Health Professions Student Education in Cultural Competence

By

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Abstract

Disparities in health outcomes exist between patients of color and lower socioeconomic standing and White upper and middle-class patients. There also exists a long history of discrimination toward patients in the former categories and a predominantly White health care workforce. To address these disparities and discrimination, the idea of educating the healthcare workforce in cultural competency was developed (Cross, Bazron, Dennis, & Isaacs, 1989). Cultural competency education was implemented into professional health care training curriculum starting in the late 1990's. The idea of being "competent" in any aspect of health care is not considered instantaneously achievable and instead, is achieved slowly, with study and practice, over time (Axley, 2008). Several qualitative studies examining cultural competency education exist within the literature. These studies generally do not contain any specific information regarding a standardized curriculum or accepted definition of cultural competence. No studies evaluate or examine learning from the student perspective. Narrative inquiry, a qualitative methodology which examines stories of both individual and collective experience, contextualized within social spaces, over time, respects and honors the stories of the participants while providing the researcher with new knowledge and understanding (Clandinin, 2013; Clandinin & Connelly, 2000). Using narrative inquiry to examine these learning experiences, as told in the students' own voices, may provide new understandings of how White health professions students engage in learning about cultural competency.

CHAPTER ONE:

INTRODUCTION

Introduction

To address the disparities in positive health outcomes between patients of color and low socioeconomic standing and White middle and upper- socio-economic class patients, health care organizations and professional health care education programs have sought to improve communication between health care providers and diverse groups of patients by teaching cultural competency (Brach & Fraserirector, 2000). The need to improve the cultural competency of the healthcare workforce and healthcare professions students has become more urgent in the last decade as government organizations such as the U.S. Department of Health and Human Services have begun to focus on holding health care organizations accountable for how patients are treated, especially those in marginalized racial and cultural groups. Government insurance payments (Medicare and Medicaid) to health care organizations now have become partially dependent on positive feedback from patients on their overall experience in the health care setting. Surveys of patient experience include questions about treatment and communication in all dimensions of the health care experience in the institution at which they received care. Specifically, patients are asked whether they felt that the health care workers treated them with respect and understanding and communicated effectively across cultural and linguistic differences (U.S. Department of Health and Human Services, 2017). Even with the increased attention on educating the health care workforce to provide culturally competent care, creating and delivering curriculum that may be effectively shown to improve communication and understanding between a mostly White health care workforce and patients of color, continues to be a challenge (Alexander, 2009; Chapman, Katz, & Carnes, 2013).

Among the many challenges in creating an effective cultural competency curriculum for healthcare professionals and pre-professional health care students, is that there is no consensus on an accepted definition of cultural competency, nor are that there are any reliably accepted standards or guidelines for curricular development. Additionally, the research methods with which the existing curriculum has been examined, have been limited to the use of a single, validated, self-reported test which gives quantifiable results (Kardong-Edgren, et al., 2010; Pilcher, Charles, & Lancaster, 2008; Shattell, et al., 2013) and a few studies which use very generalized qualitative methods (Durand, Abel, Silva, & Desilets, 2012; Hawala-Druy & Hill, 2012; Shattell, et al., 2013). The single validated test that is used to quantify cultural competency asks students to answer several questions based on general characteristics of patients based on their identity that includes race, gender, religion. The test does not account for differences in communication between patients and health care providers which may be influenced by intersecting aspects of patient plus provider identities (Campinha-Bacote, 2010). No studies include a practical assessment of students' abilities to demonstrate culturally competent care, nor a definition of which abilities should be included in the definition of cultural competence. This omission is particularly significant since the achievement of competency in any discipline of health care, includes the ability to demonstrate a practical skill in the clinical setting. To achieve competency, a student must first have a cognitive understanding of the theory behind the skill and then apply the theory to the psychomotor learning domain until the expected skill may be demonstrated consistently (Axley, 2008). The idea of achieving cultural competency is further complicated by the fact that all culture is situated in society, where certain cultures are privileged over others (Apple, 1995) and communication between patients and providers may be affected by any number of intersecting aspects of identity and inherent biases

on either side (Carnes, et al., 2012; Chapman, et al., 2013). The use of quantitative research to study cultural competency, which provides only numeric data, is not able to acknowledge or address questions of how students learn, only how much they may have learned about general characteristics of certain populations. Memorizing quantifiable and general facts about populations of people has the added risk of reinforcing negative stereotypes and exacerbating issues related to inherent bias (Fulbright Sumpter & Brooks Carthon, 2011). An attempt to quantify learning for any type of competency is also problematic as the consensus for determining competency in healthcare includes a requirement for the student to exhibit the abilities necessary to perform a task. Since there may be significant individual variation within the accepted performance standards, this makes numeric grading of competence very subjective in nature (Axley, 2008). Generalized qualitative methods, which in these studies, are only defined enough to say that they do not include quantitative statistics and that the results were "positive or negative" (Durand, et al., 2012; Hawala-Druy & Hill, 2012) lack the rigor needed to uncover data that may lead to an increased understanding of how students learn in this area (Crotty, 1998). It is for these reasons that a study of how students learn about cultural competency in health care would benefit from the use of narrative inquiry as a specific qualitative methodology.

Narrative inquiry has evolved as a qualitative methodology within the larger area of narrative analysis. Specifically, narrative inquiry focuses on examining stories of individual experience situated within larger social, cultural and institutional narratives (Clandinin & Connelly, 2000). Narratives may be gathered in many ways, including observing, listening and interpreting texts or writing. Narrative inquiry is especially useful for studying experiences that are unique, based on individual experiences in specific social settings and contexts (Clandinin,

2013; Coles, 1989; Mattingly & Garro, 2000). Although narrative inquiry has not been used to study health professions students' learning experiences, it has been used in other areas of health care to examine patient and physician experiences with illness and healing and situational bioethics (Charon, 2003; Coles, 1989; Mattingly & Garro, 2000; Nelson, 1997). Narrative inquiry is especially valuable in that the readers of the research learn about experiences first-hand, as told by the participants, which may reveal nuanced and complex experiences without which more subtle themes may not otherwise emerge. Since stories may reveal different aspects of understanding to different readers, narrative inquiry is not limited strictly to the analysis rendered by the researcher and may continue to offer new insight to the same researcher and other readers, even after the initial analysis is complete (Clandinin, 2013; Nelson, 1997). Narrative inquiry may be especially valuable in studying stories that take place over longer periods of time and are complicated by social settings and the intersecting aspects of the identities of the individuals who are involved (Cole & Knowles, 2001). In this research, where much learning occurs in the experiential realm, narrative inquiry gives space for students to relate feelings, thoughts and complex musings as they relive experiences in both the social and professional settings that impact their understanding of cultural competence. Given the lack of a standardized curriculum in cultural competency and the experiential nature of achieving competency in health care and the complexity of cross-cultural communication between health care providers and patients, narrative analysis may provide new insight into student engagement and learning in this area. An analysis of the narratives of health professions students who are learning about cultural competency has the potential to give a more complete and accurate understanding of the evolution of learning of students in this contested and complicated area. The information revealed in these student narratives may provide educators, current healthcare

professionals, health care administrators and patients with a better understanding of the complications and challenges presented in teaching and training a White health care workforce in cultural competency.

This study involved collecting narrative accounts from healthcare professions students at different stages of their professional curriculum. A narrative for each student was composed through interviews, participation in discussions and the completion of assignments that involved the examination of issues stemming from diversity, discrimination and health disparities within health care. This research attempts to understand how students engage, resist and assimilate formal classroom learning in cultural competency in the context of their own lived experiences, epistemology and ontology (Clandinin & Connelly, 2000). A constructivist perspective and critical theoretical lens were used to evaluate the student narratives as they included discussions surrounding how the participants learn to interact and communicate with patients based on their understanding of difference and situated within the context of each student's lived experiences. The thoughts, feelings, and identities of the patient and the care giver in health care situations make for individualized and unique interactions that are never precisely replicable. Additionally, the narratives revealed in the interviews were constructed in the context of the teacher and student dynamic. Although I did not teach any of the courses in which assignments were collected or discussions recorded, I was the director of the educational program at the time of the interviews. This study is informed by Critical Race Theory (CRT). CRT relates to critical theory which involves the identification and exploration of situations through a lens that closely examines power inequity and hegemony in given situations and relationships (Apple, 1995). The use of CRT to inform this study is essential for three reasons. First, the history of western medicine and health care is full of examples of discrimination and exploitation of vulnerable

groups of people, especially people of color. The context of patient and health care provider interactions in American culture is one in which there is an ever-present power difference which favors the educated healthcare professional, who is very likely to be White. This history and the power inequity have shaped a present system in which many patients, especially people of color, are reluctant to seek out or trust the advice of predominately White health care professionals (Fiscella, et al., 2002). Second, the power inequity and the identities of the patient and health care provider have a significant influence on whether interactions are positive or negative within the health care setting, which in turn, impacts health outcomes. Last, all student participants in this study identify as White and grew up in areas in which Whites were in the majority. The students are all engaging with learning in this area from a dominant racial perspective as White people are overrepresented in health care, in the United States (U.S. Department of Health and Human Services, 2017). The theory of intersectionality found within critical race theory is an important one in which to consider the White student narratives (Crenshaw, 1991). Intersectionality is a specific component of critical theory that illustrates constructed experiences that are influenced by multiple dimensions of an individual's identity, including, race, gender and socio-economic status (Crenshaw, 1991). In health care, the patient is almost always in a vulnerable position, seeking the help of the health care providers for diagnosis or treatment and being in various stages of illness, injury or pain. For patients of color, low socioeconomic status, low health literacy levels, alternative gender identification or any other non-dominant social identity, the power differences that already exist in health care interactions are further magnified by the intersecting aspects of both the identity of the patient and health care provider. Health care experiences are constructed and outcomes influenced by a combination of these factors.

The intersections of race, gender and socio-economic status influence and complicate negotiations that occur in sensitive and emotional settings such as healthcare.

Participants and Data Collection

This study includes transcripts of semi structured interviews, writings and video observations of discussions for twenty-one healthcare professional students in various stages of their two-year healthcare professional curriculum. All students identified as White, between the ages of 20 and 30 years and native to the state in which the training program was situated. Eighteen of the twenty-one students reported spending most of their lives in small cities or towns of 25,000 people or less. The healthcare profession training program in which the research was conducted is one that is situated in a large academic health care organization and in which students attain a baccalaureate degree upon graduation. Students attend didactic classes two, eight-hour days, per week and learning in the clinical setting on the other three days of the week, for eight hours each day. The didactic and clinical curriculum focus largely on healthcare profession specific information and students are prepared in the cognitive, affective and psychomotor learning domains to become competent to perform a wide variety of examinations and procedures on patients in many different health care settings, including inpatient, outpatient, urban, rural and speciality clinics. Portions of the didactic curriculum that concern teaching student about patient interactions and communication in the clinical setting or medical ethics, contain assignments that require the students to engage in learning about how diversity, culture and a history of medical discrimination may impact the ability of White healthcare professionals to provide care and communication that is culturally appropriate based on the identity of the

patient. The assignments in which the students participated for this study include, 1) watching the documentary and writing a reflective paper on the film, *Miss Evers' Boys*, (Sargent, 1997), which examines the Tuskegee Syphilis Experiment from the perspective of the African American nurse who was hired to recruit subjects into the study, 2) reading and discussing in class, the book, *The Man with the Iron Tattoo*, (Castaldo & Levitt, 2007), which contains short stories told from the viewpoint of the physician as he or she engaged in caring for diverse patients, 3) viewing and writing a reflective essay regarding the documentary film, *Sicko*, (Moore, 2007), which examines the state of health care in America, including how people live with the complications of being ill and lacking health insurance or access to quality services, 5) reading and discussing in an asynchronous online format and in class, the book, *Amazing Grace*, (Kozol, 1995) which profiles stories of children and their families who live in the poorest neighborhoods in the South Bronx, including their struggles to access healthcare and 6) viewing and writing a reflective essay on the documentary *Worlds Apart* (Maren Grainger-Monsen & Haslett, 2003), a documentary which profiles several actual patient and health care provider interactions where the healthcare professionals and patients identify as culturally different from one another.

The interviews were semi-structured, between 15 and 20 minutes in length and took place in my office which is in the same area and building as the classrooms. I personally conducted all the interviews and asked all students the following questions:

1. What does cultural competence mean to you?
2. How have you learned the most about cultural competence, both within and outside of a classroom?

3. Which experiences or courses do you believe have helped you learn the most about being culturally competent?

Data was assembled into a single file for each student, rendering an individual student narrative that included the writing assignments, interview and notes on the student interactions during the classroom discussions.

Analysis

The narratives were analyzed and coded for major themes and the data was triangulated within each narrative and examined for validity. Themes within the narratives were revealed through three cycles of open coding, including, In Vivo, Versus and Emotion coding. In Vivo Coding involves identification of the participant's actual words (Saldana, 2013). I chose to use In Vivo Coding in the first cycle of open coding because I wanted to identify the participants' language in describing learning activities as well as capture their definitions of cultural competency. The frequent use of the word "different", across the narratives, prompted the use of Versus Coding as the second cycle of open coding. Versus Coding is promoted for use in critical studies since it may be helpful in identifying power relationships (Saldana, 2013). The frequent use of "different" was contrasted with the infrequent use of the word "same", to identify subconscious references to power relationships that the students had negotiated in their lives. The emergence of emotion relating to the topic of race prompted the use of Emotion Coding. Emotion coding aids in identify the presence of emotion associated with specific themes (Saldana, 2013). Emotion was coded through inflections, lengthy pauses or excessive prompting within the class discussions and the interviews. Students became emotional, specifically

embarrassed or ashamed when they discussed witnessed events or attitudes regarding diversity, difference and particularly race, in the towns in which they grew up. The same emotions were present when discussing their lack of experience with racially or ethnically different people. The major themes that were revealed, after coding the narratives, included: 1) cultural competence was defined differently by all students, 2) many of the assignments and interviews contained references to race and ethnicity, however, students were very uncomfortable and avoided discussing race and ethnicity in regards to cultural competence, 3) the students that were most resistant to learning about cultural competence had very few or no lived experiences with people of different races or ethnicities, 4) a range of emotions were present during discussions or writings concerning topics involving racial or ethnic differences. These themes have directed the organization and content of this dissertation. The following chapters explore cultural competence as a contested concept, the value of using narrative inquiry to research student learning and engagement with cultural competence, using a critical lens, informed by critical race theory in which to view the history and landscape of western health care and a deeper dive into the themes that arose in the narratives, in the students' own words. The conclusion summarizes key findings and learnings that may be valuable in the evaluation of cultural competency education in healthcare.

CHAPTER TWO:

CULTURAL COMPETENCE: A CONTESTED LANDSCAPE

Cultural Competence: A Contested Landscape

The idea of teaching White health care providers to be culturally competent emerged in in the late 1980's as a potential solution to mitigate disparities in health outcomes between White patients and patients of color. Bias, racism and historic discrimination against patients of color have resulted in a medical system in which the power inequity between predominately White healthcare professionals and patients of color results in inequitable treatment and poor health outcomes that disproportionately affect communities of color (Ahmed & Bates, 2017). However, in the two and half decades since cultural competency education was introduced in healthcare education, to improve communication and understanding between health care providers and diverse patients, it has failed to have demonstrated any significant impact on improving the disparities (Brown, O'Rand, & Adkins, 2012). The failure of cultural competency education to accomplish the goals it was intended to is likely due to several factors, including: 1) a lack of consensus in defining the concept of cultural competency, 2) the lack of a standardized curriculum or learning objectives or practical skill assessment for cultural competency, 3) lack of discussion and acknowledgement of the inherently biased and discriminatory nature of medicine and healthcare as a context for the concept and 4) the lack of research in how professional health care students engage with learning about cultural competency. Defining cultural competency in practice and behavior has not been accomplished. Although some have sought to define standards associated with educating health professions students (Marion, et al., 2017), the standards are not associated with the evaluation of competence, or a student's demonstration of the behaviors, communication style and interactions in the clinical setting (Axley, 2008). Additionally, the literature reveals no studies on the topic that consider the idea that White students are attempting to become culturally competent within the context of a health

care system that is full of examples of reinforcing racism in structure, policy and organization. Therefore, what it means and what it looks like to be a culturally competent healthcare professional remains a contested concept.

Cultural Competence Framework and Landscape

Cross et al. (1989) were the first to develop the concept and definition of cultural competence. Cross et al. (1989), defines cultural competency as "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). Absent from Cross, et al.'s definition of cultural competence is the specific mention of what the congruent behaviors, attitudes or policies are supposed to look like. The concept of competence in health care occupations and professions is usually one that comes with a well-defined set of expectations and criteria regarding psychomotor skills that must be observed and evaluated in the clinical setting. Axley (2008), states that competency should include "a behavior or series of actions that can be demonstrated, observed and assessed." Learning to be competent, in any discipline, is about gaining the experience necessary to apply theoretical knowledge to the performance of a practical skill (Axley, 2008). In most health care professions education programs, at least half of the students' learning time is spent in achieving competency in clinical procedures and examinations. Achieving competency is an act which relies heavily upon varied individual experience and happens at different times for any student, in that it involves both learning about a topic or procedure and then being able to connect the theoretical learning with tactile ability (Jeffreys, 2006). Competency is not considered

something that is instantaneously achievable, but instead something that is only accomplished through reflection and practice, over time (Axley, 2008; Brach & Fraserirector, 2000). Competency is judged primarily through qualitative assessments (i.e., did the student perform the exam independently or with some assistance? How could the student improve his or her skill in performing this procedure?). Additionally, serial evaluations may be required at regular intervals to verify that an individual has indeed achieved competency through consistency (Axley, 2008). Given the definitions of cultural competency and competency present in the literature, a more complete definition of cultural competency could be understood as the ability of healthcare professionals and pre-health care professions students to demonstrate the ability to provide in culturally appropriate communication and care to patients who are racially or ethnically different from themselves (Axley, 2008; Cross, et al., 1989). Although more complete, the definition above still lacks an illustration of exactly what culturally competent care looks and sounds like. Related definitions and other terms such as cultural congruence, cultural sensitivity and cultural relevance have all emerged in the wake of cultural competence to define behaviors associated with providing equitable care to patients from a range of racial and ethnic backgrounds. While the definitions of all the terms above are generally similar, cultural congruence is defined specifically as, providing care that is in alignment with the beliefs and worldviews of the patient (Marion, et al., 2017). The literature concerning this term is also devoid of characterizing exactly what this type of care looks like and how students or healthcare professionals should demonstrate their competence in this area.

Much of the literature on cultural competency education in the health professions includes lessons for White students on general characteristics, including world views, preferences and religious beliefs, associated with various racial and ethnic groups. There is a

twofold problem with attempting to promote cultural competence from this perspective. First, an increasingly multicultural population means that there are more people (and patients) who identify with more than one race or ethnicity and worldview therefore, learning about various racial and ethnic identities in a mono-cultural sequence is no longer relevant or useful. Even if a list of characteristics could be learned and memorized, students still would have no direction on what providing culturally competent care to these diverse groups of patients should include. Second, learning about generalized characteristics connected with race and ethnicity may result in the reinforcement of stereotypes, which in turn reinforces inherent biases. Inherent bias, which is also referred to as unconscious or subconscious bias, is when pre-existing attitudes and feelings about a group or groups of people, many times based on race or ethnicity, affect or determine the actions and reactions of the person holding the bias (van Ryn & Burke, 2000). This is another issue that is very difficult to address through education. Simply telling a student that they should attempt to not act based on biases that they may or may not acknowledge or understand does nothing to address the root of the issue, which is the bias itself. Biases are often formed by experiences and learning that happens outside of the classroom. Biases are also reinforced by society through many avenues such messages in the media and policies or structures which have supported attitudes, racism and discrimination against people who do not conform to the dominant narrative (Ahlquist, 1991). There are a multitude of examples in the literature of biases in medicine and healthcare both historically and into the present. While this context is explored in greater depth in the following chapter, here it is worth mentioning that there are several examples of approaches to cultural competence education that are based on historical biases on the part of the dominant White male narrative. One such example is the approach to providing cultural competence education to White healthcare professionals that

addresses barriers to quality healthcare that include learning cultural characteristics, "cultural limitations" of health care assessment and "cultural specific diseases" (Pilcher, et al., 2008). The problem with this type of approach and the use of the language above, is that puts the burden of responsibility for the health disparities on the patients and populations which are experiencing the most negative effects and worst outcomes. There is no acknowledgement in this approach to cultural competence education that the disparities are in any way the fault of an inherently biased, structurally discriminatory and mostly White healthcare workforce. If the system in which cultural competence education is supposed to be addressing disparities is biased in its policies, operations and procedures, and, the approach to providing cultural competence education is also biased, then why should we expect cultural competence education to have any positive effect on healthcare providers interactions with patients, except to reinforce negative experiences for the patients themselves?

There are a few examples within the literature that acknowledge the issues of bias and structural discrimination that are present in healthcare. The concept of organizational cultural competence, or, the development of a workforce that is demographically representative of the nation's population has been posed as a solution that may support the healthcare industry in promoting cultural competence (Betancourt, et al., 2003). These studies have shown that when healthcare providers are the same race or ethnicity as their patients, communication and understanding are improved and health outcomes may also be improved (Langer, 1999). Within this concept it is also suggested that there should be representation of people of color at all levels within healthcare, including administrators, managers and other leaders who can ensure that the policies and operations of a healthcare organization are equitable for patients of all races, ethnicities, genders and worldviews. What is not present in the literature, regarding addressing

organizational cultural competence is how a more diverse workforce may also positively influence White healthcare professional learning. If White healthcare professionals can be guided and learn about other communities and people from their peers and colleagues, instead of their patients, with whom there always exists a power differential, might this not have a greater impact on addressing inherent biases? Since most students included in this study expressed that they had learned more about people who are different from themselves through experiences outside of the classroom and building relationships, the idea that addressing organizational cultural competence could have a significant positive influence on the learning of White healthcare professionals is promising.

Cultural Competence Standards in Healthcare Professions Education

Formulating an agreed upon framework for cultural competence and the related concepts has been difficult. Agreement upon the idea of cultural competence, specifically how it should be defined and what should be included in the curriculum and evaluation, has not occurred. This makes it also difficult to agree upon the standards, criteria and guidelines that should be taught to healthcare professionals. Healthcare professionals in all disciplines agree that providing culturally competent care is something that should be addressed through education and practice, however, each discipline has developed their own professional statement, standards or competencies connected with achieving slightly different goals, in this respect. Betancourt, et al. (2003) produced much of the early work in defining a framework and standards for cultural competence within the medical community and specifically for physicians and medical students. Betancourt, et al., (2003) propose a framework that specifically addresses socio-cultural barriers

to care at all levels of the healthcare industry, which includes the workforce through organizational cultural competence (Betancourt, et al, 2003). Betancourt et al.'s work is cited heavily within the standards and competencies composed for Cultural Competence Education (2005) by the Association of American Medical Colleges (AAMA), one of the largest healthcare professional organizations, which dictates the curriculum and accreditation requirements for all U.S. medical schools. The AAMA standards for cultural competence education are some of the most prescriptive and require addressing education and measurement of student learning in three major areas of attitudes, knowledge and skills and creating curriculum that specifically addresses five learning domains, including, the rationale, context and definition of cultural competence, key aspects of cultural competence, understanding the impact of stereotyping on medical decision-making, understanding health disparities and factors influencing health and understanding cross-cultural clinical skills. The report states that students should be evaluated both quantitatively and qualitatively for learning in the areas and domains. The AAMA's report also includes a blueprint for the curriculum development and assessment of cultural competence education, the Tool for Assessing Cultural Competence Training (TACCT) and specifies that medical schools will be evaluated on their use of the TACCT to integrate cultural competence curriculum and evaluation during their accreditation process, by the Liaison Committee on Medical Education (LCME) (American Association of Medical Colleges, 2005).

Another large healthcare professional organization, the American Nurses Association (ANA) took a different approach and only recently published, within their professional standards, a new standard addressing cultural congruence (Marion, et al., 2017). Within the standard, there are thirteen specific competencies addressing various ways in which culturally congruent care is to be given, that are recommended for all registered nurses. There are seven

additional competencies for recommended for graduate level and advanced practice nurses (Marion, et al., 2017). The competencies include many of the higher level and broad goals reflected in the criteria set forth by the AAMA but with the absence of prescribing how educational programs are to develop curriculum for students to learn how to meet the competencies. Instead the standard states that, "Most registered nurses will meet the standard for culturally congruent practice with its associated competencies through the lifelong process of professional development." (Marion, et al., 2017). This is a major difference between nursing and medicine in that the ANA standard implies that cultural competence (or congruence) is something that must be learned along the way, over the span of a whole career. The standard also does not illustrate exactly how a nurse might be assessed for learning or achievement of competence, except in a general qualitative manner. This invites nursing faculty to choose how they might implement teaching on this topic in any number of ways.

Likely, the most comprehensive document concerning standards was published by the Office of Minority Health, U.S. Department of Health and Human Services in 2013, in their National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care. These standards address what all healthcare professionals and healthcare organizations should be addressing and doing to provide culturally competent care. The CLAS Standards include addressing factors within the following areas: 1) governance, leadership, and workforce, 2) communication and language assistance and 3) engagement, continuous improvement and accountability. There are fifteen standards within the report that included components, strategies for implementation and resources for how to implement and assess, for each standard (U.S. Department of Health and Human Services, 2013). The CLAS Standards are different from those set forth by the AAMA and the ANA in that they focus largely on

organizational change and how organizations can educate and train a broad healthcare workforce, including both clinical and non-clinical staff, once they are working for the organization. The CLAS standards have a very specific focus on including linguistically appropriate care and providing appropriate language support services and patient and family centered care. Because of the high level of the standards, they do not include specific competencies or how to assess competency for groups of clinical and non-clinical employees, only that training and evaluation of the environment should be ongoing (U.S. Department of Health and Human Services, 2013).

Cultural Competence in Curriculum

Given the difficulty in articulating what culturally competent care looks and sounds like, it is not surprising that there are broad differences between the standards, competencies and assessment of competency set forth in the healthcare industry. It is not surprising then that the literature contains widely varied examples of teaching healthcare students and professionals in cultural competency (Durand, et al., 2012; Carnes, et al., 2012; Hawala-Druy & Hill, 2012; Jeffreys, 2006). These examples range from an elective courses which teaches students to memorize lists of generalized characteristics attributed to ethnic groups and provide reflective journal entries about assigned topics (Durand, et al., 2012); to courses which teach students to recognize inherent biases that they may have about patients who are culturally different from themselves (Carnes, et al., 2012); to a course in which students developed educational materials for elderly patients and then taught the patients to use the materials (Hawala-Druy & Hill, 2012); and courses that are constructed based on learning and discussion of case studies (Jeffreys, 2006). Of the courses outlined above, only one contained a component in which students

interacted with the patients for whom they created educational materials and even then, the only assessment of that activity was through student journal entries (Hawala-Druy & Hill, 2012). None of the other courses in cultural competency contained any skill assessment of students in the clinical setting. It is difficult to find evidence that cultural competency is taught or evaluated for, in any health care discipline, in the same way as other types of competency, such as performing an abdominal ultrasound examination. While students may learn "about" cultural competency, most pre-professional health care students are never required demonstrate their practical skills in working with patients who are culturally different from themselves. Given the working definition of cultural competency for this paper, if, after learning about cultural competency in the classroom, the student is never assessed on his/her ability to perform culturally competent communication and care with patients, then the essential skills for which the curriculum is supposed to prepare the student, may never be developed.

According to the literature, the only validated method for quantitatively assessing pre-professional health care students' levels of cultural competency is a self-reported test, the Inventory for Assessing the Process of Cultural Competence – Student Version (IAPCC-SV) (Campinha-Bacote, 2010; Durand, et al., 2012; Hawala-Druy & Hill, 2012; Fitzgerald, et al., 2009). The score level achieved on the test is used to place the student into one of four categories, ranging from culturally incompetent to culturally proficient, that indicates the ability of the student to practice culturally competent care (Campinha-Bacote, 2010). The effectiveness of using a quantitative, self-reported test to assess cultural competency ability is debated in the literature, largely because self-reported evaluations are not considered to be valid in any other areas of medical learning. The assessment of competency while performing an examination or interacting with a patient in a highly variable health care environment is something that cannot

be done by the student and instead must be done by an experienced observer (Jeffreys, 2006; Kardong-Edgren, et al., 2010; Pilcher, Charles, ; Lancaster, 2008; Shattell, et al., 2013). While the use of a test that renders quantitative measures of self-reported knowledge to place students in categories reflective of their level of cultural competency may seem attractive to some educators in its claim to definitively measure ability levels, it is overly reductive and unreliable in that it does so based on an arbitrarily assigned meaning of what constitutes culturally competent behavior (Brach & Fraserirector, 2000). Additionally, the test does not include a practical demonstration of skills. While students may be able to answer questions on a test, based on knowledge about people of various cultures, this knowledge does not translate directly into the ability to effectively communicate with and provide care to the patients of those cultures for which the student has a cognitive base knowledge.

The use of qualitative measures to assess cultural competency learning in pre-professional health care students has been attempted (Durand, et, al., 2012; Hawala-Druy & Hill, 2012; Shattell, et al., 2013). In these studies, educators rely upon reflective writing, journal entries, and observations of in class activities and discussions. While the methods of data collection are elucidated, the epistemology, methodology and rationale for the choice of methods for data collection are not discussed (Creswell, 2007; Maxwell, 2005). In these studies, any non-numeric data that is collected is classed generally as qualitative, with no discussion on the different epistemologies or methodologies available within the large category of qualitative research. The qualitative data that is collected and discussed is handled in a generalized way, as well. An example of this is in a study by Shattell, et al. (2013). The study used qualitative methods and conducted semi-structured interviews to determine how cultural competency practice was integrated into the curriculum. The data analysis for the results was limited to

statements such as the following: "In focus groups and interviews, a lack of substantive discussion around cultural issues in both the classroom and clinical settings was lamented." (Shattell, et al., 2013). The generalized use of qualitative methods for data collection, without an explanation of the epistemological reasoning and specific methodological choice leave the reader wondering what the researchers intended to accomplish by studying cultural competency in this way (Creswell, 2007; Maxwell, 2005).

Cultural competency requires learning in the classroom and through experience that ideally results in improved communication between health care providers and diverse patients (Cross, et al., 1989; Jeffreys, 2006; Pilcher, et al., 2008). There are a variety of standards and competencies associated with cultural competence and congruence, within the literature (American Association of Medical Colleges, 2005 ; Marion, et al., 2017 ; U.S. Department of Health and Human Services, 2013). There are far fewer suggestions for how to teach the standards and competencies and virtually nothing on how students learn to become culturally competent. Because of the experiential learning component associated with competency learning, research in cultural competency should focus on *how* students experience learning in this area instead of how much. A greater emphasis on how students can apply theoretical and cognitive knowledge and participate in positive interactions with patients of cultures different from their own would reveal more about how educational and curricular efforts are effective or not. Cultural competence must be taught to have impact on a student's attitudes and perceptions. While quantitative data may be able to measure student learning in the cognitive domain, qualitative data must be used to evaluate learning in the affective domain. Research questions to evaluate what kind of education is most effective in cultural competency learning may include: 1) how do health professions students learn about cultural competency? 2) how do students

engage with or resist learning about cultural competency? and 3) How do students' attitudes change in the learning process? Since these questions are related to the process and not the quantity of learning, a specific type of qualitative research methodology must be employed to answer the question as quantitative methods are not capable of answering questions of "how" (Creswell, 2007; Maxwell, 2005). To establish rigor in the qualitative research process, there must also be an epistemological rationale for the choice of methods and methodology. The researcher should help readers to understand what the study is to accomplish and why the methodological choice will be most likely to render data which can answer the research questions. Data and understanding are lost if the researcher cannot elucidate the reasons for conducting the study in a specific qualitative methodology (Creswell, 2007). A study of students' learning the contested arena of cultural competence must also include a consideration and discussion of the context in which the learning is taking place. This requires a clear illustration of the lens with which the context is being evaluated. In the case of cultural competence in healthcare, acknowledgement must be made that this is an industry in which the structures, policies and providers have reinforced biases and discriminatory behavior against patients, especially those of color, for centuries.

CHAPTER THREE:

CRITICAL RACE THEORY AND CULTURAL COMPETENCE EDUCATION

Critical Race Theory and Cultural Competence Education

Disparities exist between positive outcomes provided by health care given to White middle and upper-class patients and patients of color and lower socio-economic standing. These disparities have been studied and discussed extensively in the literature (Betancourt, et al., 2003; Balsa & McGuire, 2001; Gamble, 1997). The disparities have not been linked to access to health care services (Brown, et. al, 2012; Ross, et. al, 2012). Instead, poor health outcomes for patients of color and lower socio-economic standing have been linked with issues stemming from communication challenges between patients and providers and inequitable or poor-quality care based on biases of health care providers (Balsa & McGuire, 2001; Carnes, et al., 2012). In the late 1980s the concept of training health care professionals to be culturally competent was proposed as a potential solution to increasing health disparities (Cross, et al., 1989). Since the concept of training health care professionals to be cultural competent was introduced, organizations like the American Association of Medical Colleges (AAMC), the American Nurses Association (ANA) and the United States Department of Health and Human Services, Office of Minority Health, have set forth standards and competencies concerning how health care professionals and healthcare professions students should be taught and exhibit culturally competent care (American Association of Medical Colleges, 2005; Marion, et al., 2017; U.S. Department of Health and Human Services, 2013). However, there are many differences among the standards and competencies. In addition, none of the standards or competencies illustrates how teachers are to teach or how students are to be assessed for competence. Given the historic emphasis on using quantitative or mixed methods healthcare studies, there are many examples of courses in the literature that attempt to quantify student learning in cultural competence

(Campinha-Bacote, 2010; Fitzgerald, et al., 2009). Quantitative data may be able to answer the question of *how much* but it cannot answer *how* students learn in this area. The other students that use mixed or qualitative methods and theories to analyze inequalities are limited, broad and general, leaving very little depth to proposed outcomes of those studies (Hawala-Druy & Hill, 2012). None of the studies in the literature proposes a curriculum or course for teaching that illustrates the context in which students are attempting to learn to be culturally competent. Given that the present United States healthcare system has a long history of discrimination and exploitation of vulnerable populations of patients, especially patients of color, the need to learn to become culturally competent was proposed mostly for White healthcare providers. The history of discrimination and racism in healthcare should be understood by all healthcare providers but mostly by White healthcare providers since it provides a context that answers why healthcare providers need to become culturally competent and why vulnerable people and people of color may have deeply rooted distrust of U.S. healthcare providers. Therefore, the use of critical theory and critical race theory (CRT) to inform the analysis of the context and power inequities in healthcare that surround cultural competency education for healthcare professions students, is proposed.

CRT arose from Critical Legal Studies (CLS) and the collaboration of, Kimberle Crenshaw, Gloria Ladson-Billings, William Tate and Richard Delgado, among others (Crenshaw, 1991). CRT has been applied to analyze various issues in primary and secondary education, including the achievement gap between students of color and White students. The assigning of people, based on skin color and cultural characteristics, into stratified groups is a societally constructed phenomenon. CRT provides tenets within which to analyze the effects of this phenomenon on people of color. Disparities in positive outcomes in medicine and public health

mirror the achievement gap present in education, in that they both negatively affect people of color, many of whom are also situated in the lower socioeconomic classes. Modern health care has developed largely from the hard sciences, biology, physics, chemistry and mathematics. The social and emotional aspects of health care have been much slower to be considered as essential parts of health care (Foucault, 1973). Until recently, there has been significantly less research on how the social-emotional status of patients and ability of health care workers to address their needs in this area, contribute to negative health outcomes for marginalized populations. The tenets of CRT, as outlined by Delgado and Stefancic (2008) provide an excellent framework for the analysis of how race intersects with other aspects of identity to negatively affect health outcomes for patients of color. Using the tenets of CRT to analyze the context of present healthcare may also inform how education for healthcare professions students should be considered, constructed and evaluated for efficacy (Ford & Airhihenbuwa, 2010).

Critical race theory has been broadly applied in the areas of education, law and the social sciences. CRT first originated in the context of critical legal studies (CLS) and the ideas of Kimberle Crenshaw and Geneva Gay, among others. CRT provides a theoretical framework, grounded in social justice, with which to examine structural inequalities based on racial and ethnic differences (Delgado & Stefancic, 2012). For the purposes of this paper, the tenets of CRT that will be applied are adapted specifically from the work of Gloria Ladson Billings, William Tate, and Richard Delgado (2012). The tenets are: 1) Racism is widely accepted and considered a normal part of life, 2) race is differentiated and complicated by intersecting categories of identity, creating multiple opportunities and forms of oppression and 3) racism promotes structural determinism and opportunities for majority interest convergence (Delgado & Stefancic, 2012 ; Ladson Billings & Tate, 1995). Each of the tenets listed above is directly applicable to

examining the current landscape of the U.S. healthcare system in which disparities persist, despite two decades of attempting to teach healthcare professionals how to provide culturally competent care (Brown, et al., 2012).

Racism is Widely Accepted and Considered Normal

Race is a visible marker of difference within society. For centuries, race has served as means of institutionalizing oppression and making racism inherent to all societies (Delgado & Stefancic, 2012). In the health care setting, issues of racial and cultural differences have been largely ignored because traditional education in the disciplines of medicine, health and science focuses on the treatment of the disease decontextualized from the full identity of the patient (Ford & Airhihenbuwa, 2010). Objectivist ontology has long been viewed as essential for health care providers. Since the foundations of formal education in medicine, physicians have been taught that to practice "good medicine", they should separate the disease or condition from the patient and be a "pure observer" thereby eliminating bias in the course of treating the patient (Foucault, 1963). However, as Foucault points out in *The Birth of the Clinic* (1963), the patient is inseparable from the physical, social, and geographic spaces in which he or she resides. If we attempt to separate the patient from the spaces that he or she occupies, we lose critical information about the patient and the patient's history that may affect diagnosis and treatment of diseases (Foucault, 1963). Additionally, more recent literature concerning inherent biases, both in medicine and in society at large, argues that because we are sensory beings, that can identify physical markers of difference, we are unable to be completely free of bias, in any setting (Carnes, et al., 2012). The existence of discrimination in health care, based on both overt and inherent biases, is supported by a plethora of historical and contemporary evidence. The

examples outlined in the following paragraphs support the claim that racial discrimination has been and continues to be present in medicine and health care.

One of the earliest published examples of racism in medicine, in the United States, is found within the period of slavery. The social and religious justifications for slavery were numerous and invaded almost every corner of White society. However, few people realize that medicine was also used to justify both slavery and the abhorrent treatment of slaves by their White owners. In 1851, a prominent Southern physician, S.A. Cartwright, used "scientific evidence" to support repeated beatings of slaves. Cartwright introduced his "discovery", or invention, of a racially specific disease, called dysthesia, at a meeting of the Louisiana Medical Association. Cartwright postulated that all African Americans suffered from this disease of inadequate breathing, which did not allow enough blood to flow to their brains and negatively impacted their intellect. The only cure for the disease was to beat slaves several times a day so that the blood from the beatings could be exposed to oxygen, thereby raising the oxygen levels in the blood so that the slaves could continue to do their work in a manner consistent with the behavior expectations of the plantation owners. Almost incredibly, Cartwright continued to use medicine to diagnosis slaves who tried to escape with a fictitious mental disease called drapetomania. To keep this disorder at bay, slave owners were to treat slaves like children, neither too nicely or too cruelly to keep them submissive and prevent them from running away (Gould, 1996).

The use of scientific evidence to justify racist and discriminatory behavior continued through the study of craniology and evolution in the first half of the nineteenth century. Robert Bean was a craniologist who used measurements of the cranium and certain structures within the brain to prove that Blacks were inferior to Whites and that women were inferior to men in both

races. The inferiority of women in both races was easy for Bean to prove by showing that women had smaller brains than men. However, after discovering that whole brain sizes in men of both races were equal, Bean quickly buried that data and instead focused on finding a different conclusion through the creative use of numbers. He limited his measurements to only certain parts of the brain, concluding that because of the size of the frontal and posterior portions of the Black brain, Black people were more similar to orangutans than they were to (White) humans (Gould, 1996). Bean's outrageous conclusions were accepted by many people because of a popular belief in the disciplines of medicine and science that numbers represented absolute objectivity and could not possibly be subjected to bias. The faith in numbers as purely objective measures persists into modern medicine and science to this day. Discussion of the potential for misuse of quantitative data is rarely incorporated into any post-secondary science courses and instead is limited to courses in philosophy and ethics (Balsa ; McGuire, 2001).

The Tuskegee Syphilis Study is one of the most infamous research studies conducted in the United States. This study, conducted by the U.S. Department of Public Health Services, spanned forty years from 1932 – 1972. Over the course of forty years, African American and Black males who developed syphilis had treatment withheld, even though it was readily available, so that physicians could study the physical effects of the disease, until the death of the study participant. The allowance of the study to continue, even after penicillin was widely available and accepted as a definitive treatment for syphilis, resulted in the death and debilitation of hundreds of people. The victims of the study were not only the men enrolled in the study but their wives, partners and children who developed or were born with syphilis, as well. In addition to the fact that the study was egregiously harmful and ethically contemptible, the study also targeted a specific group of participants, based on race (Jones, 1993). Many healthcare

professionals and students are unfamiliar with this history of the industry. It is not mandatory in any healthcare professions curriculum that this history be taught or that students learn it. This means that many practicing healthcare providers know little about the context in which they are attempting to practice culturally competent care. This is evident within the data in this study and discussed in greater depth in chapter five. Current articles in medical and health care journals devote very little discussion to the racially discrimination in healthcare. In some instances, there is a deliberate attempt to diminish the significance of the history and present examples of racial discrimination in medicine, as they contribute to current attitudes of distrust of the health care system and medical research present in African American and Black communities (Poythress, Epstein, Styles & Edens, 2011; Freimuth, et al., 2001).

Samuel Kelton Roberts, Jr., in his book *Infectious Fear* (2009), provides a comprehensive examination of Jim Crow segregation policies and the effects of those policies on the tuberculosis epidemic among African Americans living in industrial cities during most of the nineteenth century. Because of the rapid rise of industrialization, segregation, combined with poor living conditions in segregated neighborhoods, the death rates from tuberculosis, of African Americans when compared with Whites, were between two and three hundred percent higher across all age groups. For the same reasons, rates of tuberculosis infection in the African American communities took much longer to decrease when compared with White communities. Tubercular infection did not exhibit a statistically significant drop in African American communities until the late 1970's, years after antibiotics were accepted as an effective treatment for the disease and made widely available. Like Cartwright's invention of diseases to support the continued slavery and abhorrent abuse of African Americans, conservative members of the medical community, many of them physicians, attempted to class tuberculosis as a genetically

inherited disease, mostly limited to certain races, to promote the perpetuation of segregation policies well into the latter half of the nineteenth century (Roberts Jr., 2009).

Stories of medical discrimination continue into a multitude of more contemporary individual narratives which are to be largely ignored in scientific medical literature. The story of Henrietta Lacks is an example of one such narrative, told by remaining survivors of multiple generations in her family, about how her cells were taken during her treatment for cancer in 1951, without her knowledge or permission and without compensation of any sort. Biotechnology companies then began selling Lacks' cells over the course several decades for a huge profit. The sale of Lacks' cells continues to the present day. Not once has Lacks' family been offered compensation or contacted by the medical community for anything other than to request the collection of more genetic samples from family members (Skloot, 2011). Contemporary narratives from Black patients that illustrate racist and discriminatory behavior from healthcare professionals continue to this day. Gamble (1997) examined African Americans' distrust of the medical system using examples from patients, including the one that follows.

> When Althea Alexander broke her arm, the attending resident at Los Angeles County – USC Medical Center told her to hold her to "hold her arm like you usually hold your can of beer on a Saturday night." Alexander, who is Black, exploded. "What are you talking about? Do you think I'm a welfare mother?" The White resident shrugged: "Well aren't you?" Turned out she was an administrator at USC medical school. (Gamble, 1997, p.1176).

Ross, Lypson and Kumagi (2012), collected narratives from African Americans to explore their perspective on racial discrimination in health care. One particularly tragic story from a retired professor stands out.

> My wife had sickle cell anemia and she had a sickle cell event. It took the health care delivery people over an hour to get to our home. When they finally arrived, she was dead.

> I was told by the locals that the treatment was the standard operating procedure for dealing with African Americans. The practice was that they did not service African Americans in need of emergency health care unless they had nothing else to do. That was my introduction to how this society values Black human beings. (Ross, Lypson, & Kumagi, 2012, p. 531)

With such a history of discrimination based on race in medicine and health care, it is almost unbelievable that racial discrimination has not received more attention as a *primary* contributing factor to health disparities. Most contemporary literature which examines the role of ethnicity and culture in health outcomes is overly reductive in pointing to lack of understanding of our cultural differences as the primary barrier to communication in the health care setting (Brown, et al., 2012). While literature concerning the importance of effective, two-way communication to patients' understanding and acceptance of treatment and advice and consequently, improved health, has increased in the last twenty years, most articles fail to include any discussion of the role that historical racism in medicine has played in creating the distrust of patients of color, in our present health care system (Betancourt J., et, al., 2003; Balsa & McGuire, 2001). In fact, Pothyress et al. even argue, in their 2010 study of inmates who refuse to participate in medical research, that the history of racial discrimination in medical research does not play a significant role in the inmates' refusal to participate because they lack an understanding of examples of discrimination and exploitation in health research (Poythress, et. al, 2011). Articles such as these, while not refuting that racism existed and might still exist, in medical communities, attempt to downplay its role in the present system, instead pointing to other, less inflammatory causes for distrust such as low socio-economic levels and lack of education. Nevertheless, racism and health disparities continue to exist (Balsa & McGuire, 2001). A primary problem with downplaying the role of medical racism on the attitudes of patients of color toward health care is that if we do not acknowledge and highlight the impact of

historic racism on the present healthcare system and health disparities, it is difficult to make clear the importance of why healthcare professionals should be educated in how to provide culturally competent care. The fact that health disparities continue to exist even after two decades of cultural competence education, elicits the question of whether learning outcomes would improve in cultural competence if we would require all students to become familiar with the history of racial exploitation in healthcare and health research to provide context for learning?

Educating health professions students about cultural competency has not yet been shown to be effective at mitigating health disparities (Balsa & McGuire, 2001). At least three factors concerning cultural competency curriculum are limiting the potential efficacy of this type of education. The first is that the lack of widespread acknowledgement that racist behavior by medical professionals both historical and contemporary, has perpetuated fear and distrust of the system in communities of color (Ford & Airhihenbuwa, 2010; Gamble, 1997). Cultural competency curriculum should include an extensive discussion of the history of medical discrimination through to the present day. Only by learning about this history, will students be able to understand why patients of color may not be as accepting of medical treatment, or communication, and not seek care until the latter stages of illness (Jacobs et al., 2006; Ford & Airhihenbuwa, 2010).

The second factor is that while medical and nursing schools require that some cultural competency be taught within the curriculum there are many other health careers, requiring formal post-secondary education, that do not require any cultural competency education whatsoever (American Association of Medical Colleges, 2005; Marion, et al., 2017). This means that over half of healthcare professionals who interact directly with patients are may never have any education regarding the way in which they communicate and interact with diverse patients.

They may never consider that there may be a need to communicate differently with a patient who is fearful and distrustful of the system (Murray-Garcia, et al., 2005). Additionally, among the programs which do mandate cultural competency education, there is a lack of standardized curriculum, resulting in a wide variation of teaching on the topic. Many courses include teaching students to memorize lists of generalized characteristics of larger cultural groups and assessing for knowledge using self-reported tests which generate quantitative data and may reinforce stereotypes and inherent biases (Durand, et al., 2012; Hawala-Druy & Hill, 2012). None of the literature regarding specific coursework in cultural competence includes a discussion of the historical evidence of medical discrimination in health care as a context for why students should learn about cultural competence.

The third issue with extant cultural competency curriculum in health professions education is that the majority of classes fail to provide students with the opportunity to practice communicating with patients who are different than themselves or be evaluated in their interactions and communication with diverse patients. In fact, among ten articles outlining cultural competency courses in health professions education, only one contained an experiential component involving providing education for elderly patients (Hawala-Druy & Hill, 2012). Communication across cultural and racial differences is a difficult undertaking in any area of society because of the lack of understanding people come from diverse racial and ethnic backgrounds. Because race is a visible marker of difference, there is a tendency to treat people of color as the "other" in spaces, such as healthcare, which have been dominated by White culture (Gomez & White, 2010). While cultural competency curriculum attempts to teach students about patients who are different from themselves, if it does so without an acknowledgement of the lasting effects of a long history of medical discrimination then many

White students do not fully understand "why" they must learn to provide culturally competent care at all.

The history of medical discrimination and the resulting devastation on certain racial and cultural groups is not widely acknowledged within health care provider communities, nor is this history a standard component in cultural competency education for healthcare professionals. Therefore, attempts to discuss the contributions of medical racism to the reluctance of patients of color to seek medical treatment or follow up with their providers, continue to negatively impact health outcomes in communities of color. Until racism in health care is acknowledged and systematically addressed, it will continue to contribute to health disparities for patients of color. In addressing racism, cultural competency education for health professionals needs to be standardized to include an examination of inherent biases and the historical medical discrimination of patients, based on race, gender and socio-economic class. Only then will students fully understand why learning about cultural competency is directly linked with patient outcomes and can develop skills that they may use to improve their communications with patients who are different than themselves.

Racism is differentiated and complicated by intersecting categories of identity creating opportunities for multiple forms of oppression

The identities of all people are comprised of more than one characteristic. Some people think that characteristics such as race and gender are easily identifiable by looking at someone. Other aspects of identity such as sexual orientation or socioeconomic class are not as easily identifiable. In health care, due to the nature of illness, patients often share multiple aspects of their identities, even the invisible ones, with their health care providers. This increases the

power differential between patients and their providers, who may have unconscious biases. This provides many opportunities for oppression and discrimination to occur. Kimberle Crenshaw wrote about the effects of intersecting aspects of identity and how they combine to promote oppression for minority women who are victims of violent situations, in the legal system (Crenshaw, 1991). There are similar situations in the health care setting. Although there are many aspects of identity that may intersect, making patients vulnerable to discrimination, three aspects of identity, race, gender and socioeconomic class will be the focus, in this section. The health care setting is a hierarchical system, with physicians who, until recently, were mostly White males, in the top tier. This has created a system in which the race, class and gender of a patient may intersect and combine to negatively affect how the patient is treated, communicated with or discriminated against (Chapman, et al., 2013). While patient and provider communications, because of privacy regulations, may not be available for evidence, there is plenty of evidence of discrimination and biases in healthcare literature. One example is a textbook written with case studies for physician education (Gosnik & Squire, 1976). The following examples of case studies, taken directly from the medical text reveal biases, based on intersections of patient identities. Examples are below:

> At age 19, typist Bunny Love supports a $100 a day drug habit. She is a generous young woman, however, and right now she regrets it. She comes to the Free Clinic in tears, with marked pelvic tenderness and recent exacerbation of her vaginal discharge (Gosnik & Squire, 1976, p. 103)

> Duke Mantua, 39, former teenage gang leader (presently on parole) is hurriedly dropped off in the emergency room by some of his acquaintances. Duke smells of alcohol and clutches his stomach groaning. Physical exam reveals epigastric tenderness. There *may* be an epigastric mass; however, the patient is difficult to examine and you are not sure of the finding (Gosnik & Squire, 1976).

In the first example, biases regarding the patient's age, gender and social class are made clear by the authors through the choice of her fictitious name, drug habit, and propensity for promiscuity (made evident in the diagnosis and the history of being a drug user and a "generous young woman"). In the second example, biases of the authors are again evident, given the patient's name along with a history of incarceration, gang membership and potential substance abuse, none of which are necessarily related to the diagnosis in this case. In highlighting the gender, ethnicity, ignorance, substance abuse, incarceration and promiscuity of the patients in these case studies, the physician authors are including aspects of the patients' identity that are unnecessary in making the diagnosis, in either case. Instead, the way in which these patients and their illnesses are presented only makes painfully evident the biases and prejudices of the authors. Generally, published material in a textbook is considered the result of careful thought, study and editing; however, in this case, because of the bias inherent in the case studies, this medical text also has the capacity to reinforce negative stereotypes of patients, based on the intersecting aspects of gender, race and ethnicity.

A second example of how the intersecting factors of a patient's identity combine to create multiple opportunities for oppression is in the story of Henrietta Lacks. Henrietta was a Black woman, who came from a family that was often in poverty. She was therefore, unable to pay for medical care when she developed cancer because of a sexually transmitted disease that she contracted from her husband. Because she was poor, she was given only one choice of where to get health care and subjected to participation in medical research, without her consent. As a Black woman, she was not educated by her White male physician that she had developed the cancer because of a sexually transmitted disease, making her children vulnerable to potential complications of the disease. Henrietta's intersecting factors of identity, being a Black woman

and living in poverty, combined in a way that made her vulnerable to discrimination based on all aspects of her identity, from many different people within the healthcare system and society. From her physician, to the nurses, to the researchers who harvested her cells and then sold them, Henrietta was treated as less than equal because of her race, gender and socio-economic class.

When healthcare professions students are educated to provide culturally competent care by memorizing a list of characteristics ascribed to the "average" person in culture, intersecting factors are not considered in detail and stereotypes about characteristics may be reinforced. Since, as evidenced above, multiple aspects of patients' identities may create opportunities for the magnification and / or the expansion of oppressive or discriminatory behavior rendered by health care providers, cultural competency curriculum should deliberately include extensive discussions about intersecting factors of patient identity as opposed to forcing students to memorize generalizations and stereotypes. It is essential for health care providers to understand the potential for increased patient vulnerability due to membership in several groups of people who are marginalized by the dominant racial and ethnic narratives of White people. A first step in learning is to require that health professionals are trained to recognize their own inherent biases and if possible, how to overcome them or at least suppress their own judgment and reactive behavior. Even if the health professions student has a good cognitive understanding of various aspects of patient identity, this does not mean that the he or she will accept the identity of the patient, especially if they themselves have an inherent bias against any part of it. There is no guarantee that subconscious acts of discrimination will not be evident in communicating with the patient, in these cases. It has been proven that health care providers will interact more positively with and spend more time communicating with patients with whom they feel that they can personally identify. Patients as well, respond more positively when they can identify with their

health providers (Carnes, et al., 2012). The lack of the presence of common aspects of identity between patient and provider promotes opportunities for misunderstanding and inability to surmount barriers to effective communication, making positive outcomes less likely (Byars-Winston, Gutierrez, Topp, & Carnes, 2011). When a health care provider is viewed as unaccepting, judgmental or outright discriminatory through either subtle or overt communication, the patient is much less likely to accept any assessment, advice or treatment from that provider (Alexander, 2009). The inability of health care providers to understand or counter reactions stemming from their own inherent biases is detrimental to addressing the already present power inequities and communication barriers that exist in situations with patients who are different, sometimes in many ways, from themselves.

Racism provides advantages for a dominant race and class that enable hegemonic societal structures and interests to be preserved and maintained

The U.S. healthcare system attempts to substantiate the claim that we have the most superior system in the world by spending more money on health care, per patient, than any other developed country (Betancourt, et al., 2003). In contrast to this assertion, statistical outcomes for patients who are other races than White, low income, identify as having sexual orientations other than heterosexual, are female or any combination of these identities have been shown to have significantly poorer outcomes in our health system (Alexander, 2009; Betancourt, et al., 2003; Olson, et al., 2010; Balsa & McGuire, 2001). Given the confirmation of these statistics across multiple studies, we can confidently say that the health care system in the United States does *not* work well for all of people, including infants and children that are not White, above. If this evidence is to be believed, then why does the narrative still exist? The answer to this question

lies in how we define "the best" health care system. Arguably, the best health care should result in increased life expectancies, increased rates of recovery, decreased infant mortality and better overall societal health, regardless of race, gender or socio-economic class. In America, our health outcomes are poorer than over one hundred different industrialized countries in all the categories above (Olson, et al., 2010). Additionally, the health care system has been extremely slow to respond to promoting ways to address the inequities. This is most likely because for many middle and upper class White patients, the system does work. If a patient is White and has good health insurance and a moderate amount of knowledge about the way the system works, the patient will likely receive excellent care. If you do not fall into the categories above, however, the likelihood is the opposite.

The health care system has a hierarchy, which is largely based on educational level (physicians at the top), race, gender and knowledge. This hierarchy is reflected in the patient population, where the greater a person's education level and income, the more likely it is that they will receive high quality health care. Knowledge of the health care system, anatomy, physiology, and pathology enables a patient to ask appropriate questions of health care providers. A patient's knowledge of these things is readily evident to health care providers either in the questions that a patient asks or does not ask. If a patient has the knowledge to advocate for their own health care, their outcome will likely be very different from someone who does not have the knowledge to advocate on their own behalf. However, given that the health care system and professionals within it have been shown to discriminate based on race, gender and socio-economic class, patients of color and lower socio-economic standing must work much harder to have their questions heard. Many times, they do not have the education necessary to ask relevant questions and are instead pushed through the system and more likely to have poorer outcomes.

Distrust of the health care system has been built into communities of color through years of medical discrimination and racism. This is reflected in the lower numbers of students of color who choose to pursue careers in the health professions. A report published by the Bureau of Labor Statistics, rendering a breakdown of health care workers in professions by race and ethnicity, revealed that in professional and technical health care positions, Black or African Americans only represented an average of 10.5 percent of those employed, across professions. Latino or Hispanic people made up only 7.2 percent of the work force and Asian people made up 9.3 percent of the work force, in the same category (Bureau of Labor Statistics, 2013). This report demonstrates that the majority of health care workers in the positions requiring the most education and earning higher pay are White. The unequal representation in health professions is historically supported by the fact that the first Black man did not graduate from medical school until over eighty years after the establishment of the first such school in the United States. The first Black woman to become a physician graduated eighteen years later (Balsa & McGuire, 2001). In the United States, White male physicians have both established and dominated medicine the field of medicine for over two hundred years. Given this history and present statistics, the structural determinism in medicine is easily identified.

As with knowledge and the ability to ask questions, monetary resources also allow choices. If a patient does not like how the doctor is managing their care and they have money, they can easily seek a second opinion. In the same way, a patient with economic capital may be able to buy expensive medications for treatment that would not be an option for someone of more modest means. Medicine is a very profitable industry and the pharmaceutical, health insurance and medical device companies who can sell products at very high prices profit from lobbying physician groups and large corporate health systems to continue to buy, use and be

reimbursed for their services. The focus is not upon making their products more available to larger groups of patients, but instead on making them available to patients who can pay for the products. On a smaller scale, physicians who have completed the highest levels of training and education tend to be respected solely for knowledge they possess and income they earn and not necessarily for the positive outcomes of the patients they treat. Health care industry administration and high level, specialist physicians still tend to be overwhelmingly White and male (Carnes, et al., 2012). If the hegemonic system in medicine continues to be populated and controlled by White males, change will be slow to happen.

Power disparities are present in the health care system in the United States. These disparities exist due to differences in income, education, medical knowledge, skin color, illness, gender and sexual orientation between patient and health care provider. In the current structure of hierarchy in health care, which works well for middle and upper-class Whites and White males in particular, (as they represent the dominant race and gender based on statistical reports) discrimination based on race, culture, income level and sexual orientation can be dismissed as a by-product of inability to pay, follow medical directions, or come back for follow up appointments (Balsa & McGuire, 2001). These "by-products" of the system now become the fault of the patient and not the fault of health care providers. Simultaneously, racism and discrimination work to preserve the predetermined place and amount of power of everyone involved in the system, including patients, thereby preserving the status quo and promoting the interests of the White and moneyed majority.

Structural racism and hegemony are difficult concepts on which to educate largely White health professions students. In the context of entrenched structural determinism, unstandardized and elective cultural competency training for healthcare professions students appears to have

little potential to affect the power inequities between patients of color and their health care providers (Carnes, et al., 2012; Chapman, et al., 2013). Cultural competency curriculum in the literature reflects that most efforts have been in educating White students *about* diverse patients but not educating them to work alongside a diverse healthcare workforce (Balsa & McGuire, 2003). Betancourt, et. al (2003) state that to build a comprehensive framework to address cultural competence, the health care system and each healthcare organization should place emphasis on becoming organizationally culturally competent. This means that interventions should be used to build racial and ethnic representation into leadership and the workforce that are reflective of the patient populations that are served (Betancourt, et al., 2003). Given that the AAMC, ANA and U.S. Department of HHS have proposed standards for cultural competence that all include a focus on the importance of healthcare workers having experiences that build their cultural competence, would not the idea of working alongside a diverse healthcare workforce perhaps give more White healthcare providers valuable learning experiences devoid of the power differential that exists between patients and providers? Recent literature regarding cultural competency within organizations reveals that many health care organizations are attempting to address building workforce diversity. Organizational cultural competency has become a focus of many health networks, largely in response to new requirements for Medicare payments based on patients' satisfaction with their health care experiences (Gertner, et al., 2010). In addition to more comprehensive cultural competency training for employees, some human resources departments are also focusing on building a workforce that is ethnically and racially representative of the patient population served by a given institution (Betancourt, et. al, 2003; Gertner, et al., 2010). Pursuit of organizational cultural competence, along with a projected health care workforce shortage across all professions over the next ten years, has placed

emphasis on the creation of pipeline or pathways programs which educate and encourage middle, high school and college students, particularly those of color and lower socio-economic status, to consider careers in health care (Global Health Workforce Alliance, 2012; Health Professionals for a New Century, 2014).

In promoting the health professions, through pathways programs, to more students of color, those constructing the curriculum should consider the theories associated with multicultural education, a similar, but more focused approach to achieving cultural competency in schools. Multicultural education as defined by Grant (2011) is education that "..addresses the needs and talents of culturally diverse populations to ensure equity for all." Multicultural education should systematically address the specific learning needs of all students who identify as part of a marginalized group or groups to provide more equitable education for *all* students, not just the majority (Sleeter & Grant, 1987). Ideally, multicultural education practices would provide for the equitable education of students of all races, ethnicities and cultures in a way that legitimizes their identities and community interests instead of continuing to privilege the cultural literacy of the White majority. Comprehensive cultural competency education for health professions students should not be primarily focused on teaching them about patients who are different from themselves and instead include a focus on including curriculum that highlights the histories and accomplishments of healthcare professionals of color. This new focus in the curriculum, along with efforts and resources devoted to recruiting more students of color in to the healthcare professions would help to address the issues of structural racism and hegemony by posing an alternative narrative for White students to consider. Highlighting and including the stories of accomplished health professionals of color removes the reinforced structural power inequities that are present when students only learn about diversity within patients, who are sick,

ill and in need of their help. White students learning about "others" in mostly White classrooms with White instructors may provide a comfortable environment for White students to learn about cultural competency but it will not provide them with the necessary experience of learning how to communicate with peers, not patients, who are different from themselves (Gomez & White, 2010). Health professions educators should understand that the inclusion of multicultural education practices in pre-health profession curriculum will certainly not be without resistance and the potential for confrontation (Amos, 2010; Ladson-Billings, 1996); however, students have the potential to gain much more understanding of the need for equity among diverse groups, when they are also learning about positive stories of the contributions and accomplishments of professionals of color, not only about the history of discrimination.

Summary

The history of health care and medicine, including medical research, is filled with examples of racism and discrimination. To a large extent, all but the most egregious of stories exist quietly, never making their way into common public knowledge. The effects of medical racism continue to create distrust of the system in communities of color. In the literature, even the literature concerning cultural competence, this history of racism and discrimination is often ignored and certainly not explored as a primary cause for present health disparities. Acknowledging that racism is part of daily life in all socially constructed communities (Delgado & Stefancic, 2012), including health care, is necessary and essential in learning about cultural competency as it encourages an examination of both historical and contemporary narratives concerning the experiences of patients of color and other vulnerable groups. It is especially

necessary for younger White health professions students to learn these histories so that they might begin to understand the fear, distrust, and reluctance of patients of color to seek or follow through with medical treatment. While the standards and competencies that have been mandated for physicians and nurses, within their educational programs, do include learning broadly about historic discrimination in healthcare, the way in which the curriculum is designed is entirely dependent on the faculty teaching the course. Additionally, for most of the other clinical healthcare workforce, there are no standards or competencies mandating that students should even learn about cultural competency. This means that much of the current healthcare workforce has little or no knowledge of the history of racism and discrimination that is still present today.

Awareness of the context of historical and present racism is one aspect that should be present in cultural competency teaching and learning. A second essential component of cultural competency curriculum should be to include discussions of power inequities that are present between patients and health care providers which may be further magnified by intersecting aspects of the patient's identity, including, but not limited to, race, gender and socioeconomic class. Patients who identify with more than one underrepresented groups are at risk for discrimination of many forms. Healthcare professionals should be taught to regularly perform critical self-examination that provides them with a comprehensive knowledge of their own culture and inherent biases along with an understanding of how the various aspects of the patient's identity might conflict with their own beliefs (Carnes, et al., 2012; Chapman, et al., 2013). Further, students should be provided with opportunities to interact with diverse patients in a setting that allows instructors to provide both patient and educator feedback. This feedback should include information about how students can work to suppress and mitigate negative behaviors with patients against whom they may have inherent biases.

A third aspect of cultural competency should be to acknowledge structural determinism and hegemonic practices that are present within the healthcare system and to look for solutions to interrupt and eradicate the practices and policies that perpetuate the systems. Two ways in which to interrupt the hegemonic systems are: 1) to include within all cultural competency education, the stories of the accomplishments of healthcare professionals of color and 2) to focus on recruitment of more students of color into healthcare professions. Education and socioeconomic achievement must not be a privilege limited to those that have both the knowledge and the monetary resources, which are currently required. Following the practices of providing multicultural education by highlighting the stories and notable accomplishments of healthcare professionals and scientists of color interrupts the false narrative in which most or all the great accomplishments were made by White men. Including stories like that of Jane Cooke Wright, who was one of the first African Americans to graduate from Harvard Medical School and pioneered the use of chemotherapy to treat cancer. She is credited with making chemotherapy a first line treatment option and saving millions of lives (Crosby, 2016). The telling of these stories also allows White health professions students to learn positive stories of people of color, absent the context of the power inequities that are always present between healthcare provider patients (Gomez & White, 2010; Grant, 2011). Studying the positive stories of professionals of color also aids in interrupting the false narrative that communities of color are seen to be living in a negative or deficit context (Alexander, 2009). Along with the telling of positive stories, there must also be greater efforts and resources devoted to recruit students of color and limited into healthcare professions. Pathways programs must be built for students of color that do not ignore a history of racism and discrimination, but that also highlight the accomplishments and contributions of people of color to medicine and healthcare. Students of color must be able to

see themselves in positions of accomplishment and leadership through the stories of those who look like themselves and must be supported in the attainment of these goals, if we are expected to make strides toward organizational cultural competence in healthcare.

CHAPTER FOUR:

NARRATIVE INQUIRY IN CULTURAL COMPETENCE EDUCATION

Narrative Inquiry in Cultural Competence Education

Among the many challenges in creating an effective cultural competency curriculum for healthcare professionals is that there are presently no required standards or guidelines for over half of the health professions. Even within health professions education for physicians and nurses, where competencies and requirements are in place, there is no uniform way in which students are expected to engage with learning about cultural competence, leaving the literature full of widely varied examples of cultural competence curriculum and education. Additionally, the research methods with which the existing curriculum has been examined, have been limited to the use of quantitative, mixed or general qualitative methods. Many of the studies which attempt to quantify student learning in cultural competence include the use of a validated test which gives quantifiable results through student self-reporting, (Kardong-Edgren, et al., 2010; Pilcher, et al., 2008; Shattell, et al., 2013). The studies which use general qualitative methods to evaluate student learning usually consist of evaluating and analysing a single reflective assignment at the end of the course that only broadly captures how the students felt about the course itself, not necessarily the content or learning (Durand, et al., 2012; Hawala-Druy & Hill, 2012; Shattell, et al., 2013). No studies include a practical assessment of students' abilities to demonstrated culturally competent care in the clinical setting. This omission is significant since the achievement of competency in any discipline of health care, includes the ability to demonstrate a practical skill in the clinical setting (Axley, 2008). Evaluating teaching and learning in the area of cultural competency is complicated by the fact that all culture is situated in society, where certain cultures are privileged over others (Apple, 1995) and communication between patients and providers may be affected by any number of intersecting aspects of identity

and inherent biases on either side (Carnes, et al., 2012; Chapman, et al., 2013). Learning for health professions students in this area may involve engaging with ideas related to attitudes, ontology and biases. Learning in the affective learning domain is sometimes difficult for students, especially if it requires the deep examination of their own behavior, position and power (Ahlquist, 1991). The use of quantitative research methods to study learning in cultural competence is not able to acknowledge or address questions of how students learn, only how much. An attempt to quantify learning for any type of competency is problematic in that the demonstration of competency requires an exhibition of learning in the affective and psychomotor domains, within which there may be significant individual variation within the accepted performance standards (Axley, 2008). Generalized qualitative methods, which in these studies, are only defined enough to say that they do not include quantitative statistics and that the results were "positive or negative" (Durand, et al., 2012; Hawala-Druy & Hill, 2012) lack the rigor needed to uncover data that may lead to an increased understanding of how students learn in this area (Crotty, 1998). Since learning in cultural competence in healthcare is one in which experiences over time are essential and the learning may require multiple points of self-examination and discomfort on the part of the student that a study of how healthcare professions students learn about cultural competency in would benefit from the use of narrative inquiry as a specific methodology. The telling of learning about cultural competence, in the students' own words, across interviews and assignments has the potential to provide a deeper understanding how students engage, struggle and learn in an area that requires significant individual introspection.

Narrative inquiry has evolved as a qualitative methodology within the larger area of narrative analysis. Specifically, narrative inquiry focuses on stories of individual experience

situated within larger social, cultural and institutional narratives (Clandinin & Connelly, 2000). Narratives may be gathered in many ways, including observing, listening and interpreting texts or writing. Narrative inquiry is especially useful for studying experiences that are unique, based on individual experiences in specific social settings and contexts (Clandinin, 2013; Coles, 1989; Mattingly & Garro, 2000). Although the literature is absent of examples of the use of narrative inquiry study healthcare professions students' learning experiences, it has been used in other areas of health care to examine patient and physician experiences with illness and healing and situational bioethics (Charon, 2003; Coles, 1989; Mattingly & Garro, 2000; Nelson, 1997). Narrative inquiry in these areas is especially valuable in that the readers of the research learn about experiences first-hand, as told by the participants (Clandinin & Connelly, 2000). Since stories may reveal different aspects of understanding to different readers, narrative inquiry is not limited strictly to the analysis rendered by the researcher and may continue to offer new insight to the same researcher and other readers, even after the initial analysis is complete (Clandinin, 2013; Nelson, 1997). Narrative inquiry may be especially valuable in studying stories that take place over longer periods of time and are complicated by social settings and the intersecting aspects of the identities of the individuals who are involved (Cole & Knowles, 2001). Due to the lack of a standardized curriculum in cultural competency, the experiential nature of achieving competency in health care and the complicated contextualization of communication between health care providers and patients, an analysis of the narratives of healthcare professions students who are learning about cultural competency has the potential to give a more complete and accurate understanding of the evolution of learning of students in this contested and complicated area.

Narrative Inquiry in Illness, Healing and Bioethics

Although it is difficult to locate studies in pre-professional health care or cultural competency education, in which any specific qualitative methodology is identified and explained, there are many examples of where narrative inquiry has been used in studying other experiences of patients and health care providers. Most of the studies conducted with narrative inquiry concern the phenomena of illness and healing and issues in bioethics, as experienced from either the patient's or the health care provider's point of view (Charon, 2003; Coles, 1989; Mattingly & Garro, 2000; Nelson, 1997). Narrative inquiry used in the setting of illness and healing is often referred to as "narrative medicine" (Charon, 2003) and is used to help readers understand the lived experiences of others, in health care. Narratives in the health care setting are particularly valuable in 1) teaching readers about experiences of which they may have no prior knowledge, 2) providing new understanding for patients and health care providers on ethical and emotional dilemmas in health care that are not widely discussed, in order that the care delivered to patients may be improved, and 3) help patients who may be experiencing illness themselves to understand and find strength in the experiences of others (Charon, 2003; Coles, 1989; Mattingly & Garro, 2000; Nelson, 1997). Charon defines narrative medicine as, "..medicine practiced with the narrative competence to recognize, absorb, interpret, and be moved by the stories of illness." (Charon, 2003). She goes on to illustrate narrative medicine is valuable in forming connections and expanding understanding:

> Medicine practiced with narrative competence will more ably recognize patients and diseases, convey knowledge and regard, join humbly with colleagues, and accompany patients and their families through the ordeals of illness. These capacities will lead to more humane, more ethical, and perhaps more effective care (Charon, 2003, p. vii)

The phenomena of illness and healing are impossible to fully understand until they have been lived. Narrative medicine enables health care providers to make important emotional connections to patients who are experiencing illness and healing, instead of distancing themselves through the practice of clinical diagnosis and treatment (Charon, 2003; Mattingly & Garro, 2000). In understanding the emotional nature of illness, which is often neglected in healthcare professions education, providers learn to have greater compassion and empathy in treating their patients. In health care, where providers are privileged with power based on education (Apple, 1995) and sometimes on race and socio-economic standing, the development of empathy is important but often neglected even though it is necessary to providing compassionate care and positive patient outcomes (Chapman, et al., 2013).

Narrative accounts of illness, healing and bioethical situations encountered in health care are also valuable for teaching health care providers, healthcare professions students and patients (Nelson, 1997). Case studies have long been used in most medical disciplines as the best way to teach health care providers and students to think critically through hypothetical scenarios, usually based on real examples. Case studies are particularly valuable for teaching students in an environment where they may take extra time to analyze and problem solve, outside of the pressures of thinking within an emerging clinical situation (Jeffreys, 2006). Narrative inquiry provides case studies that are the result of actual lived experiences as opposed to carefully constructed mock scenarios provided to meet specific learning objectives in an educational setting. Cases based on patient and provider narratives often include social and emotional components, which are essential to a more complete understanding of situational encounters (Nelson, 1997; Ross, et al., 2012). Narrative cases are essential for understanding aspects of

situational privilege and power complicated by the experiences of illness. A study by Ross, Lypson and Kumagi (2012) uses patient narratives to promote an increased understanding of effects of racial discrimination in health care:

> My ex-wife was miscarrying and…when we went to the emergency room. They were saying, "Can we see your insurance," and I don't know if it was a doctor or what…but someone walked in and said, "Oh, that's [name] of the Lakers," and all of a sudden boom boom, boom. The treatment got 100% better when they found out. They snatched her in right away. I got irritated and I said, "Damn it, what if I wasn't a Laker?" What if I wasn't a Laker? I don't know whether it's the total medical profession, but I can definitely tell you there is a different way of treatment with minorities and people of no "status" than it is of a regular person (Ross, Lypson, & Kumagi, 2012, p. 534).

Narratives are multidimensional which makes them incredibly valuable in education as different readers may encounter different understandings than other readers from one patient's story (Nelson, 1997). Because of their multidimensional nature, narratives may prove particularly valuable in teaching and learning in cultural competency in health care, as evidenced by the study above (Ross, et al., 2012).

Narrative Inquiry in Learning Cultural Competence

In the pursuit of achieving competency in any area of health care, students learn from a variety of experiences, both in and outside of the classroom setting. Although the specific requirements for achieving competency in each area may differ, based on the expectations of what a student is to be able to demonstrate, all competencies in health care, except for cultural competency, require at least one graded assessment by an experienced observer, confirming that the student can perform the expected task (Axley, 2008). Education in cultural competency is

complicated by the lack of a standardized definition, learning objectives, and requirements for demonstrating abilities in interactions with patients. It is further complicated by social and situational aspects of privilege, race, and inherent bias (Apple, 1995; Balsa & McGuire, 2001; Carnes, et al., 2012). Recent studies on cultural competency education in pre-professional health care, place great emphasis on deciding if students "become" competent as the result of the curriculum, which is largely theoretical in nature (Brach & Fraserirector, 2000; Campinha-Bacote, 2010; Hawala-Druy & Hill, 2012; Jeffreys, 2006). Given the lack of common and specific standards and competencies associated with culturally competent practice it may be more valuable to focus on *how* students learn *about* cultural competence.

Literature concerning cultural competence education lacks a discussion or analysis of how White students experience learning in this area, which may provide new understanding of how students experience, process and demonstrate cultural competency learning. Narrative inquiry would provide a means to study the stories of health professions students as they learn to communicate and understand patients from diverse cultures contextualized within society and the setting of health care. As with all stories, these accounts may be used in a variety of different ways, read, told, compared, analyzed or invoked, depending on what is intended to be accomplished (Nelson, 1997). An examination of the thoughts, critical thinking, emotions, and reactions of the students as they learn, may provide the understanding necessary to improve cultural competency education both in and out of the classroom. The stories of health professions students' learning may also serve to create coherence in understanding the multiple contextualized influences on encounters between patients and their health care providers (Mattingly & Garro, 2000; Ross, et al., 2012).

Data Generation

The healthcare workforce majority, including all professions, identifies as White and female, which is the demographic of all students in this study (U.S. Department of Health and Human Services, 2013). IRB approval was granted in September 2013 and data collection commenced in October 2013. Sonography students in the last two years of professional undergraduate curriculum were recruited to participate in the study. All participants attend the same school of sonography, of which I was program director at the time. Students in each of the two cohorts, junior or senior, experienced and engaged with the curriculum from which data was collected. Twenty-two students were offered the opportunity to participate in the study and all students elected to participate. The opportunity to participate was give by another faculty member in the program of study. Since I served as the program director for the school, I did not want my position of power to impact student choice to participate in the study. Data was collected from the narratives of twenty-two healthcare professions students who attend the same educational institution, experience the same didactic curriculum, have similar clinical experiences and share the same race, age range and gender. During data generation and collection, one student left the program, without participating in all activities or the interview and so her narrative was not included in the study. This study involved collecting narrative accounts from sonography students at different stages of their professional curriculum.

The health professions training program in which the research was conducted is one that is supported by a large academic health care organization and in which students obtain a baccalaureate degree from one of four different colleges or universities through affiliation agreements. Students attend didactic classes two, eight-hour days, per week and learning in the

clinical setting on the other three days of the week, for eight hours each day. The didactic and clinical curriculum focus largely on health professions specific information and students are prepared in the cognitive, affective and psychomotor learning domains to become competent to perform a wide variety of examinations and procedures on patients in different health care settings, including inpatient, outpatient, rural hospital and specialty clinics. Portions of the didactic curriculum that concern teaching students about patient interactions and communication in the clinical setting or medical ethics, contain assignments that require the students to engage in learning about how diversity, culture and a history of medical discrimination may impact the ability of White health care professionals to provide care and communication that is culturally appropriate based on the identity of the patient.

A narrative for each student was composed through interviews, participation in discussions and the completion of assignments that involved the examination of issues stemming from diversity, discrimination and health disparities within health care. This research attempts to understand how students engage, resist and assimilate formal classroom learning in cultural competence, within the context of their own lived experiences, epistemology and ontology (Clandinin & Connelly, 2000). A constructivist perspective and critical theoretical lens were used to evaluate the student narratives as they included discussions surrounding how the participants learn to interact and communicate with patients based on their understanding of difference and situated within the context of each students' lived experiences.

Data Collection

The narratives of this group of students, collected as they engaged with coursework pertaining to cultural competency, were produced from individual, semi-structured interviews, online discussion postings, and recorded observations of classroom discussions. The assignments in which the students participated for this study include: 1) watching the documentary and writing a reflective paper on the film, *Miss Evers' Boys*, (Sargent, 1997), which examines the Tuskegee Syphilis Experiment from the perspective of the African American nurse who was hired to recruit subjects into the study; 2) reading and discussing in class, the book, *The Man with the Iron Tattoo*, (Castaldo & Levitt, 2007), which contains short stories told from the viewpoint of the physician as he or she engaged in caring for diverse patients; 3) viewing and writing a reflective essay regarding the documentary film, *Sicko*, (Moore, 2007), which examines the state of health care in America, including how people live with the complications of being ill and lacking health insurance or access to quality services; 5) reading and discussing in an asynchronous online format and in class, the book, *Amazing Grace*, (Kozol, 1995) which profiles stories of children and their families who live in the poorest neighborhoods in the South Bronx, including their struggles to access healthcare; and 6) viewing and writing a reflective essay on the documentary *Worlds Apart* (Maren Grainger-Monsen & Haslett, 2003), a documentary which profiles several actual patient and health care provider interactions where the healthcare professionals and patients identify as culturally different from one another. I purposefully deleted instructor input from any of the discussions or assignments due to my status relationship with instructors within the school. I conducted all individual interviews for all participants.

The individual semi-structured interviews were conducted in my office after classes were concluded for the day and over the course of the months of November, December and January of 2013. I served as the Program Director for the educational program at the time I conducted this research but did not teach any of the classes in which data was collected. I acknowledge that there was a power inequity in my relationship with the students which may have influenced the information and stories shared within the interview. I avoided collecting data from any assignments in the classes that I taught, to avoid the power inequities associated with assigning grades. During the months in which the interviews were conducted, students engaged with the assignments from which data was collected, to give students a frame of reference for discussing cultural competence. The interviews were semi-structured and included three basic questions:

1. What does cultural competence mean to you?
2. How have you learned the most about cultural competence, both within and outside of a classroom?
3. Which experiences or courses do you believe have helped you learn the most about being culturally competent?

Each interview lasted between ten and eighteen minutes in length with follow up questions which were asked, based on student answers to the three main questions (Seidman, 2006). Some of the questions were: 1) can you tell me more about your experiences outside of the classroom?; 2) which experiences do you think you learned the most from?; and 3) how do you think your experiences and learning in this area has changed the way that you provide care for diverse patients?

Data Analysis

Data was compiled into a file for each student, to render a single narrative belonging to each participant. Each section of the narrative was identified by the method of communication of the narrative. Each narrative contains the following sections: interview, online discussion, reflective writing assignment, reaction writing assignment, in-class discussion and video observation. Themes were then identified within each student's single narrative document. Themes identified included: resistance, grief, openness, active learning, self-identification and / or discomfort. Supporting evidence for the identification of each theme was then identified in other sections of the narrative and in coding of student language.

In the analysis of the first interview, the first participant shared a very personal story of her experiences with her African American sister-in-law, revealing a theme of self-identification within the informal learning context, while struggling to recall significant classroom experiences with cultural competency learning. I adjusted the interview flow to include additional questioning about this student's personal experiences outside of the classroom that helped her to learn about cultural differences, since these experiences seemed very important. Subsequent interviews revealed that students who had significant personal relationships with individuals who were a different race or ethnicity from themselves counted these experiences as much more important than any classroom experiences. Conversely, students who could not recall having any personal experiences with people who were ethnically or racially diverse seemed to count classroom activities as significantly more important to their learning about cultural competency.

Open coding was performed on the interviews in three cycles, utilizing In Vivo, Versus and Emotion coding. In Vivo Coding involves identification of the participant's actual words

(Saldana, 2013). I chose to use In Vivo Coding in the first cycle of open coding because I wanted to identify the participants' language in describing learning activities as well as capture their definitions of cultural competency. The definitions of cultural competency given by the students were all different. Student 1 stated that, "cultural competency is knowing different types of religion and how people react…when certain situations arise and knowing not to be judgmental...". Student 2 stated that, "…you realize that there's all like different cultural aspects and like everybody's diverse and you just have that knowledge". Student 3 stated that, "…kind of knowing what you kind of have biases against and then kind of not holding them against other people, so to speak." In Vivo coding revealed that while all students associated different types of knowing, awareness and actions associated with cultural competency, all of the definitions included the terms, "knowing about", "different", "difference", "other", "biases", and "stereotypes". All students spoke from a majority viewpoint with the unspoken "we or us" being in the majority and associated cultural competency with knowing about one's own biases or having general knowledge about the "others" who were in the minority. In reflecting on these linguistic choices, it was clear to me that it should not be surprising that individuals who spend most of their lives in the majority portion of the population should refer to those that are different in these ways. All participants in the interviews used the terms above to describe learning experiences with culture. In looking at the list of terms generated by In Vivo Coding, by far the most used descriptive term was "different". One student used "different" six times within her definition of cultural competency alone.

It was the excessive use of the word "different" that prompted me to perform Versus Coding as the second cycle of open coding. Versus Coding is promoted for use in critical studies since it may be helpful in identifying power relationships (Saldana, 2013). I reasoned that if

"different" was used so many times as a descriptor I should look for uses of the word "same" to identify subconscious references to power relationships that the students had negotiated in their lives. Interestingly, none of the students used the word "same" to describe diverse people or patients. Some participants used, "not different", "not diverse" to describe their towns or schools, but this was the closest terminology to "same" that was present in the interviews. Another significant finding with Versus Coding had to do with the way that these participants talked (or didn't talk) about race. Students did use contrasting terms such as "I", "we", "us" and "they", "them", and "others" in describing their knowledge about cultural competency. Their use of the terms "I", "we", and "us" helped to further ground the use of narrative from the dominant social position and included me, by race and gender, in the narrative of "us". If I had been of a different race or ethnicity than my participants, this would not have been possible. This contrasting language also identified the separation between the students and those that they considered to be different from them. In defining cultural competency, only one of the students used the term "racism". The use of racism in that case was less of a voluntary mention of race as difference than it was a reference to having bias or stereotype. Students used the term, "White", "mostly White", "all the same" and "White majority" to describe their towns and high schools. Using Versus Coding, I then looked for any mention of any other specific races to contrast with the categorization of themselves as white. Only two of the students used the term "Black" or "African American" in contrast to "White". In those cases, the mention of race was contextualized in the recounting of personal stories about relationships with one other individual who was black or African American. This was an important and prominent story in that student's interview. In the recounting of those stories, it seemed difficult for students to articulate or discuss the aspects of tension and difficulties that were due to race in their stories. Only two of

the students mentioned personal relationships with anyone of a different race and none of the students voluntarily discussed race or racial tension in connection with cultural competency. Questions about race in the classroom discussions also seemed to bring out emotion in many of the students.

It was the latent emergence of emotion with the topic of race that prompted me to use Emotion Coding. To identify the presence of emotion, I listened to the interviews with the transcripts in front of me and documented emotion through inflections, lengthy pauses or excessive prompting on my part. Embarrassment was present when students discussed the sizes or attitudes present in the towns in which they grew up. Embarrassment was present when discussing their lack of experience with racially or ethnically different people. In the interviews where students mentioned having relationships with people of different races, shame was present when recounting things that happened in their towns when they were with their friends or family members who were African American. I also reviewed the videotaped classroom discussions with the transcripts for emotion. In the discussion of *The Man with the Iron Tattoo* (Castaldo & Levitt, 2007), I didn't identify any strong emotions elicited by participants. Having read that book, I know that it doesn't recount any stories that identify or discuss race. In contrast, during the discussion of *Amazing Grace* (Kozol, 1995), anger was present for much, if not all, of the discussion. Fully half of the twelve students in the discussion never speak during the entire thirty-four minutes of recorded discussion. The students who do participate in the discussion are clearly eager to talk, raising their hands, nodding when other students speak and seem generally enthusiastic in their participation. These students share their thoughts and interact with one another and the instructor. In contrast, the students who do not participate in the discussion stare at the floor or their computers, never smile, rarely make eye contact with any other students and

never make eye contact with the instructor. The general mood of this discussion was very different than the discussion of *The Man With the Iron Tattoo* (Castaldo & Levitt, 2007). In that discussion, every student participated at least 3 or four times within the twenty-eight-minute discussion. All students were interacting, smiling at times, and talking with their peers.

During the three cycles of initial coding, I wrote reflective memos on each interview and after each observation. In the memos, I noted patterns that had begun to emerge from the open coding. The memos aided me in transitioning to axial coding which is used in a second cycle of analysis to determine which of the codes or themes in the initial cycle are dominant and which are less important (Saldana, 2013, p. 218). In this phase, I attempted to identify patterns and make summary statements based on similarities that were present within the interviews. In the memo I wrote after I finished coding the five interviews I noted that, "personal experiences seem to be the most notable and memorable way in which students recall learning about cultural competency." In looking back at the personal stories that were recounted during the interviews, it was also apparent that students who had personal relationships with people of different races or ethnicities for longer than one semester seemed to be more open to learning about cultural competency. Students who had these longer relationships with people who were different from themselves emphatically attributed their present open mindedness and ability to work with diverse patients to those relationships as opposed to anything that they had learned in the classroom. Students that did not recall or recount longer term relationships with diverse people pointed to viewing videos in the classroom, especially the film *Worlds Apart* (Maren Grainger-Monsen & Haslett, 2003), which profiles health care providers and their interactions with patients who are racially and ethnically different, as teaching them the most about cultural competency.

Given the similarity of experience and demographics, one expectation of the data was that the stories of these students would be largely similar. Although there are similarities, the differences in the narratives, including a strong presence of resistance to learning about cultural competency, were unexpected. An example of resistance to learning was posted in an online discussion forum in response to questions about Jonathan Kozol's *Amazing Grace* (1995).

> Although I understand your reaction to Mrs. Washington's anger and bitterness, I think Mrs. Washington clearly shows in her statement that she realizes not all white people are the same. Both [Student Name] and you touched on how racial profiling works in both directions and I completely agree with this. I think that is why a lot of us struggle with constantly discussing cultural diversity. I think in a way it makes us feel as though people believe we need this and that makes us feel as we are being profiled as "racist". This is how I personally feel regarding the matter at least.

The use of narrative inquiry to examine data in this study is particularly promising since it allows for the presentation of the complexities surrounding the learning and teaching of cultural competency. The student narratives exhibit a depth of expression and provide an understanding of the emotions and struggles, contextualized in the larger societal issues of racism and privilege, that students experience in learning in this area, and aspects of learning cultural competency that are absent from other studies (Durand, et al., 2012; Hawala-Druy & Hill, 2012; Kardong-Edgren, et al., 2010).

The narratives of the students in this study are also particularly valuable in examining aspects of their own identities, including inherent biases, that may not be apparent to the students themselves, but that may strongly influence their interactions with patients who are culturally different than they are (Carnes, et al., 2012; Chapman, et al., 2013). This is evidenced in another student response from an online discussion about *Amazing Grace* (Kozol, 1995).

> I agree with your response that I disagree that Whites take for granted their lifestyle, there are still poor white people as well that I'm sure go through

> the same situations. Also along with your statement I think that most people are understanding to minorities and it may just be that they are uneducated about their situations.

Allowing students to express their understanding and identities through their own narratives may be a much more effective way to facilitate self-examination and discovery than by asking them to take a self-reported test to assess a level of cultural competency or inherent bias (Carnes, et al., 2012; Campinha-Bacote, 2010). Care must be taken to preserve privacy when aiding students in discovering aspects of their identities that they may not be willing to accept (Carnes, et al., 2012; Chapman, et al., 2013). however, one of the most revelatory ways in which self-discovery may be encountered is through the examination of one's own words and expression, as opposed to taking a test, in which the writers of the test are the ones to tell the person about his or her identity (Czarniawska, 2004; Mishler, 1999) and (Fitzgerald, et al., 2009).

The data provided above exhibits a few ways in which using narrative inquiry to examine White healthcare professional student learning about cultural competency may provide important insights which are not evident in other studies (Durand, et al., 2012; Hawala-Druy & Hill, 2012; Kardong-Edgren, et al., 2010; Shattell, et al., 2013). The use of the participants' stories to examine how they learn about cultural competency provides insight into the multiple factors that influence patient and health care provider interactions, including identities, inherent biases, race power, and privilege (Apple, 1995; Carnes, et al., 2012). Just as in using narratives to examine patient's experiences of illness, these narratives of learning about cultural competency may continue to render very different insights to the readers, even after the initial analysis is completed (Clandinin & Connelly, 2000; Czarniawska, 2004; Mattingly & Garro, 2000). In the same way one patient's story of illness and healing may help a health care provider develop a greater sense of empathy and simultaneously provide a sense of solidarity to another patient with

a similar illness (Charon, 2003; Mattingly & Garro, 2000), narratives of Healthcare professional students may provide both educators and other pre-professional health care students with different insight and understanding. Although the knowledge that is gained may be different, given the various identities and positions of the readers to the narratives, the value is no less important in any one instance.

Using the students' own stories to examine how they learn about cultural competency is especially valuable in studying an area in which the identities of the patient and health care provider strongly contextualize and influence the communication and events that take place, in each interaction (Chapman, et al., 2013; Alexander, 2009; Brach & Fraserirector, 2000). In some cases, a telling of the same story to different readers may render very different insights to the readers. For instance, in studies that use narrative inquiry to examine how patients experience different types of illness, the story of one particular patient may help provide a sense of solidarity to other patients who are experiencing similar phenomenon, aid patients in distancing themselves from their illness to gain fresh perspective, and enable healthcare professionals to provide better care to patients who are ill, given a new understanding of how patients experience illness (Charon, 2003; Mattingly & Garro, 2000). Although what is gained is very different, given the various identities and positions of the readers, the value is equal, especially if the ultimate result is an improvement in how healthcare professionals provide culturally competent care to diverse patients. In order to honor the students' stories in using narrative inquiry to study their cultural competency learning, a study must be constructed carefully in a way that: 1) provides opportunities for the students to tell their stories in more than one setting, understanding that students may be both encouraged and / or restricted from sharing their authentic stories in certain settings, 2) compares the stories of engaging with cultural differences, both in and out of the

classroom, noting both common themes and significant differences, and 3) identifies within the stories, areas of struggle, understanding and resistance in relation to engagement with specific readings and discussions.

Limits of Narrative Inquiry and Consideration of Other Qualitative Methodologies

Narrative inquiry has at least three important limitations in studying cultural competency learning that must be discussed. First, the narratives given by the students, especially when they are shared with school faculty, may not be authentic or may lack the mention of significant events. The power relationship between the faculty member conducting the study and the student participants must be fully acknowledged and potential issues of inauthenticity in the narratives or unwillingness to share important aspects of stories must be considered (Ahlquist, 1991; Apple, 1995; Chase, 2010; Clandinin D. J., 2013). Second, the use of narrative inquiry will limit the data as relevant only to the individuals and specific circumstances, both positional and temporal, which are included in this study. The results may not be used to form conclusions that will be applicable to other healthcare professions students (Creswell, 2007; Maxwell, 2005). Third, the results of arising from the use of narrative inquiry may not be construed as definitive. Stories may hold different meaning to different individuals and are always open to re-interpretation by any reader, even long after they are told. (Clandinin & Connelly, 2000; Cole & Knowles, 2001; Czarniawska, 2004).

The potential issue of inauthenticity or omitted details of stories shared by participants when using narrative inquiry risks the collection of data that may be misleading. However, since the methods used to collect the stories of participants with narrative inquiry are either similar or

the same as methods used for data collection with other qualitative methodologies, no other choice of methodology would eliminate this risk. The collection of interviews, observed discussions and reflective writings are also employed in studies using ethnography, grounded theory, phenomenology and case studies as qualitative methodologies as well (Creswell, 2007; Corbin & Strauss, 1990; Maxwell, 2005). The power relationship between the researcher and the participants in this study is likely more of a potential influence on the issue of encountering inauthentic data. Power relationships always exist, in some manner, between the researcher and the study participants. Therefore, acknowledgement of the researcher's position, both to the subject matter and the research participants, in the study report is an essential part of any qualitative research study (Creswell, 2007; Maxwell, 2005). In this study, the position of the researcher to the students is that of a senior faculty member who does not teach any of the courses in which the students' narratives were collected. It is also important to acknowledge that I share the same race and gender as the students. This position must be discussed and carefully addressed since the power relationship between a faculty researcher and a student participant is not inconsiderable (Apple, 1995).

The issue of irreproducibility, as the stories are unique to these individuals, time and circumstances is one that also must be acknowledged carefully in the report, however, is also present with any other qualitative methodology. Grounded theory is the only qualitative methodology which renders results through multiple levels of coding and via inductive or deductive reasoning that may be used to support claims, in some instances, of potentially generalizable findings (Corbin & Strauss, 1990; Saldana, 2013). Although grounded theory was initially considered as a methodology for this study, upon close examination of the coding levels required to perform grounded theory with rigor, it was determined that the rigor of coding may

have had the capacity to decontextualize the data to the point where the voices of the students and important details of their stories and identities would be lost if the data were limited or reduced to coded words or phrases (Corbin & Strauss, 1990; Crotty, 1998; Charmaz, 2010; Saldana, 2013). The narratives, as shared by the health professions students, are stories which are unique and are products of the setting, the time and the identities of the participants. Dissection of the stories with grounded theory would have less potential to produce insightful data or new understandings to the readers. Narrative inquiry honors the stories of the participants in presenting them as complete and unique products of the person who relates them (Chase, 2010; Clandinin, 2013; Coles, 1989).

Last, a study using narrative inquiry may not be expected to produce findings that are definitive (Clandinin & Connelly, 2000; Creswell, 2007). This is both an advantage and a potential challenge to using narrative inquiry in studying cultural competency learning. Narratives offer the potential for re-interpretation based on the identity and understanding of the reader. After the initial analysis is published, each subsequent reader will continue to make sense of the stories, possibly different from the researcher's sense, with each examination. In this way narratives provide the advantage of being used to continually render new insight and understanding. Care must be taken not to present findings as definitive or reproducible and instead acknowledge that the position of the researcher to the data limits the perspective by which the data is analyzed and the findings are presented. Leaving the data open to the interpretation of the reader and presenting it as such may be more of a risk in narrative inquiry that in other methodologies. Narrative inquiry requires that the stories be told as the participants told them. The use of narrative inquiry also limits the amount of re-interpretation, by coding, word counts, or other empirical data that may be generated. The story must not be deconstructed

to the point where important details are lost (Charon, 2003; Clandinin & Connelly, 2000; Czarniawska, 2004; Charmaz, 2010; Gee, 1999).

Although narrative inquiry may pose potential issues in performing a study on cultural competency learning including the possibility of collecting inauthentic data, participant reluctance to share narratives based on extant power relationships, rendering conclusions that are neither generalizable or definitive, these issues are outweighed by the potential that it contributes to the study. Narrative inquiry will respect the voices of the participants, while offering a richly detailed examination of the context and content of student learning in an area conflicted by power, privilege and health disparities (Brach & Fraserirector, 2000; Clandinin, 2013). A study of cultural competency learning with narrative inquiry offers a glimpse of the struggles, understanding and revelations from the perspective of the student, which is presently absent from the literature.

Summary

In two decades, education in cultural competency has not been shown to influence narrowing the gap in positive health care outcomes between White middle and upper-class patients and those of color and lower socio-economic standing (Brach & Fraserirector, 2000; U.S. Department of Health and Human Services, 2013). The implementation of cultural competency curriculum and training programs for health care providers and pre-professional health care students has been especially difficult considering many differing opinions about how cultural competency should be defined, taught and assessed (Brown, et al., 2012; Cross, et al.,

1989). Caring for an increasingly multicultural patient population presents opportunities for difficulties in communication and understanding between health care providers and patients with whose cultures they are not familiar or against which they hold inherent biases (Carnes, et al., 2012; Chapman, et al., 2013). Studies of cultural competency coursework and the level of cultural competency among healthcare professionals or students have rendered widely varied results, both quantitative and qualitative. There is very little evidence by either quantitative or qualitative outcomes that the healthcare professionals and pre-professional health care students who experience courses in cultural competency come away with anything more than an increased knowledge of the general characteristics of people of some cultures (Carnes, et al., 2012; Campinha-Bacote, 2010; Durand, et al., 2012; Hawala-Druy & Hill, 2012; Shattell, et al., 2013). None of the studies examined included a required assessment of the demonstration of culturally competency care in the clinical setting as is required of all other competency learning in health care (Axley, 2008). The importance of the experiential learning component, essential to competency learning, is largely neglected in the discussion or education on cultural competency, leaving extant curriculum to depend on the delivery of mostly theoretical and base cognitive information regarding the cultures of potential patients. Achieving cultural competency remains ill-defined and unattainable (Brach & Fraserirector, 2000; Jeffreys, 2006).

Narrative inquiry allows experiences to be understood and meaning made through the telling of stories which occur over time (Chase, 2010; Charon, 2003; Clandinin & Connelly, 2000; Czarniawska, 2004). Narrative inquiry may be used to provide learning opportunities to the researcher, research participants and readers on multiple levels and in many ways and is particularly useful in the study of lived experiences (Chase, 2010; Nelson, 1997). Narratives have been used in medicine to study patients' and health care providers' experiences with illness,

healing and bioethics. The practice of narrative medicine has been especially helpful in aiding physicians in developing empathy and communication skills that facilitate more positive interactions with patients (Charon, 2003; Mattingly & Garro, 2000; Nelson, 1997). Narratives in medicine have also been used to teach students about complex ethical situations that may arise in the clinical setting so that they may develop critical thinking skills and the ability to contribute to positive outcomes in complex ethical situations (Nelson, 1997). Narrative inquiry provides the researcher with the ability to examine the lived experiences of the participants as contextualized in complex social spaces and times (Charon, 2003; Clandinin, 2013). For these reasons, a study of how pre-professional health care students learn about cultural competency may serve to fill a void in existing literature by providing an understanding of how students struggle with learning how to care for patients who are different from themselves.

A narrative inquiry study of how Healthcare professional students learn about cultural competency would honor the voices of the students and simultaneously offer insight and understanding that is unavailable in studies which use quantitative measures, arbitrary assignments of ability levels in cultural competence or very generalized qualitative methods to assess student learning (Brach & Fraserirector, 2000; Durand, et al., 2012; Fitzgerald, et al., 2009; Clandinin D. J., 2013; Mattingly & Garro, 2000). Narrative inquiry in a study of how students learn about cultural competency also has the potential to aid students in uncovering biases and aspects of their own identities, of which they may not have been cognizant, in a way that encourages revelation through their own stories instead of by assessments made by others through test taking (Carnes, et al., 2012; Chapman, Kaatz, & Carnes, 2013). Narrative inquiry may also provide understanding to other readers which are different than the ones uncovered by the researcher (Charon, 2003; Mishler, 1999). The position of the researcher, in any narrative

inquiry study, should be disclosed and addressed since the power inequities present in the relationship between the researcher and the participant may influence the content and delivery of the stories. Care must also be taken not to represent the data as generalizable or reproducible, given the unique identities of the student participants and their lived experiences, as related at a time and place. Results of a narrative inquiry study will not be definitive in nature as readers may continue to re-read and re-interpret stories, long after the initial study is concluded (Clandinin, 2013; Clandinin & Connelly, 2000; Czarniawska, 2004).

The study of experiences of healthcare professions students in learning about cultural competency with narrative inquiry offers a needed examination of the perspective of student learning in an area that is fraught with controversy in definitions, learning objectives and socially constructed issues of power, privilege and race. This study, if undertaken with other qualitative methodologies such as grounded theory or case study, this study might lose important contextual details and the potential for new discoveries which are needed, to better understand how learning about cultural competency may present struggles and opportunities for healthcare professional students (Creswell, 2007). As stories may offer new insights to different readers, student participants may benefit from a reading of their own narratives as this may aid them in better understanding their own identities, an essential first step in understanding how to communicate with and understand patients whose culture is different from their own.

CHAPTER FIVE:

IN THEIR WORDS: HEALTH PROFESSIONS STUDENT LEARNING IN CULTURAL COMPETENCE

In Their Words: Health Professions Student Learning in Cultural Competency Curriculum

Although the expectation that healthcare professionals should be educated in cultural competence has been widely reported and studied, the idea that any person may become culturally competent remains elusive. In the almost three decades since the concept that healthcare professionals should learn to become culturally competent, to address health disparities, was introduced, there have been no standards developed regarding how exactly the skills required are to be taught or learned. There remain many people in the healthcare workforce who have very limited encounters with teaching or learning in cultural competence, as it is not mandated or embraced to the same extent in all educational programs or healthcare organizations (Balsa & McGuire, 2003). In studies of current cultural competence curriculum, there is a lack of the use of rigorous qualitative methods for evaluation, inclusion of the historic context of discrimination and racism in healthcare and an absence of student voices or narratives as they engage with learning in this contested area. This study examines how White female health professions students engage with learning about cultural competence across time and professional curriculum.

Participants and Data Collection

After IRB approval, twenty-one health professions students completing the last two years of their undergraduate degrees, were recruited to participate in the study. All students identified as White, between the ages of 20 and 30 years and native to the state in which the training

program was situated. Eighteen of the twenty-one students reported spending most of their lives in small cities or towns of 25,000 people or less. The health professions program in which the research was conducted is one that is supported by a large academic health care organization and in which all students are obtaining a baccalaureate degree. Students attend didactic classes two days per week and learn in the clinical setting on the other three days of the week, for eight hours each day. The didactic and clinical curriculum focus largely on health professions specific information and students are prepared in the cognitive, affective and psychomotor learning domains to become competent to perform a wide variety of procedures in many different health care settings, including inpatient, outpatient, rural hospital and specialty clinics.

The assignments from which the data in this study was collected were dispersed across subjects, instead of limited to learning about cultural competence within a single course. This way of providing students exposure to learning about cultural competence is supported by the standards for cultural competence education set forth by the American Association of Medical Colleges (AAMC), which is responsible for dictating curriculum for medical schools (American Association of Medical Colleges, 2005). Students in the study were asked, within the interviews, about experiences and learning about cultural competence that had occurred over time which is a concept supported by the American Nurses Association (ANA) within their standard on cultural competency education (Marion, et al., 2017). Students engaged with a variety of ideas, perspectives and viewpoints within the assignments and were asked to examine their own perspectives and key learnings within the interviews. The interviews were semi-structured and relied upon answers to three main questions:

1. What does cultural competence mean to you?

2. How have you learned the most about cultural competence, both within and outside of a classroom?
3. Which experiences or courses do you believe have helped you learn the most about being culturally competent?

In addition to the interviews, data was collected from reflective writing assignments, online discussions and videotaped observations of class discussions about movies or readings that concerned diversity or cultural competency. The videotaped classroom discussions were of the first-year class of nine students as they discussed books *The Man With the Iron Tattoo* (Castaldo & Levitt, 2007) and the second-year class as they discussed, *Amazing Grace*, (Kozol, 1995) which profiles stories of parents, students and educators in the Bronx. Online discussion postings were collected concerning *Amazing Grace,* (Kozol, 1995). Reflective writing assignments were collected after students viewed *Sicko* (Moore, 2007), *Worlds Apart* (Maren Grainger-Monsen & Haslett, 2003), a documentary which profiles several real patient and health care provider interactions where the health care professionals and patients identify as culturally different from one another and *Miss Evers' Boys* , (Sargent, 1997) which tells the story of the Tuskegee Experiment from the view point of an African American nurse who was used to recruit the participants into the study. It is also important to note that I did not teach any of the classes in which assignments were collected or discussions observed, to avoid having a potential conflict in grading the classes in which I was researching the responses to the assignments. It is also important to note that all faculty who taught the classes also identified as White and female. Given that race, gender and other aspects of identity come together to influence and construct unique interactions between people, if the faculty or I had identified as a different race or gender

than the students, it should be acknowledged that the interactions and narratives would render different understandings (Charmaz, 2010).

Analysis

The student narratives reveal a depth of struggles, emotion and discomfort with examining diversity and perspectives of communities that are racially and ethnically different from themselves. The discomfort and emotion were less present when examining aspects of diversity that did not include race or ethnicity, such as socio-economic or gender differences. Open, In Vivo, Versus and Emotion coding were all used to identify major themes (Saldana, 2013). The themes within the narratives that arose from the coding are discussed within three major areas in this chapter: 1) differences in defining and understanding cultural competence, 2) challenges and emotion in discussing race and ethnicity, and 3) the influence of lived experiences in engaging or resisting in learning about cultural competence.

Defining Cultural Competence

Cultural competence is broadly defined based on the early work of Cross et al, (1989) and includes, "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). This is a very broad definition which does not specify what "effectively" means. While others have attempted to specify certain aspects of cultural competence, given that culture and competence may be widely varied and

subjective terms, it is not surprising that there were both variations and similarities in the definitions from all students in this study. Representative examples of the ways in which students defined cultural competence are illustrated in the following narratives of the student responses in the interviews, to question one, (What does cultural competence mean to you?):

> Umm, I would say cultural competency is knowing different types of religion and how people react and you as like a health care professional or any person knowing how to react when certain situations arise and knowing not to be judgmental, I guess would be the biggest thing with being culturally competent is being accepting of everyone's views. (Student 1, 2013).

> Just that you realize that there's all like different like cultural aspects and like everybody's diverse and that you just have that knowledge that there are (pause) people think about things in different ways or do things in different ways and like there it's not one clear cut way to have a view on anything or think about anything (Student 2, 2013).

> Um, I think just … kinda knowing the different cultures and uh, being aware and first knowing like … your um, like if you have any racism or any kind of thing, like, towards a different culture and just kinda being aware of all the different traditions and … knowing how to approach a patient or someone that has a different culture than you (Student 3, 2013).

> Uh, I think it pretty much means, um, well first, kind of knowing what you kind of have biases against and then kind of not holding them against other people, so to speak. So … … it means kind of … um, allowing other people from different backgrounds and races and all, to kind of believe and act the way they want but you not judging them or have…holding biases toward them, and understanding that, so to speak (Student 4, 2013).

> Knowing different cultures and maybe different ways they like just strictly in the medical field. Knowing which way or how they generally think about this. And how they you know get medical treatment. So like the whole thing with blood transfusions and that kind of way like just being cultural competent like knowing how to what is offensive or what to different cultures. So, I mean you see a lot of different cultures here in the United States especially in the medical field. And so knowing what might offend someone and how to go around that so you're not offending (Student 6, 2013).

> I think cultural competency means that you're aware of cultural differences among people and did you know that there are some other people that exist besides your

culture (Student 8, 2013).

I would say it's the understanding and acceptance of different cultures and beliefs and just accepting it and not judging it before you know (Student 10, 2013).

When I think of cultural competence, I think of you know Caucasian White and Asian and things like that and just being aware of the differences between each of them respectively and trying to do your best to treat everyone with respect and be competent enough to perform these exams in a non-biased manner (Student 13, 2013).

I think that in healthcare specifically you're seeing a wide range of patient nationalities and diverse groups of people and someone who is culturally competent is just going to leave everything out the door and treat every patient the same and not have a bias if they can and you know every patient deserves your best care and that's all that you're there for. you're not there to judge them or treat them with any biases (Student 14, 2013).

Just understanding of a wide variety of patients or people in general and just where they're coming from or just who they are I guess (Student 15, 2013).

I think cultural competency is being aware of people who are different than you and that sometimes you have to do things differently depending on how they interact with you and who they are as a person (Student 16, 2013).

It means being aware of you know different ethnicities different cultures and you know being open minded and willing to learn about different cultures (Student 18, 2013).

I think for me it's no matter what patient walks in no matter what they look like or anything it's treating them all the same and just being empathetic to their situation. If they're really sick or not really sick or if they're like nervous or whatever it may be just treating everybody the same (Student 19, 2013).

I think it's just kind of knowing the differences between cultures and knowing when to tailor a situation to meet that kind of need to bridge the cultural gap (Student 20, 2013).

So I think being culturally competent means that you have educated yourself about different cultures and that you're aware that there is differences and yet similarities. And that you yourself examine how you feel about those differences as well (Student 21, 2013).

Examining the differences and similarities with which the students articulate what cultural competence means to them is important to gain an understanding of what students think

they are learning about cultural competence and why they believe they are learning it. The use of Versus coding was especially helpful in identifying what students believed cultural competence *was* versus what they believed it *was not* (Saldana, 2013). These themes were then contrasted with the accepted definition from Cross, et, al., for cultural competence. Most students used at least one or more of the following words to describe cultural competence: "awareness", "culture", "knowing" and "educated". Several of the students mentioned "judgment" and "bias" and only three students mentioned race, specifically. No students mentioned improving communication or giving care based on a patient's cultural preferences, which are two key components to the definition of cultural competence proposed by Cross, et, al. (1989). Two of the students mentioned that cultural competence to them meant learning to treat patients from all cultures "the same", which is not mentioned at all in the literature regarding the goals of providing culturally competent care (Ahmed & Bates, 2017). In the published standards and competencies, much of the learning regarding cultural competence is expected to occur in the affective learning domain which involves exploring individual attitudes and biases. Although a few students did mention "judgment and bias" in regard to learning about cultural competence, most of the students used the words "understand", "aware", "know about" or "knowledge" in regard to "learning about differences", indicating that most students strongly associated learning in the cognitive domain with cultural competence. Given these themes, it seemed to indicate that students were not familiar with the definition of cultural competence present in the literature, nor familiar with the idea that learning in this area is strongly associated with learning to change attitudes and reactions to people who are different than one's self (American Association of Medical Colleges, 2005). This finding prompted an examination of the narratives for any indication of student understanding regarding the context or the "why"

associated with learning about cultural competence.

Establishing Context

Students need a context and background in which to ground understanding and rationale for learning, in any subject. Otherwise, a student may simply think that they are being forced to learn in this area and exhibit signs of resistance to learning (Amos, 2010). According to the literature, the need for cultural competence arose from the identification that challenges in cross-cultural communication between patients and a largely White healthcare workforce were contributing to disparities in health outcomes (Cross, et al., 1989). In this study, like others in the literature, the context, or why, we need training in cultural competence was never specifically introduced to or discussed with the students. Additionally, they all had different levels of understanding and familiarity with the history of discrimination and racism in medicine. The challenges associated with not providing an adequate context for student learning, especially in an area that may be sensitive, such as cultural competence, were that students did not always understand why they needed to learn and reacted to the assignments in many ways. The only assignment from which data was collected that gave students insight into the context and history of discrimination in medicine was watching the movie *Miss Evers' Boys* (Sargent, Miss Evers' Boys, 1997). Some examples of students not understanding the context were evident in their answers to a question in their reflective writing that asked, "Do you think watching this movie was valuable to your education?":

> **Student 10:**
> I personally don't feel that this was a very educational activity as a student. This is because, we have done so much "learning" on cultural diversity

> and research ethics that it's difficult to gain anything beyond the points we have already learned.
>
> **Student 21:**
> I do think this movie is valuable but I do not find it necessary. We have had almost every class with cultural diversity spattered in and I do not feel the move is needed in order to reiterate the cultural diversity idea.

Another student reacted in a similar way when responding to a question in an online discussion about the book, *Amazing Grace*, (Kozol, 1995):

> **Student 16:**
> Both [Student Name] and you touched on how racial profiling works in both directions and I completely agree with this. I think that is why a lot of us struggle with constantly discussing cultural diversity. I think in a way it makes us feel as though people believe we need this and that makes us feel as we are being profiled as "racist". This is how I personally feel regarding the matter at least.

These students not only exhibited resistance to engaging with the material, but even seemed to be emotional in their resistance. None of the students included above defined cultural competence in a way that included communication or that included that cultural competence was necessary to incorporate into practice, in order that more equitable care may be provided for patients who identify as racially, ethnically or culturally different than the predominantly White healthcare workforce. If students do not fully understand what cultural competence is, nor do they understand the context for why it is important, then the risk is that the students will disengage from learning, such as in the class discussion example, or worse, they will start to resent that they feel "forced" to learn about it, as is the case above. This likely provides students with an even worse view of cultural competence and diversity than before they began to learn about it, which in turn may serve to reinforce deeply held biases or negative stereotypes. It is also important to note that the assignments above, in which students wrote about their resistance, involved two out

of only three assignments that specifically included reflection on the stories of people of color. It was the emergence of resistance with emotion that prompted the use of Emotion coding which I found present in other areas, such as the interviews, when students talked about race.

Challenges in Discussing Race and Ethnicity

Having noted the emotion in the examples of student resistance to learning about diversity and having noted that these examples were present in the context of responding only to assignments in which the race was highlighted, I used Emotion coding to look for other examples of where emotion was present. I listened to the interviews with the transcripts in front of me and documented emotion through inflections, lengthy pauses or excessive prompting on my part. In several of the interviews emotion was present when students discussed the sizes or attitudes of some individuals in the towns in which they grew up or when discussing their lack of experience with racially or ethnically different people. It was also present in the interviews where students mentioned having relationships with people of different races. A good example of this is below from the interview with Student 1 who relates the experience of having a sister in law who was African American and the way in which she was treated in the small town in which the student grew up.

> So people just say (long pause) have used inappropriate terms when they refer to her and that to me (pause) was very offensive (pause) cuz like she's a very nice girl and you can't judge someone off their skin color (pause) stuff like that (pause) and I had also (long pause) like when people like (pause) we had a lot of Hmong, I guess, at my school and they were very closed off because I know like in their culture they kinda stick together and like people made fun of them and like were not as nice, I don't know (pause) like I felt uncomfortable when people were saying things and I was just kind of like sitting there.

Student 4 also exhibited emotion when recounting her experience in dating an African American man.

> Yeah, um (pause) my ex-boyfriend was actually from a different culture. He was African American. And I don't know (pause) I kind of noticed, like (pause) if we were in public like (pause) different people would look at us differently (long pause) but I mean, that's just kinda how people perceive it sometimes, but (long pause) so other people are, you know, it didn't-it didn't matter. But um, actually when I brought my ex-boyfriend back home we had gone out to, like, a public place (pause) and (pause) our town's really small and very racist, so, one of, I had one of one of (pause) one of the older gentlemen had, um, said something just like to a different person and it got back to me and it was just … uh (long pause)'OK'.

I also reviewed the videotaped classroom discussions for emotion. In the discussion of *The Man with the Iron Tattoo* (Castaldo & Levitt, 2007), which was not specifically about encounters with race and diversity, I didn't identify any strong emotions elicited by participants. Having read that book, I know that it doesn't recount any stories that identify or discuss race. In contrast, during the discussion of *Amazing Grace* (Kozol, 1995), emotion was present for much, if not all, of the discussion. Fully half of the twelve students in the discussion never speak during the entire thirty-four minutes of recorded discussion. The students who do participate in the discussion are clearly eager to talk, raising their hands, nodding when other students speak and seem generally enthusiastic in their participation. These students share their thoughts and interact with one another and the instructor. In contrast, the students who do not participate in the discussion stare at the floor or their computers, never smile, rarely make eye contact with any other students and never make eye contact with the instructor. The general mood of this discussion was very different than the discussion of *The Man With the Iron Tattoo,* (Castaldo & Levitt, 2007). In that discussion, every student participated at least 3 or four times within a 28-minute discussion. All students were interacting, smiling at times, and talking with their peers.

In addition to noting that emotion was present in conjunction with discussions about race, it was also noted that the students who spoke of specifically about race in the interviews or assignments, tended to use language that established people of races other than White as the "other" (Gomez & White, 2010). Othering is a social phenomenon in which a dominant group negatively defines and subordinates another group (Foucault, 1963). Othering has been established as hegemonic practice in medicine and healthcare. It is so entrenched in practice that most providers are not conscious that they are participating in the "othering" practice. It is easy for the patient to be viewed as the "other" in healthcare based on the patient's limited knowledge of illness and medicine and the provider's superior knowledge and power to heal (Gould, 1996). Patients are "othered" based on the relationship with the predominantly White healthcare providers. Patients are viewed as limited or less than because they "need" the provider to answer the question of what is wrong and to fix it. This "othering" of patients is complicated and amplified when patients have intersecting aspects of their identity that also do not conform to the dominant White narrative (Crenshaw, 1991). The risk that this poses in healthcare is that patients who are classified either overtly or subconsciously as the "other" often are at risk for receiving suboptimal care (Roberts & Schiavenato, 2017). Health disparities are evidence that this is common practice, even today. Versus Coding was helpful in identifying instances of "othering" as it is promoted for use in critical studies since it may be helpful in identifying power relationships (Saldana, 2013). Most students did use contrasting terms such as "I", "we", "us" and "they", "them", and "others" in describing their knowledge about diverse cultures. Their use of the terms "I", "we", and "us" helped to further identify within the narratives, the dominant social position. It is worth noting in the interview transcripts that every single student uses the words "different", "they", or "other" at least once in their definitions of

cultural competence. There are also instances in which students use negative words to talk about their interactions with communities of color as reflected below in the interview with Student 5:

> But just being aware that there is a diverse culture in our country. You know I had a few experiences back in high school taking Spanish classes and being forced to be out in the community a few times then even taking a few courses you know getting just the experience with a different population like you know even though there's a huge Hispanic population now that they're practically not a minority anymore. Yeah but just realizing that there's different people that you're going to encounter all the time. It's what it means to me and how you can handle it appropriately.

Student 7 expresses "othering" through mutual exclusivity. She believes that, to understand the beliefs of others, you should "step away" from your own.

> I think its understanding the different cultural beliefs and even kind of opinions. I think depending on where you come from and what you believe and where your Race or religion is. I think it's just understand the broad spectrum of like other people's beliefs. So like, you know being able to step away from yours.

Almost all the students in this study believe that cultural competence has something to do with learning about "other" people and their differences. Given the common and hegemonic practice of "othering" already present in medicine and health disparities, effective teaching strategies in cultural competence should include exercises and strategies to identify and challenge the "othering" of patients. This could be accomplished in having students critically examine their own narratives, such as in this study. A focus should be placed on examining narratives regarding patients of color or who have intersecting aspects of identities that do not conform with the dominant White narrative, as race is a very visible marker of difference. As with inherent biases, students and healthcare providers likely do not realize that they are complicit in the "othering" of patients (Ahmed & Bates, 2017). It is only through learning to

challenge the characterization of someone who is racially different as "other" that we might begin to interrupt hegemonic practices and structural racism (Apple, 1995; Ladson Billings & Tate, 1995).

Lived Experiences and Engagement with Cultural Competence

Although only seven of the students recounted lived experiences with people of races and ethnicities different from themselves, the students who did share experiences, seemed to engage in learning about diversity and cultural competence to a greater degree than other students who did not related or have any experiences. This was noted during the three cycles of initial coding, during which I wrote reflective memos on each interview and after each observation. In the memos, I noted patterns that had begun to emerge from the open coding. The memos aided me in transitioning to axial coding which I used in a second cycle of analysis to determine which of the codes or themes in the initial cycle are dominant and which are less important (Saldana, 2013, p. 218). In this phase, I attempted to identify patterns and make summary statements based on similarities that were present within the interview. In examining the stories of experience that were recounted during the interviews, I attempted to identify themes that were generated.

The overarching theme that arose in this section was that students learned the most about cultural competency from having lived experiences, either through developing personal relationships people of different races and ethnicities, or immersive experiences in which they were the racial minority, such as studying abroad. Students who had these experiences with people who were different from themselves all said that the experiences, as opposed to anything

that they had learned in the classroom, had been much more impactful in learning about cultural competence. The remaining fourteen students, that did not recall or recount relationships with diverse people, pointed classroom assignments as having been more helpful to them in learning about diversity and cultural competence. For the students who identified classroom learning as the most impactful, several noted the film *Worlds Apart* (Maren Grainger-Monsen & Haslett, 2003), which documents real health care providers and their actual interactions with patients who are racially and ethnically different from themselves, as teaching them the most about cultural competency. Examples of the positive correlation between the students with lived experiences and the level of engagement in the assignments and the negative correlation between the students without experiences is discussed and supported in this section.

The students who had lived experiences with people of races or ethnicities different from themselves counted those experiences as most helpful in understanding and engaging in cultural competence. Student 20 recounts her experiences with studying abroad where she got sick and had to go to the hospital in Chile and in Finland:

> **Student 20**: Like I had health care experiences in both of the countries that I was studying in and I went to the hospital when I was sick and I had a totally different experience than when I went to the hospital when I was in Chile and it was just like I did not understand the language and kind of like the level of interpretation that I was given. When I was in South America I wasn't given an interpreter at all and it was really scary because I couldn't understand at all. I was told after my doctor's visit that I had to pay all the bills right away. Before I left and I didn't bring cash. I'm going to get paid. And I had to get fingerprinted to prove that I was going to pay and I was going to come back with the money. So kind of it really made me understand that you know I'm an educated person. I was 19 years old and had gone to the doctor before but I didn't know how their system worked. I didn't understand it. And it was kind of scary and a little bit confusing and it definitely gives you a better appreciation for patients who are coming to the hospital we're kind of afraid of the American medical system and how they might be feeling and how they might think that they have to pay their bills right away and. Just kind of the uncertainty that surrounds the medical field so I was very stressed out. So I kind of it gives me a different view, like how you put myself in the patient's shoes and know how they're feeling.

> **Interviewer:** When you think about cultural competency do you see a difference between learning about it and becoming culturally competent?
>
> **Student 20:** I definitely think it's something that you have to experience. When I was in Finland my whole family was with me and they understood enough and the doctor spoke a little English. So there was a little bit easier but they told me I had something called angina, which is chest pain but which it wasn't. There it is tonsilitis but that was the Finnish word for it. A little bit of misunderstanding but it helped me know how people feel when they don't understand the language. Yeah. And that certainly played a big role and to how I treat patients clinically. Especially when I don't know their language. With Hispanic patients I can usually understand what they're saying. But with people of different cultures it's harder to understand. So it's important.

Student 4 who recounted her experience in dating a man who was African American in the last section also recounts the value of her experience in understanding racism:

> **Student 4:** I think if I were to see someone else, like, maybe a different couple or just even friends, like, you can't really judge people by the color of their skin. (mumble) Like, they could be completely different, like, they don't fit what you think. Like, with our situation, um … he had a family member that, like, didn't-didn't approve of me because … I was …. White.
>
> **Interviewer:** Did that help you understand your boyfriend's experiences better?
>
> **Student 4:** Yeah, like if I were someone, like, I could see how, like, if you were different - from a different culture and you were in a, like a whole class, or city with limited people of different-of the same culture … see how that has the effect of… how they feel I guess.

The students who recounted lived experiences talked in their interviews about the value of having experiences that helped them understand how other people might feel in situations where they are in the minority. Student 20 counts her experiences of being sick in different countries from her own, as "essential" to being able to learn to be culturally competent.

In contrast, Students 10, 21, and 16, who gave examples of resistance and resentment at having to learn about cultural competence did not recount any lived experiences and pointed to some of the classroom assignments that they wrote about with anger as some of the most valuable in teaching them about diversity and culture. Student 21 who commented that watching *Miss Evers' Boys*, (Sargent, Miss Evers' Boys, 1997), was not valuable to her education in cultural competence, in the previous section, had this to say about the value of reading and discussing *Amazing Grace*, (Kozol, 1995):

> So I think learning about different activities like (teacher name) class that we just got through with. Her book The Amazing Grace. Amazing. Yeah. Because all the books I think those have just really helped. Things that you maybe have thought of one way and then it brings to light just the other aspects that you may not have considered. So, learning cultural competency elsewhere has not been as (pause) I guess in-depth as it has been here. And I think it's helped kind of refine what I thought cultural competency was. And also just learned more about different cultures together. I think the in-person talking discussions helped the most. Not so much the written discussions because they get long sometimes. By talking back and forth to each other really made me appreciate other people's opinion a lot more as you could see their emotion on their face. And you can hear the emotion along with getting their actual feedback on what they thought too because there is a lot of people who I thought would think one way about the situations in Kozol for example and then they are completely different. So great.

Ironically, this student was one who did not participate in the discussion about *Amazing Grace* at all. She did not contribute to the discussion at any time during the recorded observation. Students who did not have lived experiences to refer to, talked about classroom learning and assignments as the most valuable to their education but some of those students were the most resistant and emotional about participating in the activities that they said were increasing their education. This is important to note as, it may indicate some of the internal struggles that White students deal with in learning about cultural competence, which for many of these students, was

an area in which they had not had much prior experience.

Learning in any area comes with fear of the unknown and risks associated with making mistakes. For the students in this study, they were also asked to learn in an area which was not well defined, there was very little, if any, context and understanding as to why they were learning, and the content, especially concerning race and ethnicity, elicited strong emotions. Simultaneously, they are learning and training in healthcare, where for the first time, they are encountering and providing care to patients who are in various states of illness and injury. The narratives in this study give rise to a much deeper understanding of some of the complications, challenges and struggles for White students learning about cultural competence. The study also reveals some key areas where teachers or faculty who are engaging health professions students in learning about cultural competence may find valuable. Establishing a base understanding and definition of the concept of cultural competence is important, since this is an area that has been interpreted differently across the literature (Betancourt, et al., 2003). Outlining the context in which the learning is taking place is also equally important, especially when the learners are students and may not have much prior learning or understanding of the healthcare industry. The context should include an accurate narrative of the history and present U.S. healthcare system, with an underscoring of why learning about cultural competence is important (Gould, 1996; Borrell, et al., 2007). An understanding of the health disparities that exist, especially in communities of color, is essential for all students, but especially students to whom this learning is unfamiliar (Ford & Airhihenbuwa, 2010). Providing the understanding of the context should be balanced carefully with positive stories of the contributions and careers of healthcare providers and scientists of color, in order, to interrupt the tendency of White healthcare professionals to "other" their patients (Roberts & Schiavenato, 2017). Cultural competence

teaching should be approached with the care and understanding that, for many students this is a frightening experience. Teaching, especially by White faculty, should be undertaken with the understanding that learning in this area is never complete and that instead, we must be willing to be lifelong learners in cultural competence. Students should be made aware that to experience emotions or reactions in learning about cultural competence may be surprising it should also be expected in this sensitive topic. Finally, the importance of seeking out experiences within communities who are racially and ethnically diverse should be discussed and encouraged as essential to learning. Caution should also be given that seeking experiences should not be undertaken aggressively or with a personal agenda on the part of the White student, but instead undertaken with the utmost respect and gratitude for the opportunity to experience, learn and grow, so that we may be more compassionate, culturally competent and provide care that is not the same but instead, equitable and tailored to respect the cultural identities for all patients.

CHAPTER SIX:

CONCLUSION

Conclusion

The original intent in formulating the concept of cultural competence was to address challenges in communication between White healthcare providers and their increasingly diverse patients, which were contributing to lower quality care, experience and poor health outcomes, especially for patients of color (Cross, et al., 1989; Balsa & McGuire, 2001). In the over twenty-five years since the concept was introduced, educating the healthcare workforce in cultural competence has failed to make any measurable impact on improving health disparities. While progress has been made in establishing some standards and framework for teaching cultural competence (American Association of Medical Colleges, 2005; Marion, et al., 2017; U.S. Department of Health and Human Services, 2017), there are no examples in the literature of courses or programs of study that have been successful in education healthcare professionals in a way that successfully improves their interactions with patients. There also are no examples of where training and education has been linked to an improvement in health outcomes for patients (Betancourt, et, al., 2003; Renzaho, et. al., 2013). This is likely due, in part, to the reality that cultural competence is a contested concept (Brach & Fraserirector, 2000). Agreement is not present in the literature on what it means to be culturally competent, or how it might be taught or measured (Ahmed & Bates, 2017). Examples of courses in cultural competence for healthcare professionals demonstrate that there is a wide range of differences in curriculum, content, teaching and measurement methods. Many examples demonstrate the use of curriculum that promotes learning in the cognitive domain and uses quantitative measures of how much students learn about other cultures (Pilcher, et al., 2008; Campinha-Bacote, 2010). Some examples use

curriculum that includes readings, discussions or experiences that students are asked to reflect upon or write about (Durand, et al., 2012). Some courses focus on student exploration of inherent or unconsious biases (Chapman, et al., 2013). While most studies include an evaluation of learning outcomes, either qualitative or quantitative, there is very little on how students engage with the material as they are learning. Two studies were identified that measure student engagement through end of course or term with Likert style surveys that render some limited data about what students thought about the courses and frequency of cultural competence curriculum (Fulbright Sumpter & Brooks Carthon, 2011; Walsh Brennan & Cotter, 2008).

This study provided a deeper examination of undergraduate health professions student engagement across time, assignments and experiences, using narrative inquiry. Narrative inquiry allows experiences to be understood and meaning made through the telling of stories which occur over time (Chase, 2010; Charon, 2003; Clandinin & Connelly, 2000; Czarniawska, 2004). Narrative inquiry may be used to provide learning opportunities to the researcher, research participants and readers on multiple levels and in many ways and is particularly useful in the study of lived experiences (Chase, 2010; Nelson, 1997). Narratives have been used in medicine to study patients' and health care providers' experiences with illness, healing and bioethics. The practice of narrative medicine has been especially helpful in aiding physicians in developing empathy and communication skills that facilitate more positive interactions with patients (Charon, 2003; Mattingly & Garro, 2000; Nelson, 1997). Narratives in medicine have also been used to teach students about complex ethical situations that may arise in the clinical setting so that they may develop critical thinking skills and the ability to contribute to positive outcomes in complex ethical situations (Nelson, 1997). Narrative inquiry provides the researcher with the

ability to examine the lived experiences of the participants as contextualized in complex social spaces and times (Charon, 2003; Clandinin, 2013).

The students that participated in the study, all identified as White, female and twenty to thirty years of age. The faculty teaching the courses and I also identify as White, female and between the ages of thirty and fifty. The race, gender and ages of the participants and teachers and resesarcher is important to note as this study uses a critical lens, informed by critical race theory (CRT). CRT lays a framework for seeing the world, that includes the following understandings: 1) racism is commonplace and widely accepted, 2) intersecting aspects of identity may combine to make individuals especially vulnerable to discrimination and racism and 3) racism reinforces structures and practices that keep the dominant group in power (Crenshaw, 1991; Ladson Billings & Tate, 1995). This lens is important to this study as cultural competence involves discussions of race, class, gender, discrimination and racism which serve to contextualize the healthcare settings and to, in part, explain health disparities (Balsa & McGuire, 2001). The data was rendered through semi-structured interviews and the collection of reflective writing assignments, online discussions and recorded observations of in-class discussions. The data was assembled into individual narratives for each student reflective of their engagement and processing of cultural competence education.

The narratives were analysed and coded for themes. The categories into which the themes were rendered included: 1) issues in defining and contextualizing cultural competence, 2) emotional encounters learning that included race and ethnicity and 3) lived experiences and their impact on learning. The findings included that, students defined cultural competence in different ways but all definitions missed key components of the concept largely agreed upon in the literature, such as, learning how to provide communication or equitable care that respects and

honors cultural and linguistic differences in patients. Most students also did not understand why they were learning about cultural competence or that the lack of culturally competent care is linked to health disparities in communities of color. No students had a good understanding of racism or discrimination in medicine and healthcare or how those things worked to perpetuate disparities in health outcomes, especially for people of color (Fiscella, et al., 2002). Second, emotion and resistance were noted in several of the interviews, writing assignments and in the recorded discussions. The strongest emotions were noted in connection with discussions, assignments or the relating of experiences that involved people or communities of color. The increased resistance, tension and emotion when engaging with learning about people of color was evidenced in the contrast in student behavior and engagement between the in class discussions regarding *Amazing Grace* (Kozol, 1995), which relates the stories and struggles of communities of color in the Bronx and *The Man with the Iron Tatoo* (Castaldo & Levitt, 2007) which relates stories of physician engagement with diverse, but not specifically racially or ethnically diverse patients. There was significantly less tension exhibited in the discussion of *The Man with the Iron Tatoo* and with some prompting, students demonstrated robust engagement in discussing the short stories, none of which involved patients of color. By contrast, in the discussion of *Amazing Grace,* most students did not participate at all in discussing, even with instructor prompting. Last, experiences, especially those that are personal or more immersive gave students a better understanding of the importance and a higher engagement with learning about cultural competence. Students that did not have lived experiences pointed to classroom assignments or discussions as more impactful in their learning, at the same time exhibiting the most resistance and anger in their narratives, in regards to the classroom assignments, especially those involving communities or people of color.

While the findings in this study should not be interpreted as transferrable to other groups or used to make general assumptions about this specific group (Clandinin & Connelly, 2000), The study does render some important understandings. First, when engaging in teaching about cultural competence, preparation of a curriculum that begins with defining and framing the concept is very important. The framework should include a robust discussion of the similarities and differences between the published guidenlines, standards and competencies (Clark, et al., 2011; Mihalic, et al., 2010). It is important that students understand the general definition from Cross, et al. (1989), along with the discussion that boundaries and what should be included within cultural competence is not completely agreed upon. If students do not understand what they are learning about, it will be difficult to make any progress in comprehension. In not understanding cultural competence, combined with the knowledge that this is a sensitive area for learning, students may exhibit resistance and forced learning may promote students to hold tighter to biases, stereotypes and a resentment of difference by association with the topic. Students also must have a good understanding of the definition in order to learn about the context and why they are learning about cultural competence. If they do not understand why they are learning about cultural competence, they will not understand the larger goal of ultimately improving health outcomes. The idea of improving health outcomes for patients, by providing a superordinate goal, may motivate the students to fully engage in learning. This, in turn, may elicit more enthusiastic participation and better learning outcomes (Amos, 2010). In providing a context, for cultural competence, the history and present system and examples of bias, discrimination and racism should be truthfully related and discussed along with the contribution of these events to health disparities and deeply rooted distrust of the U.S. medical system. (American Association of Medical Colleges, 2005). Within providing the context, stories

highlighting the accomplishments and contributions of healthcare professionals and scientists, should be deliberately and liberally included in the curriculum. In embracing multicultural education theory and curriculum, students may begin to learn about diverse communities in a new and essential way. One which does not paint people of color as the perpetual victims and patients but as successful, credible and acomplished contributers to the field (Sleeter & Grant, 1987).

Second, students should be prepared that learning about cultural competence, in definition and context may be an emotional undertaking. Effectively learning about cultural competence includes changing behaviors and attitudes and involves sensitive discussions about race, class, gender, religion, age and other characteristics of identity as well as stories of illness, exploitation and suffering. Learning in the affective learning domain requires a deep level of self examination, including critical assessment of one's own identity, beliefs, attitudes and ontology, which may be difficult (Amos, 2010). Learning about the context of cultural competence also involves learning about a history that is fraught with discrimination, exploitation, racism and other instances of the mistreatment and harm to people and whole communities (Gamble, 1997). This is difficult and deep subject matter, especially for students who have never heard it before. Student learning in this area must also include an examination of their position as health care professional in the clinical setting and the power differential that exists between patient and provider which may further be complicated by the intersecting factors of race, gender and socio-economic status, among other factors (Crenshaw, 1991). Students must discuss how existing power differentials may contribute to providers, consciously or unconsciously "othering" their patients (Apple, 1995; Roberts & Schiavenato, 2017). Teachers must facilitate discussions and learning in a way that is not punitive and allows students a safe space in which to explore and

engage with sensitive topics. Teachers should be prepared to encounter reactions that are emotional, unexpected and reactive and be able to use skilled facilitation to ensure that the emotions are discussed and understood so as not to promote resistance, resentment and negativity associated with learning about cultural competence.

Last the value of experiential learning in this area should be discussed and communicated. This study revealed that the students in this group who had lived experiences, experiences of being a minority or personal relationships with people of different races and ethnicities were much more open, willing to learn and understanding of the need for learning in this area. Students should understand that experiences are essential to becoming culturally competent and that embarking upon learning in this area is a lifelong process which is never complete (Renzaho, et al., 2013). Students should also understand that seeking out experiences means that they may have uncomfortable experiences, however, as with anything else, those experiences should be repeated until the student becomes more comfortable. Students should also be cautioned that their approach in seeking out experiences with people and communities that are racially and ethnically different from themselves must be respectful and without expectations that the people and communities should be responsible for educating the student. The context and why the learning and experiences are necessary should be completely understood by the student, in that, communities of color have been historically discriminated against and silenced by the White majority. There exists distrust and resentment within the communities that should not deterr White students from seeking experiences, but should aid them in ensuring that their approach is appropriately respectful and not entitled or discriminatory (Dharamsi, 2011). Experiences may serve to teach students in a way that aids in mitigating inherent biases and provides a more impactful and lasting understanding.

This study that encompasses the narratives of twenty-one White health professional students as they engage with learning about cultural competence provides value for anyone who is learning or teaching about cultural competence in healthcare. The stories, told through interviews, writings and discussions provide insight into the struggles, emotion and way in which this group of students engaged with learning. In addition to filling a void in the existing literature, it is my hope that with each reading and re-reading, new discoveries may become apparent to each reader. Cultural competence is a lifelong learning experience for both the learner and the teacher and this study of these students' own unique words and understandings has the potential to serve as a tool to perpetuate that lifelong learning.

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APPENDIX A:

AAMA Cultural Competency Education, 2005, (American Association of Medical Colleges, 2005)

Developing and Implementing A Cultural Competence Curriculum

The five TACCT domains provide a framework for considering the components of a cultural competence curriculum. For each of these domains, there are specific knowledge (K), skills (S), and attitudes (A) that need to be taught and evaluated. The following material provides details on the components for each domain. The individual education experience developed to achieve these goals will be determined by a number of factors including, but not limited to, the level of the learner, available educational resources and other curricular experiences.

Domain I: Cultural Competence—Rationale, Context, and Definition

At the end of medical school, students will:

K1. Define—in contemporary terms—race, ethnicity, and culture, and their implications in health care.

K2. Identify how these factors—race, ethnicity, and culture—affect health and health-care quality, cost, and consequences.

K3. Identify patterns of national data on health, health-care disparities, and quality of health care.

K4. Describe national health data in a worldwide immigration context.

S1. Discuss race, ethnicity, and culture in the context of the medical interview and health care.

S2. Use self-assessment tools, asking: What is my culture? What are my assumptions/stereotypes/biases?

S3. Use Healthy People 20107 and other resources to make concrete the epidemiology of health-care disparities.

A1. Describe their own cultural background and biases.

A2. Value the importance of the link between effective communication and quality care.

A3. Value the importance of diversity in health care and address the challenges and opportunities it poses.

Domain II: Key Aspects of Cultural Competence

At the end of medical school, students will:

K1. Describe historical models of common health beliefs and health belief models (for example, illness in the context of "hot and cold," Galen and other cultures).

K2. Recognize patients'/families' healing traditions and beliefs, including ethno-medical beliefs.

K3. Describe common challenges in cross-cultural communication (for example, trust, style).

K4. Demonstrate basic knowledge of epidemiology and biostatistics.

K5. Describe factors that contribute to variability in population health.

S1. Outline a framework to assess communities according to population health criteria, social mores, cultural beliefs, and needs.

S2. Ask questions to elicit patient preferences and respond appropriately to patient feedback about key cross-cultural issues. Elicit additional information about ethno-medical conditions and ethno-medical healers.

S3. Elicit information from patient in context of family-centered care.

S4. Collaborate with communities to address community needs.

S5. Recognize and describe institutional cultural issues.

A1. Exhibit comfort when conversing with patients/colleagues about cultural issues.

A2. Ask questions and listen to patients discuss their health beliefs in a nonjudgmental manner.

A3. Value the importance of social determinants and community factors on health and strive to address them.

A4. Value the importance of curiosity, empathy, and respect in patient care.

Domain III: Understanding the Impact of Stereotyping on Medical Decision-Making

At the end of medical school, students will:

K1. Describe social cognitive factors and impact of race/ethnicity, culture, and class on clinical decision-making.

K2. Identify how physician bias and stereotyping can affect interaction with patients, families, communities, and other members of the health-care team.

K3. Recognize physicians' own potential for biases and unavoidable stereotyping in a clinical encounter.

K4. Describe the inherent power imbalance between physician and patient and how it affects the clinical encounter.

K5. Describe patterns of health-care disparities that can result, at least in part, from physician bias.

K6. Describe strategies for partnering with community activists to eliminate racism and other bias from health care.

S1. Demonstrate strategies to assess, manage, and reduce bias and its effects in the clinical encounter.

S2. Describe strategies for reducing physician's own biases.

S3. Demonstrate strategies for addressing bias and stereotyping in others.

S4. Engage in reflection about their own cultural beliefs and practices.

S5. Use reflective practices in patient care. S6. Gather and use local data as examples of Healthy People 2010.

A1. Identify their own stereotypes and biases that may affect clinical encounters.

A2. Recognize how physician biases impact the quality of health care.

A3. Describe/model potential ways to address bias in the clinical setting.

A4. Recognize importance of bias and stereotyping on clinical decision-making.

A5. Recognize need to address personal susceptibility to bias and stereotyping

Domain IV: Health Disparities and Factors Influencing Health

At the end of medical school, students will:

K1. Describe factors other than bio-medical—such as access, historical, political, environmental, and institutional—that impact health and underlie health and health-care disparities.

K2. Discuss social determinants on health including, but not limited to, the impact of education, culture, socioeconomic status, housing, and employment.

K3. Describe systemic and medical-encounter issues, including communication, clinical decision-making, and patient preferences.

K4. Identify and discuss key areas of disparities described in Healthy People 2010 and the Institute of Medicine's Report, Unequal Treatment.

K5. Describe important elements involved in community-based experiences.

K6. Discuss barriers to eliminating health disparities.

S1. Critically appraise the literature as it relates to health disparities, including systems issues and quality in health care.

S2. Describe methods to identify key community leaders.

S3. Develop a proposal for a community-based health intervention.

S4. Actively strategize ways to counteract bias in clinical practice.

A1. Recognize the existence of disparities that are amenable to intervention.

A2. Realize the historical impact of racism and discrimination on health and health care.

A3. Value eliminating disparities.

Domain V: Cross-Cultural Clinical Skills

At the end of medical school, students will:

K1. Identify questions about health practices and beliefs that might be important in a specific local community.

K2. Describe models of effective cross-cultural communication, assessment, and negotiation. (See following pages for some models.)

K3. Understand models for physician-patient negotiation.

K4. Describe the functions of an interpreter.

K5. List effective ways of working with an interpreter.

K6. List ways to enhance patient adherence by collaborating with traditional and other community healers.

S1. Elicit a culture, social, and medical history, including a patient's health beliefs and model of their illness.

S2. Use negotiating and problem-solving skills in shared decision-making with a patient.

S3. Identify when an interpreter is needed and collaborate with interpreter effectively.

S4. Assess and enhance patient adherence based on the patient's explanatory model.

S5. Recognize and manage the impact of bias, class, and power on the clinical encounter.

A1. Demonstrate respect for a patient's cultural and health beliefs.

A2. Acknowledge their own biases and the potential impact they have on the quality of health care.

APPENDIX B:

American Nurses Association Practice Standard 8, (American Nurses Association, 2015 pp. 69-70)

Table 2. Standard 8. Culturally Congruent Practice and Associated Competencies

The registered nurse practices in a manner that is congruent with cultural diversity and inclusion principles.

Competencies for the registered nurse:

1. Demonstrates respect, equity, and empathy in actions and interactions with all healthcare consumers.
2. Participates in lifelong learning to understand cultural preferences, worldview, choices, and decision-making processes of diverse consumers.
3. Creates an inventory of one's own values, beliefs, and cultural heritage.
4. Applies knowledge of variations in health beliefs, practices, and communication patterns in all nursing practice activities.
5. Identifies the stage of the consumer's acculturation and accompanying patterns of needs and engagement.
6. Considers the effects and impact of discrimination and oppression on practice within and among vulnerable cultural groups.
7. Uses skills and tools that are appropriately vetted for the culture, literacy, and language of the population served.
8. Communicates with appropriate language and behaviors, including the use of medical interpreters and translators in accordance with consumer preferences.
9. Identifies the cultural-specific meaning of interactions, terms, and content.
10. Respects consumer decisions based on age, tradition, belief and family influence, and stage of acculturation.
11. Advocates for policies that promote health and prevent harm among culturally diverse, under-served, or under-represented consumers.
12. Promotes equal access to services, tests, interventions, health promotion programs, enrollment in research, education, and other opportunities.

13. Educates nurse colleagues and other professionals about cultural similarities and differences of healthcare consumers, families, groups, communities, and populations.

Additional competencies for the graduate-level prepared registered nurse:

14. Evaluates tools, instruments, and services provided to culturally diverse populations.
15. Advances organizational policies, programs, services, and practices that reflect respect, equity, and values for diversity and inclusion.
16. Engages consumers, key stakeholders, and others in designing and establishing internal and external cross-cultural partnerships.
17. Conducts research to improve healthcare and healthcare outcomes for culturally diverse consumers.
18. Develops recruitment and retention strategies to achieve a multicultural workforce.

Additional competencies for the advanced practice registered nurse:

19. Promotes shared decision-making solutions in planning, prescribing, and evaluating processes when the health care consumer's cultural preferences and norms may create incompatibility with evidence-based practice.
20. Leads interprofessional teams to identify the cultural and language needs of the consumer.

American Nurses Association. (2015a, pp. 69-70). Reprinted with permission.

Table 3. Process for Competency Enhancement/Development

The following steps apply to the nursing process for the purpose of enhancing or developing one's own nursing competencies. The steps include:

Assessment of one's own competencies
Diagnosis of competency gaps, i.e., competencies in need of further refining or development
Establish competency goal or goals, e.g., timeframe within which competency will be more fully enhanced or developed
Create plan to achieve competency goal
Implement competency goal enhancement/development plan
Establish an on-going program to evaluate self-progress, attainment of competency benchmark, and increasing mastery of the competency

Note: Tools used to achieve new competencies include continuing education, professional reading, attendance at lectures, TED talks, seeking input and guidance from respected consumers, peers, colleagues, current or past mentors as well as methods using newer technologies, e.g., videotaping and analysis of performance in practice.

APPENDIX C:

Culturally and Linguistically Appropriate Service (CLAS) Standards, (U.S. Department of Health and Human Services, 2013)

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

Principal Standard

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

Governance, Leadership and Workforce

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.

6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

Engagement, Continuous Improvement, and Accountability

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.