Adult Education Enters the Cultural Competency Craze

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Abstract: This paper will provide a brief overview of the literature on cultural competency as it relates to health care. Cultural competency is a strategy to reduce and eliminate inequities in health care that are related to race, ethnicity, socioeconomic status, gender, and sexual orientation. The paper will provide a framework for health profession educators to understand cultural competency through the lens of adult education.

Introduction

The United States is becoming substantially more diverse in its citizenry. There are numerous racial and ethnic groups and immigrants living and working in the U.S. In addition, there has been an increase in the number of languages other than English spoken in homes, as well as an increase in the number of individuals with limited English-speaking abilities. Socioeconomic differences, gender, sexual orientation, and even religious differences have become more apparent and distinct in the U.S. The unique needs of different groups require cultural sensitivity as the demographics in the U.S. continue to change.

Research studies show a number of inequities in access and treatment care options between minorities and non-minorities. This prompted the health care industry to re-examine the ways it provides access to treatment for minorities and those of lower socioeconomic standing. Despite a significant growth in racial and ethnic minority populations in the United States, the number of minority health care workers has not kept parity within the U.S. population.

An article in the *Journal of Medical Care Research and Review* (2000) reports that "a history of health care discrimination as well as on-going extensive evidence of racial disparities argues for continued vigilance in the area of health care and civil rights" (p. 236). Similar research findings and reports from the Institutes of Medicine (1999), Agency for Healthcare Research, and Quality's National Healthcare Disparity Reports for 2003 and 2004, and the Surgeon General's Report (2000) have all noted significant inequities in health care for the poor, as well as for racial and ethnic minorities. The Institutes of Medicine (1999) study concluded that "Racial and ethnic minority patients are found to receive a lower quality and intensity of healthcare and diagnostic services across a wide range of procedures and disease areas" (p. 77). The research demonstrates that even after adjustments have been made for healthcare access-related factors such as insurance and socioeconomic differences, inequities in health care still exist.

Because of such research findings, the spotlight has focused intensely on medical and health care professionals to establish ways and means to reduce and eliminate health care disparities. One such strategy that has emerged to battle health care inequities is the development and training of health care personnel in "cultural competency." Cultural competency was designed to assist all health care providers and institutions delivering health care to recognize and understand their own biases toward racial and ethnic minority and disadvantaged groups.

Cultural competency has received a great deal of attention from the educational, legal, social services, and health care literature and is considered extremely important in the

elimination of racial and ethnic health care inequities in this country. For instance, the state of New Jersey (2005) recently implemented legislation that requires physicians, medical students, and residents to undergo educational training in cultural competency if they want to be licensed or re-licensed by the State Board of Medical Examiners. Other states have also considered and proposed similar legislation. Medical, dental, nursing, pharmacy and other allied health profession programs have implemented some form of cultural competency training as a standard competency in their educational curriculum. In the past five years, the Liaison Committee of Medical Education and the Accreditation Council for Graduate Medical Education, as well as other health professions have mandated that discussion and exploration of cultural matters must be included as part of the formal education of medical students. Yet there has been little empirical research that says cultural competency training and strategies improve the racial and ethnic inequalities in access and treatment of care (Brach & Fraserirector, 2000).

Cultural Competency Related Literature

Scholars have offered a variety of definitions of cultural competency. Cross et al. (1989) have provided the most often cited definition from the children's mental health literature: "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations (Cross et al., 1989, p. iv). According to Betancourt et al. (2003), health care providers need to understand the importance of social and cultural influences of patients' health beliefs and behaviors when treating diverse patient populations and create intervention techniques that are culturally appropriate. Purnell (2002) asserts, "A culturally competent health care provider develops an awareness of his or her existence, sensations, thoughts, and environment without letting these factors have an undue effect on those for whom care is provided" (p. 193). Similarly, Jacobson (1996) asserts that we need to understand how others make sense of their world, so that we can interact with them in more appropriate ways that will make sense to them.

How we develop cultural competency of a health care professional has seen a proliferation of intervention models. For example, Brach and Fraserirector (2000) developed a model that encompasses nine cultural competency techniques to assist in eliminating health care disparities. They include using interpreter or American Sign Language services, minority staff, non-traditional healers, community health care workers, culturally specific health promotion, and family members. In addition, the model recommends that health care providers immerse themselves into a different cultural group and ensure that the administrative and organizational structures are accommodating to patients in terms of physical location and environment and written materials that reflect the minority populations being served. Betancourt et al. (2003) provided a framework that included the elimination of organizational, structural, and clinical barriers that often keep racial and ethnic minorities and the poor from achieving quality health care services. That is, they recommended having a workforce that reflects the demographics of the general population and can accommodate the differences in beliefs, attitudes, and values of patients and their health care providers.

While there has been a great deal of attention to providing cultural competency training to health care personnel, and how to assess/evaluate cultural competency, what has received less attention is how adults learn cultural competency or how they transform their thinking to include a broader paradigm to provide culturally competent care. Cultural competency should be more about fostering ideas for change, enabling health care professionals to become agents of social

change, as well as reminding them of their responsibility to provide care for the diverse population that they serve.

Adult Education and Learning

Cultural competency training and education involves educating adult learners such as physicians, dentists, nurses, pharmacists, physical therapists, social workers, allied health care providers, as well as those in the undergraduate phase of health care training, such as medical, dental, or nursing students, etc. However, the focus in the training of adult learners in health care has not been on the process of "adult learning." When Stagnaro-Green (2004) reviewed medical literature and the literature of adult learning principles, he found that very little use was made of adult learning principles in undergraduate medical education. This provides the adult education community the unique opportunity to enter the cultural competency craze and assist in broadening the scope of medical education literature. Adult educators have consistently examined and explored the intersection of issues of race, class, gender, socioeconomic status, sexual orientation, social justice, and oppression (Cunningham 1988, 1996; Guy 1999; Johnson-Bailey & Cervero 2000; Johnson-Bailey 2002; 1994; Ross-Gordon 1990; Sheared 1994, Colin 1991, Tisdell 1993). Now they can add to that list the crossroads of health care. Adult educators can offer health care professionals and their respective fields of literature, particularly the cultural competency literature, the perfect lens to critically examine issues surrounding cultural competency. The health professional community has much to learn from the adult education community regarding adult learning and cultural competency education.

Intercultural Competency

A retrospective review of the adult learning literature can be used as a starting point for discussing a learning theory to explain the process of acquiring cultural competency. For instance, in his qualitative research study, Taylor (1994) argued that becoming interculturally competent is a long-term learning process. Intercultural competency enables an individual to function effectively in a foreign cultural environment. Taylor's concept of "intercultural competency" is slightly different from "cultural competency" that this paper addresses with regard to adult learners in health care. However, there is merit in exploring this strategy in connection with health care, because the field of health care can benefit from both culturally and interculturally competent professionals. Taylor chose transformative learning theory to explain the learning process in becoming interculturally competent, but argued that it is limited in explaining how one might become interculturally competent. He identified six components of transformative learning theory that are useful in this process. These components take into account the person's previous life and cultural experiences, followed by a period of dissonance, which causes stress or upsets the person's equilibrium. The next component looks at the cognitive and then behavioral orientations and finally moves to an evolving intercultural identity.

Situated Cognition

Jacobson (1996) argues that situated cognition offers a critical lens to understanding the process of learning about culture. Situated cognition (Brown, Collins, & Duguid 1989; Lave & Wenger, 1991; Vygotsky 1978) is built of the premise that the context or situation is an essential part of the learning process. Jacobson states, "learning a culture does not require that we fully take on others' ways of making sense, but that we recognize how others make sense, so that we can interact in ways that will make sense to them" (p. 17). As he concludes, "The framework of situated cognition offers a richer, more accurate understanding of human experience by requiring

that we make its social nature explicit" (p. 26). Health professions education can benefit by exploring situated cognition as a constructive theory to understand the learning process.

Brown, Collins, and Duguid (1989) developed situated learning model using a "just plain folks" approach that fit with the model of health professions education. Their eight instructional techniques include the use of stories, reflection, cognitive apprenticeships, collaboration, coaching, multiple practices, articulation of learning skills and the use of technology. The most important factor in situated learning theory as it relates to health care providers is the situation (context) for the cultural competency learning activity (e.g., the clinical setting, laboratory, continuing education classroom, or private office have a tremendous impact on learning). Further exploration of Brown, Collins, and Duguid (1989) learning techniques can offer the field of health care another option in enhancing the learning of cultural competency. The first technique that Brown, Collins, and Duguid (1989) recommend is the sharing of stories. In health care, talking about issues of inequities and their impact on people's lives can be an effective strategy to assist individuals in learning about cultural competency. For instance, the book *The Spirit Catches You and You Fall Down* by Anne Fadiman (1997) illustrates the story of a Hmong family and its tragic encounters with the U.S. health care system that destroys the family as their young daughter battles epilepsy.

A second technique recommended by Brown, Collins, and Duguid (1989) is time for personal reflection to analyze new situations and help determine one's course of action. This has particular relevance for health care professionals. A third technique is cognitive apprenticeships, which teams seasoned practitioners with newcomers to the field as they enter a community of practice. As new health care professionals become immersed in the culture and the delivery of health care, they would benefit from working with a more culturally competent health care professional. For instance in a social modeling process, physicians, nurses, dentists, and pharmacists could train residents and newcomers to the profession by working side by side with them. This period of observation is a key component of teaching and learning. Other techniques Brown, Collins, and Duguid (1989) recommends include collaboration, coaching, providing learners with multiple practice environments, articulation of learning skills, and the use of technology. Situated learning models have promising applications for the process of becoming culturally competent health care professionals.

The purpose of this paper was to better understand how adult learning theory can assist the health care profession in the teaching and transformation of health care providers, systems, and environment in an effort to deliver a more culturally competent form of health care. A number of theoretical frameworks from fields such as behavioral, cognitive, humanistic, and social learning can provide a useful means of viewing cultural competency from an adult learning theory perspective. Adult education can contribute to the health care field with its foundation in social justice to eradicate inequities in access and treatment care options by joining forces with the medical community in reducing and eliminating health care disparities.

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