultural Competency is a "process that requires individuals and systems to develop and expand their ability to know about, be sensitive to, and to have respect for cultural diversity. The result of this process should be an increased awareness, valuing, acceptance, and utilization of and an openness to learn from general and health-related beliefs, practices,

traditions, languages, religions, histories, and current needs of individuals and the cultural groups to which they belong. Essential to cultural competency is appropriate and effective communication which requires the willingness to listen and learn from members of diverse cultures and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of individual's cultural health beliefs and practices.”<sup>12</sup>

Culturally competent providers have academic and personal skills that allow them to appreciate and identify the health practices and behaviors of their patients across cultural and language barriers. Culturally competent providers do not have vast knowledge about several cultures. They have the capacity to appreciate and respect the lifestyles, beliefs, and values that may be defined differently for each culture.<sup>13</sup> Building cultural competency is a developmental process.

The Goals of culturally competent care are:

- Cultural Awareness: Appreciating and accepting differences.<sup>14</sup>
- Cultural Knowledge: Seeking out various worldviews and explanatory models of disease.<sup>13</sup> Knowledge can help promote understanding between cultures.<sup>14</sup>
- Cultural Skills: Learning how to culturally assess a patient relying only on written facts, explaining an issue from another's perspective, appropriately using an interpreter.<sup>13</sup>
- Cultural Encounters: Meeting and working with people of a different culture will help dispel stereotypes and prejudices that may contradict academic knowledge.<sup>15</sup>

The U.S. health care system's ability to provide quality care for all Americans in the future hinges on its capacity to meet these goals.

### **III. BARRIERS TO CULTURAL COMPETENCE**

Becoming aware of the barriers to cultural competence is the first step towards successful integration with people from different backgrounds. We must learn to develop an understanding of how prejudice and fear affect our interactions with our own patients. Lack of awareness about cultural differences creates barriers for both providers and patients to achieve the best care. Despite our similarities, fundamental differences among people arise from nationality, ethnicity, culture, as well as from family background and individual experiences. These differences affect health beliefs, practices, and behavior. Furthermore, such cultural perspectives contribute to differences in expectations the patient and provider have of each other. Merely educating people about the differences is not enough, one must confront the differences. There is often a lack of awareness of such differences and their impact on patient and physician interactions. This most likely results from a combination of factors including:

- Lack of knowledge - resulting in an inability to recognize and appreciate the factors that influence one's well being.
- Self-protection/denial - leading to an attitude that differences are not significant, or that our common humanity transcends our differences.

- Fear – trying to understand something that is new, that does not fit into one's belief system, which can be intimidating and challenging.
- Time constraints - feeling rushed and unable to look in depth at an individual patient's needs in the climate of managed care and federal cutbacks in services.<sup>16</sup>

The consequences of this lack of cultural awareness are varied. Patient-provider relationships are negatively affected when expectations are unclear or misunderstood. It can result in cancelled appointments, failure to follow treatment directions, and loss of trust in the health care system. A common scenario is failure to recognize why a patient does not follow instructions. The patient may take a smaller dose of medication than was prescribed because of a belief that Western medicine is "too strong." Likewise, the patient may reject the provider and the overall health care delivery system even before any one-on-one interaction occurs because of non-verbal cues that do not meet expectations. For example, "The doctor is not wearing a white coat - maybe he's not really a doctor," or "The doctor smiles too much. Doesn't she take me seriously?"<sup>16</sup>

As health care providers we must also consider the physical and psychological harm that the lack of cultural awareness potentially creates. The fact that culture plays a role in the response to pain is demonstrated daily in the medical wards when providers refer to patients as "complainers" or "stoics" when a patient's response to analgesia is atypical. The symptom of pain and discomfort contains a large subjective component that should be evaluated in the appropriate cultural context. A person raised in one cultural background may be allowed the free and open expression of feelings, whereas a person from another culture may have been taught that true feelings must never be revealed.

#### **IV. FUTURE DIRECTIONS AND RECOMMENDATIONS**

It is evident that problems exist in the delivery of effective health care. Our nation's expanding ethnic diversity mandates a workforce that is adequately trained and equipped to meet the challenges of the future. The Student National Medical Association is the nation's largest collective voice of minority medical students. Our role in addressing cultural competency in medical education is crucial. It will require measures that encourage dialogue from other professional organizations to explore the assumptions that underlie expressions of prejudice and bias.

Learning cultural competency will entail much more than implementation of a new curriculum. It requires diversity in medicine from the student body to the faculty who impact their education. A diverse student body encourages appreciation of one's own culture and those of others as well. Diversity promotes the development of personal and professional competence that is required to live and work in a multicultural society. Medical schools that value and take advantage of their diversity, both among students and faculty, will be better prepared to build a cohesive and effective workforce to serve the public.

Further measures in academia should include clinical training opportunities in rural and inner city communities to further increase cultural knowledge and competence. It is a priority that medical school curriculum train students to develop a set of skills in history taking and physical examination that include the cultural interview. We must

support legislation that authorizes funding to develop culturally competency curriculum at the undergraduate level through post-graduate levels.

In a time when attempts are being made to dismantle affirmative action legislation, we must continue to address the composition of the physician workforce so that the most vulnerable people in our society have access to culturally competent health care in the new millennium.

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