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Promoting Harmony Through Cultural Competence

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Race, ethnicity and cultural heritage can be related to the prevalence of a number of illnesses, including cardiovascular disease, diabetes, HIV/AIDS and cancer.[1] Understanding the diversity of patients' cultures - their beliefs, customs, values and traditions - is integral to eliminating health care disparities and providing high-quality culturally competent patient care.

Although there is as yet no universal definition, the National Center for Cultural Competence[2] at Georgetown University defines cultural competence as "having the values, skills, knowledge, attitudes and attributes to work effectively in cross-cultural situations." This includes an awareness and acceptance of cultural differences, such as communication and behavioral styles; an awareness of our own cultural values; and our willingness to adapt our work practices accordingly. For instance, the role of faith, religion and God in a patient's understanding of his or her healing may stem from strong cultural beliefs. Additionally, culture can influence the way in which medical help is sought and the consumer's interactions with health care professionals.

Increasing our cultural competence can be achieved in many ways. Local minority organizations often host cultural competency trainings. Utilizing our skills in "asking," we can inquire about beliefs, practices and values as they pertain to medical concerns. We can work with interpreters and have translated intake and consent forms available. With a deeper understanding of the patient's cultural beliefs and behaviors, we can apply this information as hypothesis, with the need to avoid overgeneralization and negative stereotyping.

Medical anthropologists developed an "explanatory model" for developing cultural competency when further information regarding the patient's beliefs about illness will enhance the patient-practitioner relationship and treatment outcomes. Kleinman[3] suggests the following questions:

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What do you think your sickness does to you?
4. How severe is your sickness? Do you think it will last a long time, or be better soon, in your opinion?
5. What are the chief problems your sickness has caused for you?
6. What do you fear most about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to get from treatment?

As a profession, we must strive for racial, ethnic and linguistic concordance by matching such characteristics between patients and practitioners. This concordance can provide a higher degree of comfort, communication and empathy between participants during the clinical experience by reducing differences in cultural and linguistic backgrounds; thus, having a positive impact on outcomes.

The U.S. Department of Health and Human Services[4] has issued recommendations for assuring cultural competence in health care. These recommendations include:

1. Promote and support the attitudes, behaviors, knowledge and skills necessary for staff to work respectfully and effectively with patients and each other in a culturally diverse work environment.
2. Utilize formal mechanisms for community and consumer involvement in the design and execution of service delivery, including planning, policymaking, operations, evaluation, training and, as appropriate, treatment planning.
3. Develop and implement a strategy to recruit, retain and promote qualified, diverse and culturally competent administrative, clinical and support staff that are trained and qualified to address the needs of the racial and ethnic communities being served.
4. Require and arrange for ongoing education and training for administrative, clinical and support staff in culturally and linguistically competent service delivery.
5. Provide all clients with limited English proficiency (LEP) access to bilingual staff or interpretation services.
6. Ensure that interpreters and bilingual staff can demonstrate bilingual proficiency and receive training that includes the skills and ethics of interpreting, and knowledge in both languages of the terms and concepts relevant to clinical or non-clinical encounters. Family or friends are not considered adequate substitutes because they usually lack these abilities.
7. Develop structures and procedures to address cross-cultural ethical and legal conflicts in health care delivery and complaints or grievances by patients and staff about unfair, culturally insensitive or discriminatory treatment, difficulty in accessing services, or denial of services.

Historically in this country, our profession has grown due in part to the evolution from consumer into healer. In a poll compiled by *Acupuncture Today* of 393 practitioners, the highest ranked reason (36.6%) for deciding to become an acupuncturist was a personal experience as a patient. In many states, lack of third party reimbursement has made access an economic issue, resulting in acupuncture being utilized most highly by Caucasians. As a non-Western modality, access to information about acupuncture can be limited by the prospective consumer's reading level, English proficiency and computer skills. Individual outreach of practitioners is typically to their respective communities and word-of-mouth flows within social and familiar groups. All of these mechanisms further propagate a homogenous practitioner and client population.

The *Journal of the American Board of Family Practice* published a study documenting the characteristics of providers of complementary and alternative medicine in the United States, including licensed acupuncturists. Two hundred twenty-seven acupuncturists were interviewed by phone. Although 20 percent of the acupuncturists were Asian, less than 2 percent were Hispanic or African-American.[5]

Creating a strategic plan to provide greater access to diverse patient populations starts with educating ourselves and implementing procedures for recruitment and retention of diverse students. Like other medical institutions in this country, our schools can implement scholarship and incentive programs, participate in urban job fairs, and expand recruitment outreach for incoming students. Increasing access to information by African-American and Latino prospective students and consumer populations should be a priority for all providers and educational institutions.

Adopting culturally competent practices can improve the quality of services and potentially impact health outcomes for our patients. It will expand access to care and enable us to respond to current and projected demographic changes in the United States. From a social perspective, it will work to

eliminate disparities in the health status of people of diverse racial, ethnic and cultural backgrounds. Enhancing diversity, in its myriad forms, is a goal that benefits the public's health on all levels.

References

1. Cohen E, Goode TD. *Policy Brief 1: Rationale for Cultural Competence in Primary Health Care*. Washington, DC: National Center for Cultural Competence, Winter 1999.
2. www.georgetown.edu/research/gucdc/nccc/index.html.
3. Kleinman A. *Patients and Healers in the Context of Culture*. Berkeley, California: University of California Press, 1980.
4. HHS Office of Minority Health and Resources for Cross Cultural Health Care; minorityhealth.hhs.gov.
5. Cherkin DC, Deyo RA, Sherman KJ, et al. Characteristics of licensed acupuncturists, chiropractors, massage therapists, and naturopathic physicians. *Journal of the American Board of Family Practice* September/October 2002;15(5):378-390.

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