REVEALING THE (IN)COMPETENCY OF “CULTURAL COMPETENCY” IN MEDICAL EDUCATION

David Paul*  
Shauna Hill†  
Shaun Ewen‡

Abstract

There are multiple factors that influence the quality of health and the health care experience of Aboriginal patients. Some of these factors include health professionals’ clinical decision-making and miscommunication between doctor and patient. A more “culturally competent” health workforce is a recommended strategy in addressing the extensively documented health disparities between Australia’s Aboriginal and non-Aboriginal peoples. Culture, its importance in, and connection to health, is being increasingly explored in medical curricula with the expectation of improved health outcomes. This literature review on cultural competency in medical curricula reveals an emerging awareness of the paucity of data showing evidence of positive health outcomes for Aboriginal patients of “culturally competent” medical professionals. This highlights the need for there to be evidence of more than just practitioner satisfaction but also of meaningful shifts in health outcomes for Aboriginal patients of a more culturally knowledgeable medical profession.

Keywords

indigenous medical education, cultural competence, cultural safety, indigenous health outcomes

* Deputy Director, Centre for Aboriginal Medical and Dental Health, University of Western Australia, Crawley, Australia. Email: david.paul@uwa.edu.au  
† Research Officer, Centre for Aboriginal Medical and Dental Health, University of Western Australia, Crawley, Australia. Email: shauna.hill@uwa.edu.au  
‡ Director, Onemda VicHealth Koori Health Unit, University of Melbourne, Victoria, Australia. Email: shaun.ewen@unimelb.edu.au
Context

The persistent health disparities experienced by Aboriginal peoples when compared with non-Aboriginal peoples in Australia have long been established, are widely known and are repeatedly identified both within the medical literature and by successive state and federal governments (Australian Bureau of Statistics, 2006; Australian Institute of Health and Welfare, 2011; Australian Indigenous HealthInfoNet, 2010; Dodson, 1995; House of Representatives Standing Committee on Family and Community Affairs, 2000; Human Rights and Equal Opportunity Commission, 2006; National Aboriginal Health Strategy Working Party, 1989). There are multiple factors that influence health and wellbeing, the majority of which are broader than the health care context (World Health Organization, 1978). That said, factors that also contribute to these disparities include differential access to material resources and services, including health care services, and the quality of the care. Once people become unwell there is increasing evidence that minority groups receive less than optimal care. Aboriginal patients tend to receive poorer quality health care than non-Aboriginal people, partly due to health professionals’ clinical decision-making, communication and engagement with patients and families (Coory & Walsh, 2005). This reflects similar findings elsewhere for both indigenous (Harris, Robson, Curtis, Purdie, Cormack, & Reid, 2007) and minority groups (Bhopal, 1998; Cooper, Hill, & Powe, 2002; Cooper, Beach, Johnson, & Inui, 2006; LaViest, Nuru-Jeter, & Jones, 2003).

There has been an increasing push to develop a more “culturally competent” medical workforce strategy aimed at better addressing the continuing disparity in health outcomes for Aboriginal people in Australia. Educating future health professionals via culturally inclusive curricula is one proposed solution to reduce the greater burden of chronic diseases Aboriginal people experience, yet there is little to no evidence to reveal the impact on patient outcomes of doing so. The very concept of “cultural competence” is undecided (Drevdahl, Canales, & Dorcy, 2008); the relevance and consequence of what is already included, if it is included at all, what should be included and the influences of its inclusion are all undetermined and debatable. Beyond that, we contend that the very use of the word “competent” or “competency” to describe an understanding of cultural influences remains problematic. Indeed, developing greater “cultural competency” may actually exacerbate rather than diminish disparity, as it can be employed as a means of reinforcing power differentials via normalizing the colonial gaze and further Othering those deemed to be different (Pon, 2009).

More “culturally competent” medical and other health professionals has been a key recommendation as a way of addressing the extensively documented health disparities of Aboriginal people (House of Representatives Standing Committee on Family and Community Affairs, 2000; National Aboriginal Health Strategy Working Party, 1989; Phillips, 2004; Johnson, 1991). Whilst competency and the need to be competent are not new in medical education, the concept of a “culturally competent” health
workforce and the inclusion of cultural competency curricula in health professional training have emerged in response to the continual poor health outcomes of people culturally different to the doctors treating them. Where to start and what to include need to be considered carefully, particularly given for some this is a nearly blank canvas (see Figure 1). In this review we draw mostly on the Australian Aboriginal context to highlight the relevance of our argument, as in Australia the need for better outcomes is so stark. There are obvious parallels in other colonial settler settings, as well as more broadly where significant health disparities also persist.

Culture and health care

Culture, when accessing and receiving health care, is important. Culture influences what we value as and believe to be healthy, making culture a fundamental factor in diagnosis, treatment and care (Betancourt, 2004). Culture is an often implicit influence which underpins doctor patient relationship. When Engel (1977) first argued for a biopsychosocial model of health care, his challenge was for the biomedical model to accept that there were psychological and social influences.

To provide a basis for understanding the determinants of disease and arriving at rational treatments and patterns of health care, a medical model must also take into account the patient, the social context in which he lives, and the complementary system devised by society to deal with the disruptive effects of illness, that is, the physician role and the health care system. This requires a biopsychosocial model. (Engel, 1977, p. 132)

The focus has since moved to incorporating culture and cultural understanding, as well as psychological and social.

The right to access health care that meets the needs of Aboriginal people can only be achieved and maintained “if cultural issues are core business at every level of the health system – systematic, organisational, professional and individual” (National Medical and Health Research Council, 2005, p. 6). With the intent to educate health professionals to better understand the importance of culture in health care came the attempt to teach physicians to become “culturally competent” (Betancourt, 2004). The reductionist tendency of some practitioners to exclude the context in which people experience health, illness and health care remains problematic (Kleinman, 1993) and impedes more effective and relevant mobilization of cultural context in health care settings. Taking a wider view than just the interpersonal doctor patient relationship, institutional racism has also been identified as a significant factor influencing access to equitable health care services and outcomes for Aboriginal peoples (Henry, Houston, & Mooney, 2004).

Regardless of what medical professionals and educators label the process of learning cultural context, the practice of acknowledging the importance of culture in health care, and
the consideration of culture during treatment, culture’s connection to health is increasingly explored and included in medical curricula for both practical reasons and with expected outcomes (Rasmussen, 2001). Primarily, studying culture in medical education is intended to prepare physicians to be better able to meet the health care needs of patients from different cultural backgrounds (Betancourt, 2003). The Australian Indigenous Doctors Association (AIDA) advise:

Recognition of culture is not by itself sufficient rationale for requiring cultural competence; instead the point of the exercise is to maximise gains from a health intervention where the parties are from different cultures. (AIDA, 2004, p. 1)

Beyond attaining cultural knowledge, the most common reason, and anticipated gain, are the assumed skills a physician gains in learning cultural consideration and consequences; skills that enable her/him to not only understand cultural diversity, but to also communicate appropriately to acquire cultural information to inform patient care (Gustafson & Reitmanova, 2010). More importantly, it is expected that these newly attained, or more finely developed skills will enable a physician to provide care that is more “culturally relevant and accommodating to the beliefs, values, and practices” of the patient (Rosenjack Burchum, 2002, p. 5). Yet, the presupposed skills utilized by medical professionals deemed as “culturally competent” are just that, presupposed and largely without evaluation. Completion of a “cultural competence” training programme resulting in an increased awareness and knowledge base are often believed to be enough to indicate a “culturally competent” professional (Kumas-Tan, Beagan, Loppie, MacLeod, & Frank, 2007), with “cultural competence” subsequently being reduced to a list of do’s and don’ts to comply with when treating Aboriginal patients (Kleinman & Benson, 2006). By comparison, clinical skills are both observed and evaluated before medical students and professionals are deemed competent. Importantly, Kleinman also urges the gaze of culture to be applied also to the clinician:

If you can’t see that your own culture has its own set of interests, emotions, and biases, how can you expect to deal successfully with someone else’s culture? (Kleinman, in Fox, 2005, p. 1316)

In other words, this is only a part of the picture (see Figure 2). Returning the gaze back onto practitioners and the dominant culture assists in countering the tendency to externalize culture and the consequent othering that it reinforces. Such action facilitates a reconsideration, and clarification, of the factors at play in health practitioner education and practice that both aid as well as impede the better health care experiences (and outcomes) for Aboriginal peoples. Clarifying these factors reveals useful strategies and issues that might be usefully addressed in health practitioner education, enabling the development of greater preparedness of health practitioners for working with Aboriginal patients and communities.

Competence

Competence describes an end point implying action—that “someone” is competent at doing “something” (Hixon, 2003, p. 634). Competency-based approaches have been described as “an exciting and challenging concept in education that may address gaps between education and practice” (Tilley, 2008, p. 63). There is some diversity of views in the literature, with competency being described as “possibly the most prevalent buzzword in medical education today” (Brooks, 2009, p. 90). The International Competency Based Medical Education Collaborators define competency as:
An observable ability of a health professional, integrating multiple components such as knowledge, skills, value, and attitudes. Since competencies are observable, they can be measured and assessed to ensure their acquisition. Competencies can be assembled like building blocks to facilitate progressive development. (Frank et al., 2010, p. 641)

A recent review found 14 articles in the health sciences education literature that defined what they meant by competency (Fernandez et al., 2012). Brooks, in his somewhat strident critique of competency approaches in medical education, considers that “competency is not what we want to use when trying to determine if someone is a good, or even an adequate, physician” (2009, p. 91). The debate regarding meaning and application in relation to a competency approach to medical education continues, with calls to move away from a singular to a more diverse and inclusive approach (Jolly, 2012). The desired and anticipated outcomes of including cultural learning in health care is impeded by the inefficient measures employed and the unequal standards placed on its importance. The complexity of culture does make it more difficult to assess, yet it is the complexity of culture that warrants effective assessment.

Competence has multiple components that may be summarized as attitudes, values, judgment abilities, and personal or character attributes (Fernandez et al., 2012). To be a “competent” health professional is to possess “the required abilities in all domains in a certain context at a defined stage of medical education or practice” (Frank et al., 2010, p. 641). To be a “culturally competent” health professional, without reducing the extent of variation amongst and within different cultures, or its various meanings, is to have the ability to develop and maintain effective relationships with patients regardless of cultural differences to him/herself by “recognising the importance of social and cultural influences on patients, considering how these factors interact, and devising interventions that take these issues into account” (Beach et al., 2005, p. 356; Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). Hence, acquiring “cultural competence” is deceptively viewed as achievable: “One is competent in interacting with patients from diverse backgrounds much in the same way as one is competent in performing a physical exam or reading an EKG” (Kumagai & Lypson, 2009, p. 782). However, to be deemed as, or to consider yourself to be “culturally competent” is, in reality, a revelation of cultural incompetence. Awareness of some of the complexities involved is important, sometimes this only provides the framework for a more complete understanding (see Figure 3).

Those who do have the ability to acknowledge the importance of culture in health care, and the skills to positively integrate cultural factors when treating patients ought to know that being “culturally competent” is an unachievable singular goal. Health professionals applying cultural recognition and consideration when treating Aboriginal patients, or indeed any patient, may provide a more positive patient experience; however, it does not indicate the professional being “culturally competent”. It is misleading to assume that a set of complex historical and present variables and behaviours that constitute culture can be reduced to a singular technical
skill that can be attained by health professionals and translated into expertise. There does need to be a revision of the language used in the discourse of “cultural competency”; there needs to be a shift towards a more reflective narrative of a learning process rather than an endpoint. The current use of deceptive language, embraced by medical professionals, educators and students, to define what must be an infinite learning process and continual expansion of knowledge of Aboriginal culture is a contradiction of its necessary inclusion in medical education and its anticipated outcomes.

Impact of cultural competence training

Health programmes targeting particular conditions can make a significant difference to health outcomes in a relatively short space of time (Hoy, Baker, Kelly, & Wang, 2000); however, they must be sustained and ongoing otherwise those improvements can be short-lived (Hoy, Kondalsamy-Chennakevasan, & Nicol, 2005). The promise that particular examples of lower than expected levels of mortality and morbidity in some settings provide needs to be seen in the context in which these examples occur. Namely, as reflections of a complex interaction of a range of factors at play, most of which are community rather than practitioner related (Rowley et al., 2008), see Figure 4.

To accurately measure or monitor how a health professional understands and implements culture in health care and treatment is difficult, problematic and lacks consistency and guidance (Canales & Bowers, 2000; Drevdahl et al., 2008; Kumas-Tan et al., 2007). When measurement is sought it is self-reported, learner-satisfaction rated, simple knowledge fact-based, and conclusive (Drevdahl et al., 2008; Kumas-Tan et al., 2007). Not unlike the deceptive language of “cultural competence”, the misleading measures employed to monitor and determine the effectiveness of cultural learning, consideration and implementation appear to be incompatible with the rationale and objectives of its existence. Whilst including opportunities for learning about the relevance of culture in medical curricula is an attempt to increase the knowledge of medical professionals with the aim of decreasing the health disparities of Aboriginal people, current measures fail to move beyond measuring self-reported perceptions of preparation to practice, knowledge, and/or satisfaction of learners. The existing measures enable us to capture “changes in knowledge” but fail to inform us how or if this change of knowledge makes any difference to patient outcomes (Kumas-Tan et al., 2007).

If the purpose of including culture in health care is to “maximise gains from a health intervention where the parties are from different cultures” (AIDA, 2004, p. 1), assessing participants’ cultural learning is only one part of the solution. Relevance of the teaching efforts needs be seen in positive shifts in health outcomes for Aboriginal people.

Despite its promotion as a widely accepted and necessary way to lower the health care disparities experienced by the Aboriginal community, research or evidence to establish the effectiveness and impact of “cultural competence” training is limited. Past reviews of articles published in medical education journals

**FIGURE 4** Something is everything.
reveal the lack of measured clinical outcomes. In one review of some 600 articles only four studies attempted to determine the impact “cultural competency” had on patient outcomes (Chen et al., 2004). Outcomes, like the language and measures used, are another casualty of the assumptions of “cultural competence”. Logically and theoretically, an inclusion of culture in medical teaching and health care could produce a better quality of care and as a result have an impact on health outcomes, yet there is no research or data to connect teaching “cultural competency” with improved quality of care, nor has care provided by a “culturally competent” physician been proven to lower health care disparities (Betancourt, 2003).

It should be noted that whilst there are no outcomes to substantiate the effectiveness of cultural learning, consideration, and implementation for Aboriginal patients, there is also no evidence that denies the effectiveness of learning culture and/or considering and implementing culture when treating Aboriginal patients. There have been no studies that follow those who have been exposed to and/or educated in Aboriginal culture(s) to assess whether they have an impact on reducing health disparities or improving the long-term health of Aboriginal people. Indeed, there has been very little focus or emphasis placed on the “study of the association between the process of medical education and quality of care” more broadly (Chen et al., 2004, p. 955).

Although limited research exists on cultural learning and knowledge and its impact on health disparities, substantial evidence exists documenting the impact learning, understanding and applying culture knowledge has in influencing and improving the awareness, attitudes and skills of medical professionals (Durey, 2010). In contrast, where health care providers fail to acknowledge, understand and consider cultural differences and differing health beliefs, evidence reveals negative implications. These include poor communication with patients, lower trust levels by patients, dissatisfied patients, and eventually higher cases of non-adherence (Betancourt & Green, 2010). Clearly, research has confirmed the advantages and benefits clinicians and health care providers receive from being well informed on culture and cultural influences as well as the negative outcomes that transpire from culturally inconsiderate and/or uninformed clinicians. However, without evidence of positive shifts in patient outcomes, evidence of doctor’s improvements in cultural learning, knowledge and satisfaction can appear to be presumptive of rather than meaningful from a patient’s perspective. Further, the absence of evidence of improved patient outcomes, whether medical professionals “applied what was taught or whether what was taught had any impact on service processes or outcomes remains unclear” (Kumas-Tan et al., 2007, p. 552). Given the lack of evidence of improvements in patient outcomes, the effectiveness of “cultural competency” in health practitioner education requires further research. Practitioners feeling better about themselves, or feeling more comfortable, when working with Aboriginal peoples is actually not useful if there is not a substantive improvement in the health outcomes as a consequence.

Perhaps an equally challenged assumption, yet one which may be usefully applied as an alternative in this context, is for the physician to “know thyself” (Boutin-Foster, Foster, & Konopasek, 2008). In doing so, the impossibility of knowing all others is reduced to the challenge of simply knowing thyself—both personally and professionally. An understanding of the professional culture of medicine—and all the good (and not so good) that comes with that—and an understanding of the socialization which shapes the personal, gives greater insight into the potential for communication across cultures which may be less than optimal. It also provides the physician with the genesis of ideas and perspectives which may lead to often unintended disparate treatment outcomes.
Conclusion

The initial growth spurts represent an increased knowledge and additional information that at first seem to make a difference. With more information, represented by the bigger and more complex and connected growths, the picture seems more impressively comprehensive. By adding more and more information, again represented by more expanding and intertwining growths of different colours, the picture begins to represent a more complete image. Yet it is not until we keep adding more connected information and expanding our cultural knowledge that it becomes clear that completion will never be reached. The perfect, whole, complete circle represents cultural competency. A symbolic exterior circle of more meaningful and achievable cultural information to learn strengthens it whilst also emphasising the difficulty of penetrating through to cultural competency. But at the same time, the growing towards and reaching for the circle looks a lot better than the nothingness we started with. (© S Hill 2011)¹

¹ The painting and interpretive story remain the copyright of the artist, Shauna Hill.

As increasing evidence emerges related to the role of clinician decision-making and behaviour in relation to disparities in health care outcomes for some population groups, the drive to ensure that health professional students and graduates don’t contribute to this disparity becomes more pressing. However, we need to move beyond the assumption that knowing, understanding and applying culture in health care will result in positive patient outcomes, just as it is assumed that learning about culture can result in competency and knowing about culture does result in competency. In building an evidence base for our activities in health practitioner education we should start to focus more on demonstrating the relationship between our efforts in education and positive shifts, or otherwise, in health outcomes (Paul, Allen, & Edgill, 2011).

As much as medical curricula have included a multi-dimensional understanding of the factors that determine health and health outcomes in health practitioner education, we need to better understand the factors at play in health practitioner education and practice that both aid as well as impede better health care experiences (and outcomes) for Aboriginal peoples. Further clarifying those factors will reveal useful strategies and issues that might be addressed in health practitioner education, further enabling the development of a health care workforce that is better prepared to work with Aboriginal patients and communities.

Just as paintings emerge from blank canvases to reveal increasing complexity and meaning, we need to ensure that we focus on revealing the connection, or otherwise, between our teaching and better health outcomes. It has been argued that the construction of “cultural competence” that essentializes difference and perpetuates dominance should be “jettisoned” (Pon, 2009, p. 68) in practitioner education, to be replaced by ensuring that practitioners have the ability to reflect on practice and the connection they have with health outcomes and the reduction of disparity. The challenge before us as educators is to continue to critically

FIGURE 5 From nothing to anything to everything to something.
question the assumptions which underlie initiatives in cultural competence. To question the assumptions opens up the possibility of new ways of thinking, doing and researching. To accept that cultural competence may be the panacea to disparity in health care outcomes fails to grasp the complexity of the challenge, and the multifaceted influences that contribute to patient health outcomes. Nevertheless, the increasing evidence which demonstrates clinician contribution requires us to look inward, question our own otherness, and not project this onto the patient.

Acknowledgments

The authors would like to acknowledge our Australian and international colleagues involved in the Educating for Equity project. See www.educating4equity.net for more details of the project and team members.

This project is supported by funding from the National Health and Medical Research Council, grant ID 634586.

References


Betancourt, J. R., & Green, A. R. (2010). Linking cultural competence training to improved health outcomes: Perspectives from the field. Academic Medicine, 82(6), 583–585.


