**Moving Beyond Cultural Competence Toward Cultural Humility and the Delivery of Equitable Patient-Centered Care**

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Abstract:

In the Accreditation Council on Graduate Medical Education's (ACGME) 2016 national report of the Clinical Learning Environment (CLE) Review, it was reported that across most CLEs, education and training on health care disparities and cultural competency was largely generic. A "generic approach" to cultural competency implies that sponsoring institutions where training programs are seated have not made an assessment of the specific needs of the patient population that they are serving. While a targeted approach is a laudable goal, it runs the risk of stereotyping the needs of individuals in a specific cultural group. We propose that the time has come to move beyond the goal of cultural competency toward cultural humility and the delivery of equitable patient centered care – care that is delivered that takes into consideration the specific needs of the patient and does not vary in quality based on personal characteristics like gender, ethnicity, geographic location, religion, sexuality, and socioeconomic status. Graduate medical education should ensure that learners develop skills critical to delivering patient-centered care that emphasize the core qualities of curiosity, empathy and respect.

Manuscript:

In the Accreditation Council on Graduate Medical Education's (ACGME) 2016 national report of the Clinical Learning Environment (CLE) Review, it was reported that across

most CLEs, education and training on health care disparities and cultural competency was largely generic, and often did not address the specific populations served by the institution. Residents and fellows reported that education on health care disparities and cultural competency happened in an ad-hoc manner. Moreover, it appeared that most CLE's did not have a formal strategy for addressing health care disparities or a systematic approach to identifying variability in the care provided to or clinical outcomes of their known vulnerable patient populations (1).

A "generic approach" to cultural competency implies that sponsoring institutions where training programs are seated have not made an assessment of the specific needs of the patient population that they are serving. While a targeted approach is a laudable goal, it runs the risk of stereotyping the needs of individuals in a specific cultural group. Frequently the needs of a specific community where the institution is seated are not elicited directly from the patient population served but are deduced from data based on outcomes. We propose that the time has come to move beyond the goal of cultural competency toward cultural humility and the delivery of equitable patient centered care. Graduate medical education should ensure that learners develop skills critical to delivering patient-centered care that emphasize the core qualities of curiosity, empathy and respect.

The ACGME already charges that residency and fellowship programs train their residents and fellows in the provision of patient centered care; one quarter of the ACGME milestones for internal medicine residents are directly related to the knowledge, skills and

attitudes related to this goal (2). For example, the resident should by the end of training, be able to demonstrate empathy, compassion and respect for patients and their caregivers, be able to anticipate and advocate for patients, ensure that patient preference be incorporated in all aspects of shared decision making, appropriately modify care plans to account for the patient's unique characteristics and needs, be able to develop therapeutic relationships with their patients, and model the principles of cross cultural communication. The importance of the ability of the physician to communicate and deliver care to a diverse patient population is highlighted in the milestones, and must occur in a way that is deliberate, thoughtful and pedagogical. However, it has been shown that directors of internal medicine residency programs think that they do not have adequate assessment tools and sufficient knowledgeable faculty to objectively evaluate and foster these critical qualities in their trainees (3).

## Definition of Relevant Terms

### Cultural humility

Tervalon and Murray-Garcia coined the term "cultural humility" in 1998 as a way to transcend and counter "cultural competence." They emphasized that clinicians who embrace cultural humility incorporate a lifelong commitment to self-evaluation and self-critique, seek to redress the power imbalances in the patient-physician dynamic, and to develop mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined populations in order to meaningfully

interact with patients who come from cultures different from themselves. (4) Prioritizing cultural humility over cultural competence leads to an awareness that implicit bias may impact the care delivered to patients, makes explicit that we must elicit the health beliefs and life experiences of patients, and finally, results in a recognition that one is never done learning about their patients, because there will always be knowledge gaps in knowing patients.

An argument against the term "cultural competency" is that it implies one can become expert in caring for a certain population. Caring for an individual patient in a patient centered manner requires an understanding of that person's experience, which is fundamentally unique and may be very different than another patient from the same culture. The goals of cultural humility reflect the required approach and attitude to cross-cultural care, and may have the added advantage of addressing the needs of those trainees who come from the same patient populations at risk for health care disparities, because of the inherent bi-directional dynamics. Embracing cultural humility ensures inclusion of trainees who come from underrepresented groups who care for patients in the "majority" groups.

Patient-Centered Care and Cultural Competence

The intersection of the terms patient-centered communication and cultural competency has been previously described, and there are similarities in approach and mechanisms in which they complement and depart from one another (5). The term "patient-centered"

was coined by Dr. Balint in 1969 and she emphasized that each patient had to be understood as a unique human being and that it was critical to explore the patient's experience of illness (6). This is similar to the objectives developed by the pioneers of cross cultural medicine, Berlin and Fowkes, and Kleinmann, who established the following minimum expectations: that health beliefs be respected, to elicit the patient's expectation of illness and perceived cause and to negotiate understanding of illness and a mutually agreeable plan (7,8). The importance of training in "cultural competency " was significantly heightened in response to the increasingly diverse demographics of the United States and demonstration of racial and cultural health care disparities reported in the 2003 Institute of Medicine's landmark report, Unequal Treatment (9).

Cross –cultural communication

Cross-cultural communication is built on three fundamental principles: empathy, respect and curiosity (10). Empathy is defined as the ability to understand the patient's perspective, and to understand what it might be like to live in that patient's shoes. It is also a strategy for mitigating bias – to identify some aspect of shared experience. Since it is abundantly evident that implicit bias may negatively impact on patient care and can result in health care disparities, it is critical that clinicians learn strategies to address their biases (11). Respect refers to the physician's ability to value the patient's perspective, to value the patient's understanding of the medical condition, and to incorporate the principles of shared medical decision-making and confidentiality. Finally, curiosity refers to the physician's desire to know their patients: their beliefs, habits,

socioeconomic status, cultural concerns, social supports, living conditions and other factors that impact on their condition and care needs.

Equitable Patient-Centered Care

Cultural competency should not be the goal of patient-physician communication because as previously stated the term competent implies that you can become expert about the patient's culture. We certainly don't seek to understand patients who come from "majority" patient populations in this way. All patients want to be regarded and understood as individuals that includes, but is not defined, by their culture, race, language, gender, sexuality, religion or ethnicity -- this is the basis of equitable patient-centered communication.

The time has come to refocus the goals of training to care for all patients – the provision of "equitable patient-centered care" – care that is delivered that takes into consideration the specific needs of the patient and does not vary in quality based on personal characteristics like gender, ethnicity, geographic location, religion, sexuality, and socioeconomic status. The term, equitable patient-centered care, necessarily reflects the need of the physician to demonstrate "structural competency" defined as the ability to discern how issues defined clinically as symptoms, attitudes or diseases also represent matters as health care and food delivery systems, zoning laws, urban and rural infrastructures, medicalization, or even about the very definitions of illness and health. (12) It requires that physicians address their implicit and explicit biases, consider the

disparities that might occur based on insurance status, social circumstances, racism, and that they consider the needs of their patients with limited English proficiency and the health literacy of their patients. It requires expertise in patient centered modalities such as motivational interviewing, and we believe, cultural humility. To care for the patient, you must know the patient.

We think that delivering a curriculum in cultural competency to trainees and faculty should not be the goal and we should be careful about language that charges us to address the specific needs of the patients of that institution. We think that directly asking the people and our potential patients in the communities we serve about what their particular medical and social needs are rather than making assumptions based on outcomes data is important. Attaining culture competency implies becoming experts in the care of particular groups of patients. But within each of these groups is unmeasured diversity that can only be determined when a physician's curiosity, empathy and respect are an integral part of clinical care of patients. The goal of training should be to ensure the trainees acquire the skills they need to care for a patient who differs from them with the ultimate goal of equitable high quality care for all patients.

We would submit that in order to address health care disparities the focus should change from an emphasis on a curriculum in cultural competency to the development of skills and attitudes important in patient communication. We must foster in our trainees an attitude that embraces curiosity, empathy, and respect for patients that ensures patient-centered care. To that end, training in recognizing implicit bias, motivational

interviewing, use of medical interpreters, and eliciting a thorough history that includes religious and cultural beliefs, ethnicity, sexuality, medical literacy, values, support systems, and the social determinants of health. The time has come to move beyond cultural competency toward cultural humility and equitable patient centered care to close the gap in health care disparities. Finally, as we focus on the goal of increasing diversity of our workforce as another tool to achieve patient equity, we must investigate the needs and experiences of our trainees who come from "at risk" populations as they manage the cross-cultural dynamics of relationships that may arise between them and patients who come "majority" populations.

References


1. Wagner R, Koh N, Bagian JP, Weiss KB, for the CLER Program. CLER 2016 National Report of Findings. Issue Brief #4: Health Care Disparities. Accreditation Council for Graduate Medical Education, Chicago, Illinois, USA. ISBN-13: 978-1-945365-07-2
2. Internal Medicine Milestone Group. The Internal Medicine Milestone Project. A Joint Initiative of the Accreditation Council for Graduate Medical Education and the American Board of Internal Medicine. July 2015. Accessed 3/13/2018. https://www.acgme.org/Portals/0/PDFs/Milestones/InternalMedicineMilestones.pdf
3. Cardinal LJ, Maldonado M, Fried ED. A National survey to evaluate graduate medial education in disparities and limited English proficiency: A Report from the AAIM Diversity and Inclusion Committee. Am J Med 2016; 129(1):117-25.
4. Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: A Critical distinction in defining physician training outcomes in multicultural education. Journal of Healthcare for the Poor and Underserved; 1998; 9(2):117-125.
5. Saha S, Beach MC, Cooper LA. Patient centeredness, cultural competence and healthcare quality. J Natl Med Assoc 2008; 100(11): 1275-1285.
6. Balint E. The Possibilities of patient-centered medicine. JR Coll Gen Pract 1969; 17(82): 269-276.
7. Berlin EA, Fowkes WC. A Teaching framework for cross-cultural healthcare – application in family practice. West J Med 1983; 139(6): 934-938.

8. Kleinman A, Benson P. Anthropology in the clinic: The Problem of cultural competency and how to fix it. PLoS Med 3(10):e294. https://doi.org/10.1371/journal.pmed.0030294.
9. Institute of Medicine. 2003. Unequal treatment: Confronting racial and ethnic disparities in health care. Washington, DC: The National Academies Press. https://doi.org/10.17226/10260.
10. Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: A Patient-based approach. Ann Int Med 1999; 130(10): 829-834.
11. FitzGerald C, Hurst S. Implicit bias in healthcare professional: a systemic review. BMC Med Ethics 2017; 18:19.
12. Metzl JM, Hansen H. Structural competency: theorizing a new medical engagement with stigma and inequality. Soc Sci Med 2014; 103: 126-33.