Statement on Cultural and Structural Competency

Student National Medical Association

Health Policy and Legislative Affairs Committee

Statement on Cultural and Structural Competency

Third Revision

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By:
Cristina Bañuelo, HPLA Committee Member
Eloho E. Akpovi, HPLA Policy Statements Subcommittee Chairperson
Jeniffer Okungbowa-Ikponmwosa, HPLA Committee Chairperson
Veronica Wright, HPLA Committee Chairperson

Originally authored in 2001 by:
Ana Sofia Lopes, MD

Introduction

Since the inception of the Student National Medical Association (SNMA) in 1964, the mission of the non-profit organization has been to address the concerns of medical students of color, as well as an attempt to resolve health care issues of vulnerable and underrepresented populations. Despite the tremendous efforts of the SNMA to improve health outcomes for these communities, health disparities continue to persist, in part due to a lack of cultural and structural competence within the healthcare system. For these reasons, the SNMA supports improved cultural and structural competence training and retraining in the United States (US) healthcare system.

Background

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."[1] 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."[2] Cultural differences exist and have an impact in health care delivery.[2,3] We learn from our own culture how to be healthy, recognize illness, and become ill. 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 reflected the needs of the patient.

Culturally competent providers have the academic and personal skills that allow them to appreciate and identify the healthy 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.[4] They must also have the humility to seek guidance

from others when they do not know of a cultural practice or perceive a cultural barrier. Building cultural competency is a constantly developing process.

The goals of culturally competent care are:[4–6]

1. **Cultural Awareness**: Appreciating and accepting differences.
2. **Cultural Knowledge**: Seeking out various worldviews and explanatory models of disease. Knowledge can help promote understanding between cultures.
3. **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.
4. **Cultural Encounters**: Meeting and working with people of a different culture will help dispel stereotypes and prejudices that may contradict academic knowledge.

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

Structural Competence

Structural competence, defined as "the capacity for health professionals to recognize and respond to health and illness as the downstream results of broad social, political, and economic structures," calls for a need to shift the focus beyond cultural competency and towards the forces above the level of the individual that influence health outcomes.[7] In its essence, structural competency is the understanding of not just race, class, sexual orientation, and other forms of identity, but the relationship between forms of identity and symptom expression. The structural framework emphasizes the consideration of social structures as key elements of cultural process, and thus, drivers of health outcomes. It is important that medical students, healthcare professionals, and the healthcare system consider institutions, communities, policies, etc. that operate above the level of the individual but still determine the individual's health. It conveys that in order to reduce the inequalities we see in health, we have to address the systems and structures outside of the control of the individual patient.[8]

The tenets of structural competency are:[9]

1. Recognizing the structures that shape clinical interactions.
2. Developing an extra-clinical language of structure.
3. Rearticulating "cultural" presentations in structural terms.
4. Observing and imagining structural intervention.
5. Developing structural humility, described as a personal guiding principle that:
6. Emphasizes collaboration with patients and populations.
7. Develops responses to structural vulnerability.
8. Does NOT assume that health professionals alone have all the answers.
9. Provides awareness of interpersonal privilege and power hierarchies in healthcare.

Structural competency requires that the healthcare system and the health professionals that work within the system to address patient health begin to think about and design and implement structural interventions as a means to improve health outcomes. Unfortunately, health professional training currently is not equipped to prepare current and future providers to be able to see structural influences, rearticulate patient cases in structural terms, and explicitly address structural barriers to healthcare.[10] A small number academic and medical institutions – Vanderbilt University, Brown University, New York University, University of California, Los Angeles, and Yale University – have begun exploring the integration structural competency into medical education and training, however, its acceptance as a core principle of medical training has yet to be widely appreciated in this country.[11–13] Without these skills, the healthcare system cannot truly generate sustainable improvements in patient health.

Scope of the Problem

According to the US Census Bureau, the ethnic diversity in our country has increased dramatically in recent years. Our demographics are changing due to the aging of the population,

the growing majority of women, and the nation's increasing ethnic heterogeneity. Additionally, immigration continues to contribute largely to the growing diversity of our country.[14,15]

As cultural, ethnic, and racial diversity increase within the US, healthcare practitioners face increasing challenges of recognizing patients' culturally defined expectations of the health care system. Although populations of color are the fastest growing segment of the US population, this proportion is not reflected in the medical school classrooms or in the clinical wards.[16,17] Currently, non-Asian racial and ethnic groups comprise 34.5% of the US population and are expected to increase to 51% by the year 2060.[18] However, these same groups comprise only 21% of medical school matriculants and a dismal 9% of the current physician workforce.[16,19] Research has shown that cultural attitudes affect relationships with physicians and other providers. The current shortage of culturally diverse physicians creates a problem given the evidence supporting an association between patient-doctor race and language discordance and poor health outcomes.[20–22] 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.

Our increasing diversity and the need for culturally competent providers are further compounded by the health disparities that exist in non-White communities. These health disparities are evident within across cultural boundaries and are defined as being unjust and preventable differences in the rates of occurrence of disease and disabilities.[23] A poignant example is the Latino Health Paradox, which describes that first generation Latino immigrants are much healthier than second generation Latino.[24] This phenomenon is very telling of the experience Latinos have growing up and living in the United States, because recent immigrants are healthier in comparison despite English being their second language, being less likely to have had a higher education, lower income levels, and less access to healthcare.[24] With the current state of health disparities it is becoming increasingly more important to have a diverse set of culturally competent physicians in the workforce. Communities with large numbers of Black/African American and Hispanic/Latino residents are four times more likely than other areas to have a shortage of physicians regardless of community income. Black/African American physicians care for nearly six times as many Black/African American patients as do

non-Black/African American physicians. Hispanic/Latino physicians care for more than twice as many Hispanic/Latino patients as do non- Hispanic/Latino physicians. Minority physicians are twice as likely as their White peers to take on leadership roles in community service or social activities and twice as likely to work in medically underserved areas.[19]

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. Diverse belief systems exist on health, healing, and wellness. Therefore, it is 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 their patient communities, we will be better able to develop effective health practices for the most vulnerable segment of our society.

Statement of Position and Recommendations

It is evident that problems exist in the delivery of effective health care. Our nation's expanding diversity mandates a workforce that is adequately trained and equipped to meet the challenges of the future, particularly given the widening health disparity gaps observed. The SNMA is the nation's largest collective voice of medical students of underrepresented ethnicities. Our role in addressing cultural and structural competency in medical education is crucial. It will require measures that encourage dialogue with other professional organizations to explore the assumptions that underlie expressions of prejudice and bias.

Effective incorporation of cultural and structural competency into healthcare will entail much more than the implementation of a new curriculum. The idea that competency is "gained" at one set point in time without the need to critically revisit our individual actions and assumptions should be cast away. Thus, the goal should be to incorporate the ideals of cultural and structural humility through an ongoing learning and engagement process throughout all levels of healthcare training and practice – medical students, resident physicians, and attending physicians, etc. The SNMA supports:

1. **Inclusion of cultural and structural competency standards for Liaison Committee on Medical Education (LCME) and the Accreditation Council for Graduate Medical**

Education (ACGME) accreditation. This standard may be met in several ways, including increasing clinical training opportunities in rural and urban communities. This will further increase cultural and structural knowledge and competence for medical trainees and practitioners. 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, trauma-informed care, and screening for unmet social needs.[25] We must support legislation that authorizes funding to develop cultural and structural competency curriculum at the undergraduate level through post-graduate levels.

2. **Increased diversity in medical education and practice.** Learning cultural and structural competency requires diversity in medicine, including the medical student body, faculty, and higher administration that impact the direction of medical education, and practicing providers and higher administration that impact the direction of medical care. A diverse student body encourages appreciation of one's own culture and experiences, as well as any differences from that of others. Diversity promotes the development of personal and professional competence that is required to live and work in the multicultural and multi-experiential society of today. Medical schools and healthcare facilities that value and take full advantage of this diversity will be better prepared to build a cohesive and effective workforce to serve the public.
3. **Improved recruitment and retention of medical students from underrepresented and vulnerable communities.** We must support legislation that enhances recruitment and retention of underrepresented students and health professionals, including affirmative action. 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 and structurally competent healthcare.

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