# Cultural competence for the 21st century dermatologist practicing in the United States

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Significant health disparities exist among under-represented minorities in the Unites States, which can partially be accounted for by the quality of patient-physician interaction. A distinguishing factor of this interaction is the ability of the provider to demonstrate cultural competence, or address the social, cultural, and community influences on healthcare behaviors and incorporate these elements into patient care. However, this practice has yet to be universally implemented in our healthcare system. These factors become even more important as the racial, ethnic and cultural distribution of the United States population changes. Multiple studies have suggested that cultural competence of the health care provider and staff leads to improved patient adherence, satisfaction, and ultimately, health outcome. Cultural competence in the workplace also leads to efficient and cost-effective healthcare and better community integration into healthcare systems. The purpose of this review is to help dermatologists understand the benefits of culturally competent care for their patients and themselves and identify methods and resources to achieve this goal. (J Am Acad Dermatol 2017;77:1159-69.)

***Key words:*** cross-cultural training; cultural competence; cultural efficacy; effective clinical encounters; health disparities; quality of care; sociocultural barriers to care.

Dermatologists practicing in the United States today must be aware of changing demographics of the population and associated health care disparities based on sex, race, ethnicity, socioeconomic status, disability, religion, and sexual orientation. This issue is not limited to the United States, because similar changes are occurring in other countries around the world. Dermatology as a specialty requires particular attention, because it has the dubious

*Abbreviations used:*

UIM: underrepresented in medicine
URM: underrepresented minorities

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distinction of being second only to orthopedics as the medical specialty with the smallest percentage of underrepresented minorities (URMs) in the United States,* specifically those who are underrepresented in medicine (UIM),† in its workforce.[1-10] In 2015, African American and Hispanic dermatologists comprised only 4.1% and 4.7%, respectively, of the US dermatology workforce, which poorly reflected the racial and ethnic profile of the US population at that time (14.3% African American and 17.4% Hispanic).[3-5,11-13] The situation does not appear to be improving, because only 1.6% of African American, 1.4% of Hispanic, and 0% of American Indian medical school graduates reported dermatology as their specialty of choice in 2011.[14]

With the increasingly diverse patient population in the United States, there is an ever-growing need for physicians and other health care providers to improve health care delivery beyond having exceptional clinical skills and successfully achieving system-wide quality measures; cultural competency should also be considered in this process. Culture is distinct from race and applies to all forms of diversity. For example, many multiracial Hispanic populations in the United States share the same culture. A patient's cultural view of health care may be unrelated to race. Cultural competence requires the health care provider to be inquisitive, accepting, and flexible in order to integrate a patient's beliefs into their care. Culturally competent care is a patient-centered approach that includes establishing rapport and engaging in shared decision-making between the patient and physician in a manner that is respectful of a patient's values, goals, health needs, and cultural background. This improves patient satisfaction, and, ultimately, health outcome (Fig 1).[15-18]

**CAPSULE SUMMARY**

- Cultural competence is underused although it is important for providing quality health care to diverse populations.
- This review helps readers understand cultural competence, its significance, and how to adopt it in the workplace.
- Cultural competence provides diverse benefits for patients, communities, and health care systems, including improved outcomes and patient satisfaction.

## WHAT IS CULTURAL COMPETENCE?

To more clearly define cultural competence, we will first highlight the definitions of associated terms, including race, ethnicity, and culture. Racial categorization divides individuals into groups based on physical characteristics, most commonly relating to shared ancestry. For example, individuals can be assigned to a racial group based on skin color and facial features. Ethnicity, however, is a term that groups individuals based on their sociocultural context, and therefore encompasses more than physical traits. Individuals of the same ethnicity usually have a common group history, such as shared language, genealogy, or religion.

*URMs were formerly defined by the Association of American Medical Colleges, Council on Graduate Medical Education, and Department of Health and Human Services as racial and ethnic groups who are represented in lower proportions in health professions than in the US population as a whole. These races/ethnicities include: African American, Mexican American, Native Americans (American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans. The National Institute of Health has expanded this definition to specifically include Pacific Islanders, which is reported by the US Census Bureau/-Office of Management and Budget under the race "Native Hawaiian or Other Pacific Islander."

The 2010 US Census Bureau defined black or African American as a person having origins in any of the black racial groups of Africa. This includes respondents who reported entries such as African American, sub-Saharan African, and Afro-Caribbean. For consistency, the term African American is used in this article.

The 2010 US Census defined Hispanic or Latino origin as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Individuals answering the 2010 US Census were asked to answer both race and ethnicity, with ethnicity defined as "Hispanic, Latino, or Spanish origin" or "not of Hispanic, Latino, or Spanish origin." In the 2010 US Census report on the overview of race and Hispanic origin, the terms Hispanic or Latino are used interchangeably. For consistency, the term Hispanic is used in this article.

†In June 2003, the Association of American Medical Colleges Executive Council adopted the following definition of UIM: "[UIM] means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." This article refers to medical providers who are underrepresented in the medical profession as UIM. The term was revised by the Association of American Medical Colleges from URM to UIM to include underrepresented groups based on changing demographics of society and the medical profession, rather than on race/-ethnicity alone. Available at: https://www.aamc.org/download/54278/data/urm.pdf.

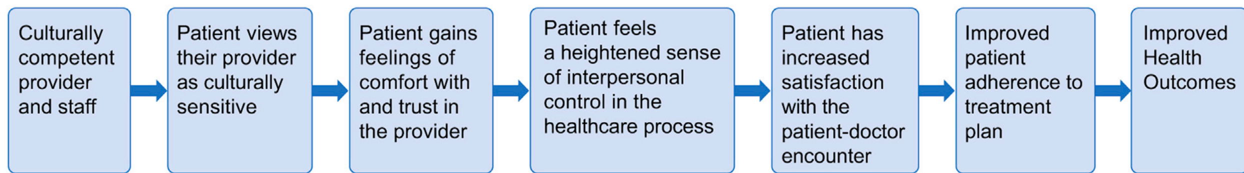



**Fig 1.** Cultural competence as part of a patient-centered approach to health care is more likely to improve health outcomes.

Culture, on the other hand, serves as a lens, or filter, through which an individual or group sees the world. Cecil Helman, South African physician, author, and medical anthropologist, provided a useful definition of culture:

> "A set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relations to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation—by the use of symbols, language, art and ritual."[19]

There have been many proposed definitions of cultural competence, all of which describe competence as the acquisition of knowledge, interactional skills, and innovation in order to provide quality health care to diverse populations.[20-22] It is also a set of skills that allow individuals to increase their understanding of cultural differences and similarities among, between, and within groups.[21-23] It is clear from this definition that patients and physicians/providers may have vastly different views of the world and different concepts of health and disease. A better understanding and appreciation of the individual patient's cultural values and health beliefs is an essential aspect of cultural competence.

Finally, the terms explicit and implicit bias describe negative attitudes toward a group of individuals that are formed consciously (explicit) or unconsciously (implicit). Implicit bias has been shown to influence clinical decision-making and patient—physician communication, which may lead to feelings of distrust by the patient, suboptimal treatment plans, poor compliance, and potentially worse health outcomes.[24-28] Much of implicit bias is a reflection of one's upbringing; the essential step is for the provider to recognize and then to manage this bias. There are many proposed methods to reduce implicit bias, including individually based concepts of self-awareness and skills training, as well as systems-based interventions (Table I).[24-41] Cultural competence training includes many of these elements. The reduction of implicit bias appears to be a promising approach toward improving patient—provider interactions and ultimately reducing health disparities. However, there is little evidence whether implicit bias training has long-term effects on reducing bias or health outcomes. In addition, the concepts behind implicit bias reduction may be difficult to translate into practical, concrete skills that can be readily used in a variety of clinical scenarios and patients.

## WHY IS CULTURE SO IMPORTANT TO HEALTH CARE?

The US population is an ever-growing and constantly changing body, with the 21st century bringing rapid change in the nation's diversity. From 2000 to 2012, population growth in the United States was driven almost exclusively by racial and ethnic minorities, particularly Hispanics, accounting for 91.5% of the nation's growth during this interval.[42] This growth will continue in the same direction during the next half century. By 2060, the nonwhite minority is projected to become the majority of the population (Fig 2). This has been termed the "majority-minority flip," and several states have already undergone this flip.[43] Recent reports have suggested an even earlier timeline, with the "flip" occurring nationwide as early as 2044.[13]

The ongoing transformation in demographics of the United States comes at a time of changing health care policy and funding models. The health care workforce, including the field of dermatology, has lagged in meeting the needs of the changing US demographics in both provider number and diversity. Moreover, URM populations have a significantly higher probability of being uninsured than the non-Hispanic white population, further limiting their access to care.[44-46] Even when surmounting the barrier of lack of access, URM populations tend to receive poorer quality of care and face communication barriers when receiving health care.[44-46] Compared to whites, Hispanics and African Americans experience more bias, stereotyping, prejudice, and clinical uncertainty on the part of health care providers.[44-46] Unfortunately, this often leads to poorer health outcomes.[46] For example, morbidity and mortality in melanoma and nonmelanoma skin cancer are worse for ethnic minorities, with a 5-year

**Table I.** Strategies to reduce implicit bias

**Individual approach—bias awareness and control**

Bias awareness strategies:
Strategy 1: Self-reflection activities to increase awareness of implicit bias
Participants complete an IAT and participate in an interactive feedback session.*
Bias control strategies:
Strategy 1: Reduce the activation of implicit associations
Examples: Seeking commonalities between provider and patient; stereotype replacement thinking; seeking individualizing information; perspective taking.
Strategy 2: Control how implicit associations influence judgment and behavior
Examples: Consider "gut" reactions as potential indicators of implicit bias; practice self-affirmation of egalitarian goals; consider the influence of emotion on bias.
Strategy 3: Engage in learning courses/skills workshops that improve patient—provider interaction, including cultural competence training
This can be merged with the RISK model of patient interviewing, as described in Table III.
Combined two-step strategy:
Step 1: Self-awareness strategy: Take the IAT and engage in an active, peer-based, feedback activity
Step 2: Bias control strategy: Acquire skills to reduce the activation and influence of implicit associations on clinical judgement and behavior

**Pros and cons of the individual approach**

| Pros | Cons |
|---|---|
| • May promote long-term reduction of bias (weeks to months)<br>• Works to control automatic responses to stigmatized patients<br>• Uses universal communication skills to improve patient—provider interaction<br>• The two-step approach proposes to be more effective than either step alone | • May induce defensiveness, feelings of blame, shame, and denial<br>• Requires active involvement, time, and engagement on behalf of the participant, which may be particularly difficult in a busy clinical or emergency setting<br>• Has yet to be rigorously tested in medical professionals, including its ability to induce long-term changes in implicit bias and health disparities |

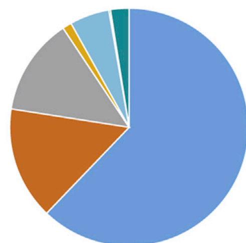
**Institutional approach—modify external factors influencing implicit bias**

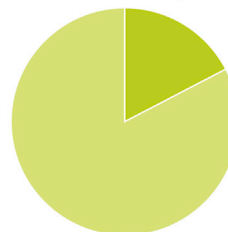
Increase multidisciplinary and multigroup contact
Strategy 1: Provide health care training that offers opportunities for positive contact across group boundaries (eg, interracial, intersexual orientation between student—faculty, patient—provider)
Reduce external factors influencing implicit bias
Strategy 1: Use strategies to reduce cognitive stress on providers, such as alleviating overcrowding, time pressure, and staff shortages, which have been demonstrated to increase implicit bias
Strategy 2: Provide clear treatment guidelines
Example: Implicit bias is more likely to influence patient outcomes when provider decisions are made without the benefit of clear guidelines.

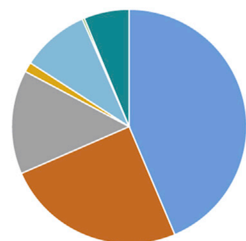
**Pros and cons of the institutional approach**

| Pros | Cons |
|---|---|
| • Encourages positive interaction across groups, disciplines, and levels of training<br>• Focuses on reducing external factors that may influence implicit bias, as opposed to relying solely on the mindfulness and individual training of the provider | • Increasing positive interaction across groups is a nonspecific parameter and may not be easily implemented or measurable<br>• System-wide changes can be costly, impractical, and time-consuming |

*IAT*, Implicit Association Test.
*A computer-based system to measure automatic associations between concepts. Tools for self-evaluation of implicit bias can be found at Project Implicit (https://implicit.harvard.edu/implicit/takeatest.html), which contains tests to assess a variety of biases, including race, sex, and sexual orientation.



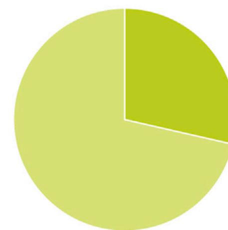




**Fig 2.** Projected majority-minority "flip" is likely to occur by 2044. *White (other) may represent Hispanic or Latino origin, although Hispanic ethnicity itself is not considered a race. Data from Colby and Ortman.[13]

melanoma survival rate for African Americans of 69% compared to 93.6% for whites.[47,48] Although nonmelanoma skin cancer is less common in ethnic minorities, these patients tend to present at later stages of disease, leading to worse outcomes.[47,49] This may be partially accounted for by poor access to health care, uninsured status, and patient mistrust of the health care system.

Aside from social factors and linguistic barriers, inadequate levels of cultural competence of providers and a lack of providers who are UIM are important factors for health care disparities.[44-46,50] It has been well documented that physicians managing culturally/ethnically unfamiliar patients are more likely to take a more conservative course of action with their patients, potentially compromising quality of care. For example, one study found that African American patients were less likely than white patients to receive noninvasive cerebrovascular testing, cerebral angiography, or endarterectomy for neurologic abnormalities, even when the clinical presentations of both groups were equal.[51] Another study that surveyed emergency medicine and internal medicine residents demonstrated implicit bias, with lower likelihood of these physicians to treat African American

**Table II.** Cultural competence education resources

| Program | Name/type | Access | Description |
|---|---|---|---|
| Online resources for obtaining and providing cultural competence training | | | |
| AAMC | TACCT | https://www.aamc.org/initiatives/tacct/ | • PDF and Excel versions of TACCT<br>• Resources for training |
| AETC-NMC, Howard University College of Medicine | Cultural competency in the management of HIV/AIDS | http://www.aetcnmc.org/index.html | • Case studies<br>• Tutorials<br>• Online training<br>• Self-assessment |
| | Translation toolkit for healthcare professionals | http://www.aetcnmc.org/translate.php | • Translation services/resources<br>• Plain language/health literacy<br>• Medical dictionaries<br>• Materials in other languages |
| | AETC-NMC online curricula series | http://www.aetcnmc.org/curricula/index.html | • Online modules<br>• Focus on substance abuse, mental disorders |
| CDC | Health literacy training | http://www.cdc.gov/healthliteracy/GetTraining.html | • Online modules in health literacy, plain language, culturally based communication<br>• Free printable materials |
| | Health literacy, cultural competency, and sustainability | http://www.cdc.gov/getsmart/community/improving-prescribing/program-development-eval/health-literacy.html | • Easily accessible resources in health literacy, cultural competency, and sustainability |
| | Program evaluation tip sheet: integrating cultural competence into evaluation | http://www.cdc.gov/dhdsp/docs/cultural_competence_tip_sheet.pdf | • Tips to ensure cultural competence in evaluation of public health programs |
| Office of Minority Health, Department of Health and Human Services | A physician's practical guide to culturally competent care | https://cccm.thinkculturalhealth.hhs.gov/ | • Online free course<br>• Small group learning materials |
| Health Resources and Services Administration, Department of Health and Human Services | Culture, language and health literacy | http://www.hrsa.gov/culturalcompetence/index.html<br>http://www.hrsa.gov/culturalcompetence/race.html | • Resources specific to ethnicity, race, sex, immigration or refugee status, and LGBT, HIV/AIDS, and homeless communities |
| Ethnomed | Integrating cultural information into clinical practice | https://ethnomed.org | • Medical and cultural information about immigrant and refugee groups<br>• Online education, videos, newsletters, patient education |
| National Center for Cultural Competence | Georgetown University Center for Child and Human Development | http://nccc.georgetown.edu/distance.html | • Online training curricula, self-assessment tools<br>• Information for organizations, providers, faculty, and families |

| | | | |
|---|---|---|---|
| TARGET Center: Tools for the Ryan White Community (HIV/AIDS) | BE SAFE MODEL, National Minority AIDS Education and Training Center | https://www.careacttarget.org/library/besafe-cultural-competency-model | • BE SAFE MODEL for cultural competence individualized to race<br>• BE SAFE: Barriers to care, ethics, sensitivity, assessment, facts, encounters |
| The Cross-Cultural Health Care Program | Nonprofit consulting organization | xculture.org | • On-site training and assessments<br>• Medical interpreter training<br>• Licensing new cultural competence trainers |
| **Key reports and information on cultural competence, health disparities** | | | |
| American Hospital Association, Institute for Diversity in Health Management | Becoming a culturally competent health care organization | http://www.hpoe.org/resources/hpoehretaha-guides/1395<br>http://www.hpoe.org/Reports-HPOE/culturalcompetentorgslides7.2011.pdf | • Guide for enhancing cultural competence in health care<br>• Self-assessment checklists<br>• List of National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care |
| Department of Health and Human Services, Agency for Healthcare Research and Quality | 2015 National Healthcare Quality and Disparities Report | http://www.ahrq.gov/research/findings/nhqrdr/nhqdr15/index.html | • Report of national health care quality and disparities<br>• Priorities of the National Quality Survey |
| The Commonwealth Foundation | 2004 report: disparities in patient experiences, health care processes, and outcomes | http://www.cmwf.org/programs/minority/cooper_raceconcordance_753.pdf | • Review of selected studies on care of underserved populations<br>• Discussion of race and language concordance between physicians and patients |
| AAMC | Cultural competence education guide | https://www.aamc.org/download/54338/data/culturalcomped.pdf | • Various example curricula with resources for cultural competence training |
| Kaiser Family Foundation | Disparities in health and healthcare: 5 key questions and answers, 2016 | http://kff.org/disparities-policy/issue-brief/disparities-in-health-and-health-care-five-key-questions-and-answers/ | • Questions answered:<br>1. What are health and health care disparities?<br>2. Why do health and health care disparities matter?<br>3. What is the status of disparities today?<br>4. What are key initiatives to address disparities?<br>5. How was the ACA affected health coverage disparities? |
| CDC | Practical strategies for culturally competent evaluation | http://www.cdc.gov/dhdsp/docs/cultural_competence_guide.pdf | • For public health program staff and evaluators<br>• Six steps to evaluating public health programs and initiatives from a cultural competence perspective |

*AAMC*, Association of American Medical Colleges; *ACA*, Affordable Care Act; *AETC-NMC*, AIDS Education and Training Center National Multicultural Center; *CDC*, Centers for Disease Control and Prevention; *TACCT*, Tools for Assessing Cultural Competence Training; *LGBT*, lesbian, gay, bisexual, and transgender.

patients with thrombolysis in acute coronary syndrome and unconsciously perceiving African Americans to be less cooperative than their white counterparts in simulated clinical vignettes.[52] Further studies on implicit bias have shown that clinicians are more likely to have negative attitudes toward African Americans, Latinos, and Native Americans than whites, as well as towards patients that are overweight/obese, gay or lesbian, or of low social status.[26] Specific to dermatology, a study analyzing the use of isotretinoin in patients with acne found that white patients were 1.8 times more likely than African American patients to receive isotretinoin for acne.[53]

To target these health disparities, inclusion of cultural competence training should be considered when planning medical educational programs. Coordinated efforts to increase representation of UIMs in dermatology will broaden the cultural landscape of our specialty. It is well recognized that physicians from URM groups are more likely to care for URM patients, accept Medicaid insurance, and practice in underserved areas.[1,5]

Ultimately, cultural competence is important to quality patient care and improved health outcomes. Most importantly, cultural competence is central to the basic principles of professionalism, particularly the requirement for a physician to be sensitive to an individual patient's needs.

## HOW DOES ONE IMPROVE CULTURAL COMPETENCE?

Improving cultural competence can be achieved in various ways, including attending didactic lectures, observing highly competent role models, immersion in culturally different clinics and communities, workshops, presentations, and conferences.[54,55] Evaluation can be performed by observed structured clinical examinations, role playing, and survey-based assessment of knowledge, cultural sensitivity, and respect for those affected by health disparities. Table II lists several sources for dermatologists to receive cultural competence education.

Cultural competence can also be implemented on the systems level, including providing check-in procedures, materials, and translators that tailor to multiple cultural styles and languages. The Association of American Medical Colleges and Accreditation Council for Graduate Medical Education have acknowledged the importance of cultural competence as a means to reduce health disparities and the duty of physicians to engage in culturally responsive care. These organizations now promote this type of training for medical students and residents.

The Association of American Medical Colleges has provided 4 recommendations for assessing cultural competence training programs: (1) the need for rigorous research to develop curricula and evaluate outcomes; (2) the selection of measurable curriculum goals; (3) alignment of curriculum development, evaluation, and assessment; and (4) applying methodologic rigor to assess curricular effectiveness.[54] Development and implementation of cultural competence educational programs and assessment tools should be considered by medical schools, training programs, and specialty societies.

While each patient must be approached as a unique individual, it is ultimately unrealistic to learn all cultures. Instead, the clinician can practice cultural competence by establishing basic principles and attitudes toward patient-centered care, with a special focus on the patient interview.[55-57] Kagawa-Singer et al[58] identified an approach to improving cultural competence in the patient interview, known as the resources, individual identity, skills, knowledge (RISK) model (Table III).[58] This easy to remember mnemonic includes defining resources available to the patient, clarifying the self-proclaimed individual identity of the patient, identifying skills possessed by the patient in navigating the health care system, and acquiring knowledge of a specific ethnic group's cultural norms. For example, are the health-related behaviors and decision-making methods family- or individual-centered? Are beliefs about illness founded on the historical, social, or political issues unique to that ethnic group?

Separate from the physician—patient encounter, the dermatologist may improve his or her cultural competence by volunteering at ethnically/racially diverse hospitals or clinics, immersion in the local community by attending cultural performances and festivals, as well as reading books and watching movies about a culturally different population in his/her community and even learning common greetings in different languages. Although these experiences may give limited insight into a culture, they provide a common point of conversation that can help break down barriers between a dermatologist and his/her patient and establish rapport. They may also increase a provider's insight into cultural views on health, healing, and disability.[59] In addition to involving the patient and family in culturally competent care, when health care providers, hospitals, and health care organizations get to know the patient's community and its culture,

**Table III.** Cultural competence in the workplace: Using the RISK model to guide clinical practice*

| Term | Provider action | What to ask about/learn | Example questions |
|---|---|---|---|
| Resources | Identify resources available to patients and families | Education<br>Insurance<br>Social Support<br>Transportation<br>Grocery shopping | Do you know others in your community who have faced similar difficulties? |
| Individual identity | Identify the personal identity and acculturation of the patient† | Individual circumstances<br>Immigration status<br>Languages spoken<br>Degree of integration within ethnic community | In what language are you most comfortable talking?<br>What are the most important concerns you have about your illness? |
| Skills | Identify skills available to the patient and their family to adapt to disease requirements | Ability to navigate the health care system<br>Ability to cope with the disease physically, emotionally, socially, spiritually | Who is there to help you (with transportation, the physical demands of the disease, child care)?<br>Where do you go for (spiritual) support or comfort? |
| Knowledge | Acquire knowledge about the patient's ethnic group, including health beliefs and practices | Attitudes toward illness<br>Communication etiquette<br>Decision-making practices: individual or family-based<br>Gender roles<br>Pertinent historical/political issues<br>Religion | Who is the head of the household?<br>Who would you like us to discuss your health with?<br>Do you use any complementary or alternative medicine? |

Adapted from Kagawa-Singer and Kassim-Lakha.[58]

*The RISK model is an effective tool to deliver culturally sensitive care to the patient. It involves identifying key strengths of the patient and culturally specific barriers to receiving adequate health care and treatment.

†The process by which cultural groups adopt the customs and behaviors of a new culture; most commonly cultural change from the place of origin to the host society.

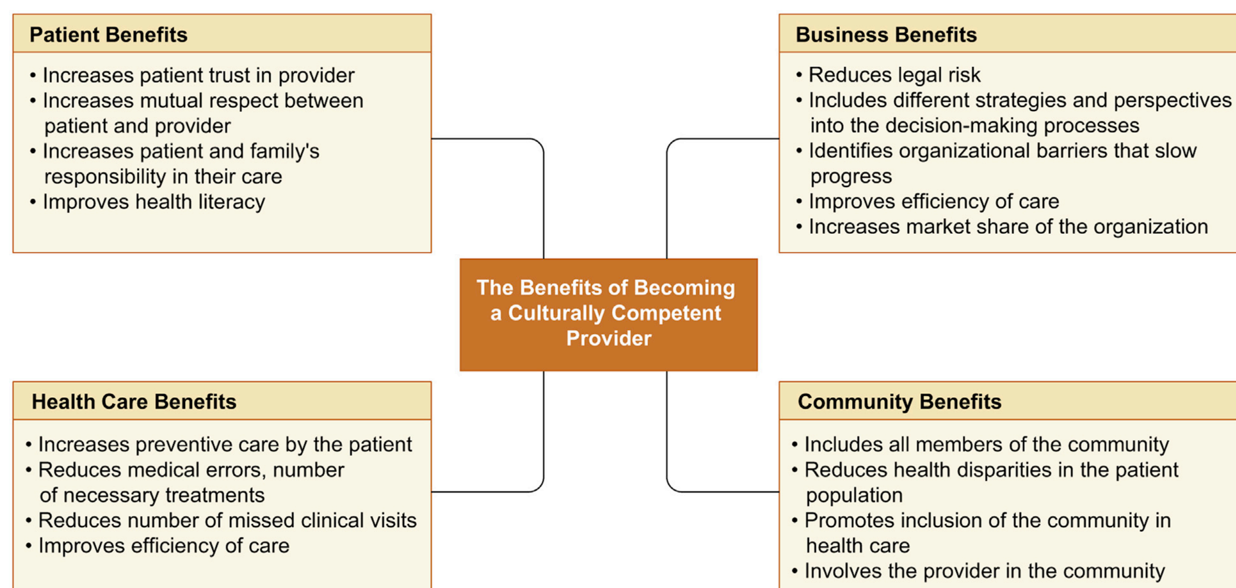



**Fig 3.** Benefits of cultural competence. Adapted from the Health Research & Educational Trust.[60]

this reaps benefits for all stakeholders, as shown in Fig 3.[60]

In conclusion, evidence is mounting that cultural competence, or the ability to integrate a patient's culturally based beliefs and behaviors with health care delivery, is critical to providing the best medical care and decreasing health care disparities. These concepts are even more important in the 21st century, during which time our population will become more diverse than ever. Paying attention to cultural differences and improving cross-cultural expertise can help a dermatologist improve patient compliance and satisfaction. Increasing diversity in the specialty of dermatology, while at the same time improving the cultural awareness of all dermatologists, is an ideal approach to addressing this important issue.[5]

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