Cultural Competence in the Era of Evidence-Based Practice

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Cultural competence has become an important concern for contemporary health care delivery, with ethical and legal implications. Numerous educational approaches have been developed to orient clinicians, and standards and position statements promoting cultural competence have been published by both the American Medical Association and the American Nurses Association. Although a number of health care regulatory agencies have developed standards or recommendations, clinical application to patient care has been challenging. These challenges include the abstract nature of the concept, essentializing culture to race or ethnicity, and the attempts to associate culture with health disparities. To make cultural competence relevant to clinical practice, we linked a cultural competency continuum that identifies the levels of cultural competency (cultural destructiveness, cultural incapacity, cultural blindness, cultural precompetence, and cultural proficiency) to well-established values in health care. This situates cultural competence and proficiency in alignment with patient-centered care. A model integrating the cultural competency continuum with the components of evidence-based care (i.e., best research practice, clinical expertise, and patient's values and circumstances) is presented. (Index words: Cultural competency; Evidence-based practice; Patient-centered care) J Prof Nurs 24:172–8, 2008. © 2008 Elsevier Inc. All rights reserved.

IN RESPONSE TO issues of health disparities, the delivery of culturally competent health care has become a goal of numerous educational, professional, and health service organizations. However, implementing cultural competence into the actual delivery of clinical health care has been problematic. This is due, in part, to a lack of conceptual clarity about the concept of cultural competency, a lack of distinction between organizational and individual cultural competency, and a tendency by the majority to associate culture solely with race and ethnicity.

Our goal is to suggest how to make cultural concerns relevant to clinical practitioners at the level of the patient–provider encounter. We present a model that integrates a well-publicized cultural competence continuum with the values of health care delivery and situates evidence-based practice (EBP) as a possible link to patient-centered care. The development of cultural competence is a growth process rather than a static evaluative performance outcome.

Background and History

The changing demographic picture in health care underscores the need for guidance in understanding how to apply cultural theories to clinical practice. The racial and ethnic disparities reported in health care access and utilization of services have captured the attention of providers as well as the public (Chin, 2000; Cohen & Goode, 1999). National concerns regarding social justice and health disparities have facilitated an increased awareness of the importance of culture in health care delivery. At a fundamental level, legal and ethical mandates have been established to prevent discriminatory practices based on race or ethnicity; however, these do not assure culturally appropriate care.
Ethics, Laws and Regulations, and Standards

Ethical principles regarding medical nonmaleficence and beneficence entreat health care providers to avoid harm. By virtue of these principles, coupled with the principle of distributive justice, health care is committed to providing safe and quality health care without discriminating against or harming any person or group.

Starting with the civil rights movement in the 1960s, laws have been enacted to address cultural destructiveness, thereby making it illegal to deny anyone his or her civil rights. More recently, Title VI requirements regarding the prohibition against national origin discrimination related to people with limited English proficiency are one example of legislation addressing harmful discriminatory practices. Other regulatory agencies have standards or recommendations in place that address concerns related to culture and managed care (Agency for Healthcare Research and Quality (AHRQ), 2002); language, patient’s rights, and patient education (Joint Commission on the Accreditation of Healthcare Organizations [JCAHO], 2007); and cultural competency standards and reimbursement (Healthcare Resource and Service Administration (HRSA), 2002). In addition, the Culturally and Linguistic Appropriate Services standards attempted to synthesize cultural competency definitions and requirements into one set of standards (Office of Minority Health (OMH), 2001). This contains a number of regulations and recommendations for health care organizations, such as providing appropriate translations, hiring policies, and so forth.

Professional and Educational Approaches to Cultural Competence

The American Medical Association, the Association of American Medical Colleges, the American Association of Medical Students, the American Academy of Nursing, the American Nurses Association (ANA), the American Association of Colleges of Nursing (AACN), and the National Association of Social Workers have all published statements promoting cultural competence. The ANA and the AACN have published position statements promoting cultural competence (ANA, 1991; AACN, 1997). The Transcultural Nursing Society has proposed standards for transcultural nursing (Leuning, Swiggum, Wiegert, & Zander, 2002). Many of these have articulated processes for implementing cultural competencies, such as A Practical Guide for Implementing Standards for Culturally and Linguistic Appropriate Services in Health Care (OMH, 2002).

A plethora of educational programs, guides, and conceptual models are available. These offerings range from brown-bag lunches to full-scale integrated curricula extending over several years of education (Gilbert, 2003). Educational strategies and models have also been proposed to more fully integrate cultural competency into medical and nursing curriculum (Azad, Power, Dollin, & Chery, 2002; Carrillo, Green, & Betancourt, 1999; Culhane-Pera, Like, Lebensohn-Chialvo, & Lowe, 2000; Green, Betancourt, & Carrillo, 2002; Hilgenberg & Schlickau, 2002; Like, Steiner, & Rubel, 1996). In medical education, the Society of Teachers of Family Medicine has developed curricula related to cultural competence (Like et al., 1996), and the American Medical Student Association (AMSA) has published resource for developing cultural competency (AMSA, 2002). It is noteworthy that in the June 2003 issue of the journal Academic Medicine, 12 articles devoted to preparing doctors for a multicultural world were featured (Whitcomb, 2003). These articles highlight a lack of consensus on the content and learning experiences that would support these competencies as well as questioning the nature of cultural competencies and dissonances in the clinical settings. Nursing has a long history of attention to cultural issues in providing holistic care. A number of nursing models have been developed and used in education and clinical practice, including Andrews and Boyle (2002); Campinha-Bacote (1998), 2002; Giger and Davidhizar (2002); Leininger (2002); and Purnell (2002).

The California Endowment sponsored the development of principles and standards by which to plan and assess the education of health care professionals as well as resources for organizations (Gilbert, 2003). Overall, health care educational approaches have focused on three components: attitudes, knowledge, and skills. Education regarding cultural attitudes generally incorporates cultural sensitivity/awareness as the foundation for cross-cultural care. However, efforts to change attitudes are difficult to implement and evaluate and often are seen as too abstract for pragmatic-oriented clinicians. Knowledge-based approaches generally use a multicultural or categorical approach and commonly focus on a set of cultural norms associated with a particular ethnic group. However, essentializing groups in this manner often leads to stereotyping, a failure to recognize the innate complexity of the individual, thereby leading to misdiagnosis and culturally incompetent care (Fuller, 2002). Such stereotyping also fails to account for the cultural orientation of the providers and the culture of the health care system. A broader knowledge base of anthropological theories, epidemiological data, socioeconomic status, and the social and historic context of the population, as well as ethnopharmacology and pharmacogenetics, would be more useful. Recently, much education has moved from cultural sensitivity to cultural competency, reflecting a move to a skills-focused paradigm. The skills orientation approach focuses on communication skills, such as eliciting patient’s explanatory models (EMs), decision-making preferences, family roles, and use of healing resources. These skills coupled with an immersion into the community and role-playing approaches may be among the more practical educational strategies (Institute of Medicine (IOM), 2002).

Problems in Implementing Cultural Competency in Health Care Delivery

In spite of the obvious professional interest, there is a lack of consensus about the best way to meet the goal of
culturally competent provision of health care at the individual patient care level. This is due, in part, to the lack of conceptual clarity associated with the concept cultural competence. This often results in a lack of distinction between individual and organizational cultural competence. This lack of distinction results in sets of rules, guidelines, or regulations that may be appropriate for organizations and provide some of the subject matter for educational programs, but these approaches do not address the unique and specific issues of clinical application with individual patients. Many anthropologists and sociologists, experts in the study of culture, have traditionally focused on the organizational, economic, and policy level, and many have not translated their knowledge to clinical practice.

Furthermore, the abstract nature of the term cultural competency often leads to confusion, complacency, and resistance by many health care providers to the application in clinical practice. In a series of interviews with managed care leaders, Betancourt, Green, Carrillo, and Park (2005) reported that although providers often were resistant to cultural competency, they felt training was necessary and cited initiatives by several health insurers to ensure culturally competent care. Dreher and MacNaughton (2002) indicated that the clinical level of patient and provider is where expectations of cultural competence are most demanding. They further suggested that cultural competence at the individual level of health care is merely another name for family- or patient-centered care. Such care relies upon the provider’s capacity to deliver holistic care, which includes therapeutic use of self and communication skills aimed at understanding the patient’s experience, expectations, and evaluation of care. It is along the journey while visiting citadels of biomedicine that the “culture of the sick” comes into collision with the “culture of health care.”

There is considerable discord about how competency is best defined, operationalized, and assessed to address contemporary health care challenges. Ludwig (1999) suggested that competent practice is complex and requires not only compliance with external influences but also ethical reflection about competence. The complex nature of competency underpins the need for competency assessments to be formative rather than summative. This view is consistent with the view of competency as a dynamic process requiring growth rather than an attainable static point, at which time a professional is “checked off” a list of competencies (Wright, 1998). According to Campinha-Bacote (2002), culturally competent health care depends upon the health care provider observing the self “becoming,” rather than “being,” culturally competent. This view is consistent with the notion of cultural competence as a process, not an end point or event. The culturally competent provider recognizes that there are more differences within, than across, ethnic and cultural groups and that cultural groupings can be by ethnicity, age, region, education, and a number of other variables (Agar, 2006).

In addition, the somewhat abstract nature of the term culture often results in a workplace definition of culture that is narrow and concrete and reduces culture to ethnic minorities. This type of thinking often leads to exempting providers from ethnic minority backgrounds from the responsibility of providing culturally competent care. It further leads to ignoring the need to provide culturally competent care to all groups, such as White men. Such a restricted notion of culture also fails to address the complexities in the relationships between an individual, his or her culture, and the culture of biomedicine, which is alien to most patients.

The abstract or “soft” nature of cultural competence also often results in complacency on the part of many providers. This, coupled with resistance to unrealistic expectations of cultural competence, contributes to standardized care that does not address cultural diversity other than language translations. Pragmatically inclined clinicians know that attaining knowledge about all cultures is unrealistic. Many who have read about a particular culture soon find discrepancies when trying to apply that knowledge to a particular client. Thus, they tend to discount cultural information that does not fit clinical realities. Knowing facts about specific ethnic groups is insufficient to understand the individual client. Furthermore, providers innately know that due to the interactive nature of communication, they cannot hold total responsibility for culturally competent care. Although the greater burden for culturally competent communication resides with the provider, it is not totally unilateral. This dissonance often results in providers dismissing cultural information as being irrelevant. In addition, providers and administrators facing staff shortages and cost containment often see implementing the somewhat vague concept of cultural competence as an extra burden. With little research substantiating the efficacy and cost-effectiveness of culturally competent care, this emphasis recedes into the background.

Some have suggested a rather concrete solution to this dilemma known as culturally concordant care or matching patients and health care providers along ethnic or racial lines (Cooper-Parick et al., 1999; Laveist & Nuru-Jeter, 2002; Saha, Komaromy, Koepsell, & Bindman, 1999). Although implementing a plan of cultural concordance may result in some people feeling more comfortable with their provider, increasing patient satisfaction in some cases, there are a number of practical problems associated with the idea. Fundamentally, it suggests that there are providers available within existing health care systems that represent all cultures, at least in terms of race and ethnicity. It is also important to consider that concordance along racial or ethnic lines contributes to stereotyping and xenophobia, potentially redacting many previous efforts lodged at reducing racism. This could result in totally segregated care. Furthermore, programs that aim to apply the principles of culturally concordant care often fail to recognize the complexities associated with such a venture.
It is vitally important to avoid racial health care disparities and not discriminate in the provision of good health care (Lillie-Blanton, Martinez, & Salagnicoff, 2001; Peterson et al., 1997). However, narrowly linking cultural competence with health care disparities leads to defining culture solely along racial and ethnic lines. At first glance, the logical solution is to provide equitable care. A view of health care disparities focused solely on racial characteristics often fails to consider other factors associated with culture, particularly individual variations within cultural groups that include treatment preferences or health-related behaviors. Individual, as well as cultural, variations in beliefs associated with illness as well as preferences for treatment are ignored. Thus, in an attempt to provide equitable care for all, a paradox arises, that is, the need to deliver simultaneously equitable yet distinct care based on individual and cultural preferences. These issues of narrow association with health disparities are further complicated by the concurrent neglect of other factors related to health disparities. Gregg and Saha (2006) argue that this mismatch leads to the reinforcement of ethnic biases and cultural stereotyping and collapses other social forces in health disparities such as poverty, violence, and racism. Furthermore, an ethnically charged perspective endangers the integration of cultural issues into the provision of health care if they are not linearly linked to health outcomes.

**Making Cultural Competence Clinically Relevant**

One approach toward making cultural competence clinically relevant is linking the concepts to widely accepted values in biomedicine and health care delivery. One of the most frequently cited works on cultural competency is a continuum developed by Cross, Bazron, Dennis, and Isaacs (1989). This continuum, illustrating cultural competence on a scale from cultural destructiveness to cultural proficiency, can be translated into well-known biomedical values that are positioned parallel with the concepts of the cultural competence continuum (Figure 1). Noting the corresponding nature of these concepts may lead to a practical means for integrating cultural concepts into health care delivery.

Nonmaleficence, meaning to do no harm, coupled with beneficence represents the cornerstone of medical ethics. Maleficence has some equivalence with cultural destructiveness, in which overt, often-intentional acts of harm are committed. Incompetence, the lack of competence, is situated parallel with cultural incapacity. Cultural incapacity refers to nonintentional destructiveness from practices or actions that may be harmful to patients and their families through ignorance, improper allocation of resources, or insensitive attitudes of staff or provider. Consistent with these ethical principles, laws and regulatory standards have identified these harmful behaviors as inappropriate in health care delivery.

**Standardized Care**

Another valued biomedical principle is standardized care. By delivering care in a standardized fashion, health care providers attempt to insure efficiency, cost-effectiveness, consistency, and quality. Formal and informal structures are erected to organize the delivery of care to meet regulatory standards. Standardization is one approach to avoid harmful or discriminatory practices. Often, guidelines are rigidly imposed, supposedly to insure equal treatment. Care delivered in this fashion is analogous to cultural blindness that assumes that all patients are alike. Although this seeks to avoid harmful discrimination, it does not necessarily provide the best care for that individual patient.

**Positive Health Outcomes**

Positive health outcomes are highly valued and a valued goal of clinical ethics. Quantitative outcome measures are often used to report to regulatory agencies that

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**Figure 1.** Model of cultural competency and EBP. Data from Cross, Bazron, Dennis and Isaacs (1989).
standards have been met and to demonstrate that a performance improvement process is in place. These measures report on such factors as patient satisfaction, length of hospital stay, symptom reduction, cost-effectiveness, adherence to treatment guidelines, and access to and appropriate utilization of health care services. Outcome measures are also used as a means for benchmarking for best practice for a provider or an organization to be recognized by managed care organizations as the provider of choice. Outcomes-focused care corresponds with precompetence on the parallel continuum. When providers begin to be concerned about issues related to diverse groups of people accessing care and appropriately utilizing health care services, they are beginning to contemplate how individuals and groups of people orient around health and health care. Aligning outcomes to cultural competence is exceedingly complex and often might not be captured by traditional outcome evaluation approaches.

Patient-Centered Care

Patient-centered care allows for the differences among patients with the same diagnosis or from the same ethnic group. The focus is on the patient and the patient's family and the things that the patient "cares about" (Gray, 2002; Haidet et al., 2001; Mead, Bower, & Hann, 2002). The notion of patient-centered care is consistent with cultural competence or proficiency at the individual patient level. Culturally competent (patient-centered) care situates the patient and family as partners with the provider in the negotiation of treatment decisions as well as evaluation of treatment outcomes. However, for the provider to enter into full partnership with the patient and family, there is a need for the provider to pay attention to cultural clues that may influence treatment decisions and adherence to treatment regimens. It is at this point that cultural competence becomes “fuzzy” to many clinicians who have not attained this degree of competence.

Evidence-Based Practice

One vehicle that unites these continuums is the triad of EBP, a highly prized principle of contemporary biomedicine, which is based on a disease management model. Sackett, Strauss, Richardson, Rosenberg, and Hayes (2000), leaders in medical education related to EBP, originally defined EBP as a three-pronged approach to best clinical practice. This triad included the best research evidence, the provider's clinical expertise, and patient's values and circumstances. In the latest version (Strauss, Richardson, Glasziou, & Haynes, 2005), patient's values and circumstances were separated into two components. Addressing all areas of this triad allows for health care to be more individualized, thus moving forward on the continuum to cultural proficiency and patient-centered care (Figure 1). Although EBP is primarily identified with population-based data, thereby more akin to standardized care/culture blindness on the continuum, recent developments in EBP are moving to patient-centered care as a core value (Hasnain-Wynia, 2006).

Patient Circumstances

This component of the EBP model includes the clinical state and the clinical setting. This area also requires that the provider individualize the understanding of the patient's illness experience to include the unique aspects of symptoms, personal life concerns, and situations. These economic, environmental, and social circumstances are inseparable from culture.

Patient Values and Preferences

Patient values and preferences include the unique expectations that each patient and family member bring to the clinical encounter. Cultural issues are crucial to all clinical care, preventive counseling, diagnosis, treatment, and management of illness because culture shapes health-related beliefs, values, and hence, behaviors (Kleinman & Benson, 2006). The clinical encounter is grounded in communication where the values and beliefs of the patient and clinician are shared. This is the nexus of the clinical interaction where cultural competence comes into play. Having cultural knowledge is necessary but not sufficient for the provision of culturally competent care. Culturally competent clinical care depends upon a clinician who is attuned to cultural cues presented in the clinical encounter. The competent clinician incorporates and responds to these cues through therapeutic interpersonal communication strategies. When the focus of health care is on disease without a context, there is a distortion of the clinical reality. Clinical reality encompasses attitudes and norms about sickness, clinical relationships, and healing activities. Examples of such include beliefs about sickness, behaviors of the sick person, treatment expectations, and ways a family responds to a sick person. Cultural beliefs and behaviors also are extremely important in health counseling and are thus crucial in health promotion, prevention, or management of chronic disease. Although clinical reality is composed of social and symbolic reality, it also relates to psychobiological and physical reality. It is in the context of the interpersonal clinical relationship between the patient and the healer that the patient is able to make sense out of the illness experience (Kleinman, 1980; Kleinman, Eisenberg, & Good, 1978).

The distinctions between disease and illness, as well as the position of illness in the context of a social matrix, have been well developed in the medical anthropology literature (Eisenberg, 1977; Kleinman et al., 1978). Kleinman et al. (1978) described the difference between disease and illness and the presence of a clinical reality that is culturally constructed. Disease is a malfunction of a physiological process, whereas illness is a discomforting experience that is influenced by individual, interpersonal, and cultural factors. The ways that an individual or group of people label an illness and seek and evaluate treatment are embedded in a cultural system that provides not only for the interpretation of an illness but also for the rules and rituals of illness behavior.

Cues for cultural issues can be found in ways that people explain their illnesses or health concerns.
Kleinman (1980) described EMs as ways that all individuals describe sickness in terms of labels, causation, onset, prognosis, chief concern, treatment, and evaluation. Biomedical health care providers organize these constructions around a pattern–relation identification that applies the rules of pathology to account for the signs and symptoms of the patient's condition. Dissonance between the patient's and provider's EMs may be a significant reason for poor clinical outcomes. Other cultural cues can be found in the expressions that patients and family members use. Good (1977) described semantic networks of meaning as a pattern of words, experiences, and feelings that cluster together for members of a societal group that allow the person who is suffering to give meaning to the experience. Illness language, a form of communicating about a sickness in a variety of social settings, including the clinical encounter, needs to be examined by clinicians to understand the social stress underpinning the illness and to negotiate a plan to relieve the distress.

Nichter (1981) further developed a conceptual aspect of the illness language and idioms of distress and illustrated the need for clinicians to understand the meaning of such expressions before determining whether a behavior is adaptive. In the absence of an analysis of idioms of distress, the clinician risks misinterpreting behavior as pathological rather than a culturally adaptive response to stress. Whether the focus of the clinical encounter is centered on the medically authorized narrative or the patient's constructed meaning partially determines the distribution of power in the experience (Frank, 1996). Kleinman and Benson (2006) have summarized what clinicians need to know in the clinical encounter is centered on the medically authorized narrative or the patient's constructed meaning partially determines the distribution of power in the experience (Frank, 1996).

Conclusion

Associating the development of cultural competence with long-standing values in the health care field may be useful for clinicians to appreciate the value of addressing culture in clinical practice. Linking cultural competence with EBP may provide an avenue for making cultural competence clinically relevant. Eliciting, articulating, and understanding elements surrounding patient's values and preferences provide opportunities for the development of cultural proficiency to clinicians who encounter the paradox associated with equitable yet distinct health care delivery needs. These opportunities exist at the theoretical, empirical, and application levels of social sciences and biomedicine.

References


