ACCP White Paper

Cultural Competence in Health Care and Its Implications for Pharmacy

Part 1. Overview of Key Concepts in Multicultural Health Care

American College of Clinical Pharmacy

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Pharmacists are caring for more individuals of diverse age, gender, race, ethnicity, socioeconomic status, religion, sexual orientation, and health beliefs than in previous decades. Not all residents of the United States equally experience long life spans and good health. Health disparities in various cultures have been documented. One critical aspect of reducing health disparities is moving health care providers, staff, administrators, and practices toward increased cultural competence and proficiency. Effective delivery of culturally and linguistically appropriate service in cross-cultural settings is identified as cultural competence. Culture is a dynamic process, with people moving in and out of various cultures throughout their lives. The failure to understand and respect individuals and their cultures could impede pharmaceutical care. Incongruent beliefs and expectations between the patient and pharmacist could lead to misunderstandings, confusion, and ultimately to drug misadventures. Models and frameworks have been developed that provide descriptions of the process by which individuals, practice settings, and organizations can become culturally competent and proficient. This article, the first in a five-part series, presents an overview of issues related to cultural competence in health care with an emphasis on the pharmacy profession. Also provided are definitions for cultural competence and related terms, a brief overview of health disparities and challenges to the common morality, and a discussion of models and frameworks that describe pathways to cultural competence and proficiency.

Key Words: pharmacy, culture, cultural competence, cultural diversity, ethnicity, minority, age, sexual orientation, gender, health policy, health service accessibility, health care delivery.

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Within today's health care system, health disparities have been well documented.[1–19] One critical aspect of reducing health disparities is improving cultural competence in health care providers, staff, administrators, and clinical practices. Pharmacists are integral members of health care teams and can play a pivotal role in the elimination of drug-related health disparities. The pharmacy profession must achieve greater cultural competence. If practitioners have culturally competent attitudes, knowledge, and skills, care can be improved for all patients. The cultural diversity of patients includes differences in age, gender, race, ethnicity, socioeconomic status, religion, sexual orientation, and health beliefs.

Models and frameworks have been developed to depict a path to cultural competence and help

to identify and overcome barriers to such practice.[9, 20–24] A typical first step within these models is a self-assessment and/or organizational assessment, which provides an increased understanding of one's own culture and the organization's culture. These assessments identify areas of current cultural competence and areas for future growth and development. Changes in self, practice, organizations, education, and research must occur to achieve cultural competence.

In this first article in a five-part series, an overview of issues related to cultural competence in health care is presented, with an emphasis on the pharmacy profession. Also provided are definitions for cultural competence both broadly and within the context of the pharmacy profession, a brief overview of health disparities, and some models and frameworks to achieve cultural competence. Part 2 will focus on cultural competence in health systems, including pharmacy practice. Part 3 will cover cultural issues and pharmacy education, and part 4 will focus on cultural competence and research. Part 5 will conclude with recommendations approved by the American College of Clinical Pharmacy Board of Regents for pharmacy and the American College of Clinical Pharmacy organization.

Culture and Related Definitions

To understand culture, it is important to define some specific terms and concepts (Table 1).[4, 9, 10, 22, 24–45] Many definitions exist for these terms. Generally, only one definition was selected; however, for some (e.g., culture and cultural competence), more than one was included. Some definitions are evolving or can be controversial such as those for sexual minority, gender minorities, or transgender.

Although most people equate culture with race or ethnicity, it also includes age, gender, disability, religion, socioeconomics, sexual orientation, and health beliefs. Thus, a person has many cultures that define who he or she is. Many of these cultural beliefs influence a patient's health beliefs. The Purnell model for cultural competence depicts many of the culturally influenced health beliefs (Figure 1).[46] This model lists primary characteristics that usually are not changeable and secondary characteristics influenced by culture that are more easily changeable and influenced by time, family, community, society, and relocation.

Culture is shared among a group of individuals, but all individuals in the culture do not necessarily think and act alike. Thus, stereotyping by universally applying cultural characteristics to all patients can lead to inappropriate, incorrect, or non–patient-specific health care decisions. For example, only 10–30% of Arab-Americans practice the Islamic faith.[47] Many of the American Muslims are of African heritage. Also, culture is a dynamic process. Many people move in and out of various cultures throughout their lives. For example, immigrants may assimilate to the culture of the United States but may also retain the culture from which they came. Culture influences a person's health, illness, and treatment decisions. The failure to understand patients and their culture could impede pharmaceutical care. Incongruent beliefs and expectations between the patient and pharmacist might lead to misunderstandings, to confusion, and ultimately to drug misadventures.[48] Inability to explain a prescription in the patient's language can lead to poor adherence, lack of effect, or toxicities.[49, 50] Furthermore, if a patient identifies the best treatment for an illness as an herbal product, prayer, or a shaman, the pharmacist must be prepared to accommodate these cultural practices by integrating these practices into a treatment plan or acknowledging acceptance of combined traditional and alternative therapies. A patient who believes that the source of her illness is spiritual might be less likely to adhere to a drug treatment plan that does not acknowledge or incorporate her spiritual traditions. Development of cultural competence in pharmacy practices has the potential to increase effectiveness of drug therapy and favorably affect health outcomes.

Health care providers and students must also understand that they belong to a professional culture—a culture of biomedicine.[51, 52] Through career selection and/or training, health care professionals predominantly believe in the use of procedures, drugs, and surgery to minimize or

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Table 1. Definitions of Terms Related to the Concept of Culture

Term	Definition
Acculturation	"The product of culture learning that occurs as a result of contact between the members of two or more culturally distinct groups."[25]
Ageism	"Prejudice or discrimination against or in favor of an age group."[26]
Assimilation	"The process by which cultural distinctions between ethnic groups are minimized or eliminated."[27]
Biomedical views	"Diseases as natural mechanistic errors, correctable with interchangeable or repairable parts or by manipulating chemical pathways that are the cause of distress."[10]
Caring	"Attitudes, judgments, and actions that show support and professional skill."[28]
Culture	"Integrated pattern of human behaviors that includes thoughts, communications, languages, practices, beliefs, values, customs, courtesies, rituals, manners of interacting and roles, relationships and expected behaviors of a racial, ethnic, religious or social group; and the ability to transmit the above to succeeding generations."[29] "Culture shapes how we explain and value the world and provides us with the lens through which we find meaning."[30] "Process in which views and practices are dynamically affected by social transformations, social conflicts, power relationships, and migrations."[31]
Cultural competence	"Ability of individuals and systems to respond respectfully and effectively to people of all cultures, classes, races, ethnic backgrounds, and religions in a manner that recognizes, affirms, and values the cultural differences and similarities and the worth of individuals, families, and communities and protects and preserves the dignity of each." (Reprinted with permission from Public Health—Seattle & King County, Seattle, WA, January 27, 2005.) A set of congruent behaviors, knowledge, attitudes, and policies that come together in a system, organization, or among professionals that enables effective work in cross-cultural situations.[24]
Culturally competent health care system	"Acknowledges and incorporates, at all levels, the importance of culture, health care system assessment of cross-cultural relationships, vigilance towards the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs."[32]
Cultural proficiency	Cultural competency with a research and dissemination component.[9, 22]
Discrimination	"Differential actions toward others according to their race."[33]
Disease	"Objective, measurable, pathophysiology that creates illness."[10]
Disparity	Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention.[38]
Diversity	"Collective mixture of any combination of individuals who are different in some ways and similar in others. This mixture includes both the primary dimensions of diversity (i.e., age, ethnicity, gender, mental/physical characteristics, race, and sexual orientation) as well as secondary dimensions (i.e., communication, education, family status, military experience, organizational role and level, religion, first language, geographic location, income, work experience, and work style)."[34]
Enculturation	"A process by which developing individuals acquire (either by generalized learning in a particular cultural milieu, or as a result of specific instruction and training) the host of cultural and psychological qualities that are necessary to function as a member of one's group."[35]
Ethic	"A set of principles of right conduct; a theory or system of moral values."[44]
Ethnicity	"Groups of people classed according to common racial, national, tribal, religious, linguistic, or cultural origin or background."[36]
Ethnocentrism	View that one's "own cultural orientation is the 'correct' view of reality."[9]
Ethnohistory	"Past facts, events, instances, experiences of individuals, groups, cultures, and institutions that are primarily people-centered (ethno) and used to explain and interpret human lifeways of particular cultures over short or long periods of time."[37]
Gender minority	An umbrella term that is used for people whose gender identity or experience runs contrary to norms. This can include transsexual, cross-gender living, intersexed individuals, and others.[41]
Generalization	"Draws on experiences and commonalities of groups or cultures while allowing room for the individual experience."[45]
Health	"State of well-being that is culturally defined, valued, and practiced which reflects the ability of individuals (groups) to perform their daily role activities in culturally expressed, beneficial, and patterned ways."[43]

eliminate disease. This culture has its own language, a strong belief in technology and medical science, and the ability to overcome disease that is defined solely in pathophysiologic

Table 1. Definitions of Terms Related to the Concept of Culture (continued)

Term	Definition
Health disparity	"Racial or ethnic differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of intervention … [but related to] the operation of health care systems and the legal and regulatory climate …[and] discrimination: … biases, prejudices, stereotypes, and uncertainty in clinical communication and decision-making."[38] "Potentially avoidable differences in health (or in health risk that policy can influence) between groups of people who are more and less advantaged socially; these differences systematically place socially disadvantaged groups at further disadvantage on health."[39]
Heterosexism	"Belief that heterosexuality is the only 'natural' sexuality and that it is inherently healthier or superior to other types of sexuality."[40]
Homophobia	An irrational hatred and fear of lesbian and gay people that is produced by biases against a nonheterosexual orientation.[41]
Illness	"Meaning of disease to the individual or her/his social group; etiology can be natural, supernatural, or metaphysica."[10]
Institutional culture	"Learned, shared, and transmitted values, symbols, beliefs, norms, and lifeway practices within a short-term or long-term health care setting or organization that guides the thinking, decision making, and actions of residents and staff in serving others."[43]
Institutional racism	"Differential access to the goods, services, and opportunities of society by race"; differences in material conditions and power.[33]
Insurgent multiculturalism	Movement beyond cultural competence and multiculturalism tolerance to the influence of power and the foundations of inequities that allow some groups but not others to acquire and keep resources.[42]
Morality	"The quality of being in accord with standards of right or good conduct. A system of ideas of right and wrong conduct, e.g., religious morality."[44]
Personally mediated racism	Intentional or unintentional prejudice or discrimination, acts of racism omission and commission; lack of respect, suspicion, devaluation, scapegoating, and dehumanization.[33]
Prejudice	"Unjustified negative attitude based on a person's group membership."[38]
Race	"Possessing traits that are transmissible by descent and sufficient to characterize it as a distinct human type."[36]
Sexual minority	A person with an orientation toward people of the same gender in sexual behavior, affection or attraction and/or a person who self-identifies as gay, lesbian, or bisexual.[4, 41]
Sociocultural barriers	"A social or cultural quality, characteristic, or experience of a racial/ethnic group or individual that led to differential treatment and varying quality of care."[32]
Stereotypes	"Imposing preconceived assumptions or observations about behaviors, beliefs, and actions to individuals without evaluating unique values and experiences."[45]
Subculture	"Group that deviates in certain areas from the dominant culture in values, beliefs, norms, moral codes, and ways of living with some distinctive or unique features of its own but usually closely related to the dominant culture."[43]
Transgender	An umbrella term that is used for people whose gender identity or experience runs contrary to norms. This can include transsexual, cross-gender living, intersexed individuals, and others.[41]

terms. Initially, this culture was hierarchical with a health care provider, usually the physician, as the center focus, but it now is adopting a patient-centered focus. Also, this culture once focused predominantly on disease and treatment, but over time began to focus on health, wellness, and prevention. Initially, this culture ignored nonbiomedical treatment options; slowly it is encompassing complementary and alternative medicine, but frequently only if scientific evidence is supportive. Thus, in addition to personal cultures, the biomedical professional culture itself can create ethnocentrism. Therefore, professional ethnocentrism can also create a need to evaluate one's cultural beliefs and practices.

Cultural Competence and Related Definitions

Effective delivery of culturally and linguistically appropriate service in cross-cultural settings is identified as culturally competent practice. To achieve cultural competence, health care professionals and the health care systems in which they work will increasingly be expected to undertake changes in awareness, attitude, behaviors, and skills.

Cultural competence is a continuous process

undertaken to ensure that care is delivered in an appropriate manner among diverse populations of patients, health care providers, and staff. Becoming culturally competent also requires a conscious effort to reduce any ethnocentric biases that one may have. Ethnocentrism describes the belief that one's own culture is superior to that of others.[9, 43] This belief exists in all people, shaping attitudes and actions at both a conscious and unconscious level. Ethnocentrism tends to shape behavior of groups toward members of outside cultures. When values, attitudes, or beliefs of different cultures conflict, individuals of one culture might disregard, dismiss, or try to influence or control the expression of the other culture. For instance, within a pharmacy setting, pharmacists treating patients might dismiss the patients' concerns or try to enforce their beliefs on the patients. In another scenario, a patient interacting with the pharmacist, pharmacy technician, another health care provider, or the health care system might disregard instructions. In either case, barriers to the adequate provision of care could arise from a

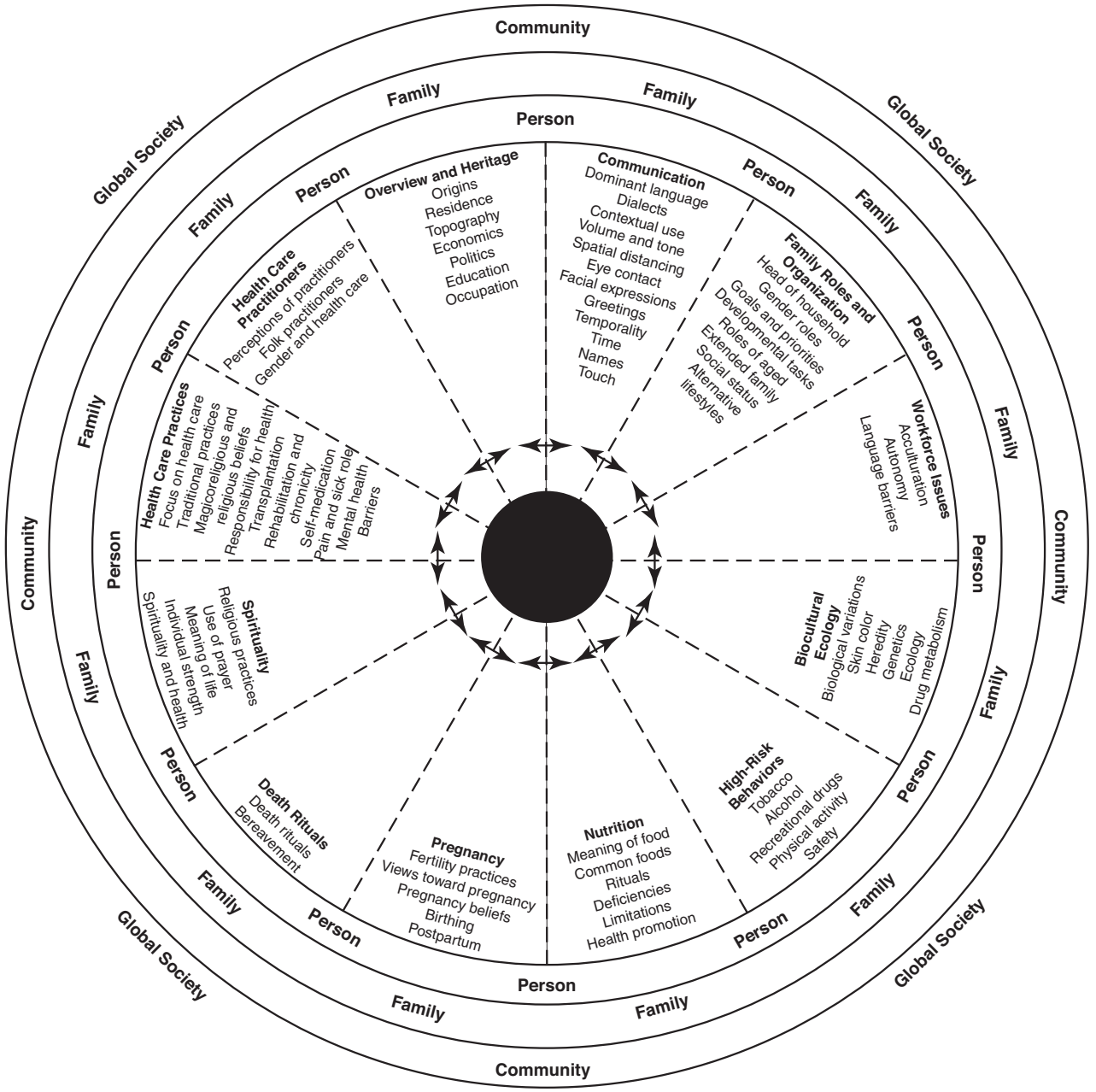

Figure 1. Purnell model for cultural competence. (From reference 46 with permission.)

Table 2. Examples of Diversity in Population Demographics and Characteristics

Characteristic	Comment
Age	In the 2000 U.S. Census, 25.7% of the population were < 18 years and 12.4% were ≥ 65 years.[58] Over the next 50 years, the U.S. Census Bureau estimates a 114% increase of those aged 65–84 years and a 389% increase of those aged ≥ 85 years.[63]
Disability	In the 2000 U.S. Census, 8% of those 5–20 years old, 19% of those 21–64 years old, and 42% of those ≥ 65 years old listed a disability.[59]
Education	During the last census, 88% of non-Hispanic whites, 79% of blacks, 86% of Asians and Pacific Islanders, and 57% of Hispanics had completed high school.[60]
Gender	Although overall equal numbers of women (50.9%) and men (49.1%) were identified in the total 2000 U.S. Census population, women outnumbered men in later years: 54% in the 65–69-year cohort, 56% in the 70–74-year cohort, 59% in the 75–79-year cohort, 63% in the 80–84-year cohort, 69% in the 85–89-year cohort, and 76% in the > 90-year cohort.[57]
Parenting	Approximately 2.4 million seniors are the primary caregivers for their grandchild(ren).[61]
Poverty	Data reported in the 2000 Census revealed that 24% of blacks, 23% of Hispanics, 11% of Asians and Pacific Islanders, and 8% of non-Hispanic whites lived below the poverty line. The rates for poverty among children of varying race were 33% blacks, 30% Hispanic, 12% Asians and Pacific Islanders, and 9% non-Hispanic whites.[60]
Religion	In the Pew Forum on Religion and Public Life Survey, 55% listed Protestant, 22% Catholic, 2.7% other Christian (e.g., Christian Scientists, Church of Jesus Christ of Latter-day Saints [Mormons], Orthodox churches), 2.7% other faiths (e.g., Hindus, Muslim, Buddhist, Unitarian Universalists, New Agers), 1.9% Jewish, and 16% unaffiliated (e.g., unaffiliated believers, secular, atheist, agnostic).[62]
Sexual orientation	Estimated values range from 1.4–4.3% for women to self-identify as lesbian or bisexual and 2.8–9.1% for men to self-identify as gay or bisexual.[4]

lack of communication, inappropriate use of position or power, or loss of trust due to a perceived cultural violation.

United States Population

Population demographics in the United States are changing with rapid growth in racial and ethnic minorities. The self-declared race categories in the 2000 U.S. Census data were as follows: white 75.1%, black 12.6%, Asian 4.1%, American Indian or Alaska Native 1.4%, Native Hawaiian and other Pacific Islander 0.3%, and other races 6.4%.[53] At this time, 13% of the population self-declared themselves to be Hispanic or Latino. Eleven percent of the population was foreign born, with 52% from Latin America and 26% from Asian countries.[54] In 4.4 million households, no individual 14 years or older could speak English "very well," which is up from 2.9 million in 1990.[55] In the 2000 Census, participants reported speaking 321 different languages.[56] The languages, in descending order, that are spoken most frequently in the United States after English and Spanish are Chinese, French, German, Tagalog, Vietnamese, Italian, Korean, Russian, Polish, and Arabic.[55] According to U.S. Census Bureau projections, current racial and ethnic minorities will constitute 50% of the total population in 2050.[57] In addition to ethnic and racial diversity, the U.S. population is characterized by other cultural differences such as age, gender, physical ability, education, socioeconomic status, religion, and sexual orientation. Examples of diversity in population demographics and characteristics appear in Table 2.[4, 57–63]

Health Disparities

Not all Americans equally experience long life spans and good health. Few studies track minority health over time; however, one important study is the Racial and Ethnic Approaches to Community Health (REACH) 2010 Risk Factor Survey, which focuses on blacks, Hispanics, Asians or Pacific Islanders, and American Indians.[8] Studies have documented cultural differences in the practice and utilization of preventive health behaviors and services.[5, 6, 8] Racial minority groups have fewer breast cancer screenings, less β-blocker use after a myocardial infarction, and fewer diabetes mellitus–related eye examinations than whites after adjustment for age, gender, and income.[5, 6] Minority groups also get fewer vaccinations, consume less fruits and vegetables, and smoke more.[8]

Racial minority groups have poorer health status compared with whites.[6, 8–11] Infant mortality is twice as high among blacks, Native

Table 3. Examples of Disparities and Barriers in Health Care Delivery

Population or System Parameter	Disparity or Barrier
Health coverage	Racial minorities are more likely to have lower end health plans with stricter limits on covered services.[38, 64]
Language	Twenty percent of Spanish-speaking patients delayed or refused health care because of language barriers.[21] When the patient and physician have language discord, more drugs are omitted, more appointments are missed, and more emergency room visits occur.[32] Many health care facilities have inadequate language support or translators.
Literacy	Low literacy increases hospitalizations and results in later stages of cancer at initial diagnosis, poorer drug adherence, higher health care costs, and more patients reporting poor self-rated health.[65]
Primary care	Racial minorities are less likely to have a primary care physician: 80% of whites, 70% of African-Americans, 68% of Asians, and 57% of Hispanics reported having a primary care physician.[9] Thus, not surprisingly, the Medical Expenditure Panel Survey found that minority patients receive primary care more often in the hospital than from a primary care physician, have more trouble getting health care appointments, and wait longer to be seen, even after controlling for health insurance status.[10] Because of cost, 16–17% of blacks, 23–30% of Hispanics, 13% of Asians and Pacific Islanders, and 11–14% of Native Americans could not see a doctor vs 8–12% for the national average.[8]
Sexual orientation	Nonheterosexual women were found to receive routine health screenings less frequently (e.g., lipid profiles, mammograms, and Pap smears), delay treatment (e.g., for breast cancer), and be less likely to have a regular primary care provider.[4, 40]
Specialist care	Minorities with human immunodeficiency virus or acquired immunodeficiency syndrome are less likely to be treated by infectious diseases specialists than are whites.[66]
Utilization	Uninsured minorities are more likely to receive less preventive health care, have a higher usage of the emergency room, have more avoidable hospitalizations, have cancer diagnosed in later stages, and have greater difficulty getting prescriptions filled.[32] Even with insurance, minorities have lower rates of cardiac catheterizations, analgesic prescriptions, surgery, and certain treatments such as mammograms and immunizations.

Americans, and some Asian-American and Pacific Islander groups compared with whites, and maternal morbidity is 4 times greater in African-Americans than in whites.[10] From 1996–2000, cancer mortality/100,000 people was 555 in blacks, 416 in whites, 289 in Hispanic-Latinos, 288 in American Indians and Alaskan Natives, and 257 in Asians or Pacific Islanders.[6] The 5-year survival rates were similar between non-Hispanic whites, Hispanic-Latinos, and Asians or Pacific Islanders, which were higher than those for African-Americans and American Indians or Alaskan Natives. Chronic disease is also greater in minorities, with 51% of African-Americans and 20% of whites reporting at least one chronic disease.[9] When compared with the non-Hispanic white majority, African-Americans have higher rates of hypertension, diabetes, tuberculosis, and infant mortality and experience higher mortality rates due to heart disease, lung cancer, breast cancer, and stroke.[8, 11] Of great concern is that racial differences in acute myocardial infarction treatment did not change between 1994 and 2000, warranting emphasis on improved health care for all.[12]

The use of the white race as the referent population when drawing comparisons among health standards can itself be considered an ethnocentric approach, perpetuating a view that a white race standard exists by which minority racial populations are measured. Of note, some minority groups have better health than whites. For example, compared with whites, new Latin American immigrants to the United States have less diabetes, and new Chinese and Japanese immigrants have less breast cancer.[10]

Although research related to minority health disparities is complicated by the interplay between socioeconomic variables and minority status, studies have identified factors contributing to these disparities in health care delivery and subsequent health outcomes. Several examples of disparities in minority health care delivery are described in Table 3.[4, 8–10, 21, 32, 38, 40, 64–66] In a sentinel article, a cross-sectional analysis of more than 150,000 patient visits by black and white Medicare beneficiaries for medical evaluation and management was conducted to assess physician qualifications and access to resources.[7] The study sample was composed of 4355 primary care physicians who participated in the Community Tracking Study Physician Survey. About one fourth (22%) of the physicians accounted for 80% of the visits with black patients. These same physicians provided only a small percentage of care to white patients.

The physicians of black patients were less likely to be board certified than the physicians of white patients and more likely to report that they were unable to provide high-quality care to all patients. Access to subspecialists, high-quality diagnostic imaging, and nonemergency hospital admissions was also reported as a barrier to care. The authors of the study noted that further research is necessary to examine the extent to which these differences could be responsible for health disparities and could affect health outcomes for racial minority groups.

Health care disparities also exist in other populations defined by age,[18, 19] socioeconomic status,[2, 13] gender,[3] disability,[1, 3, 14] and sexual orientation.[4, 15–17] As health care resources become more limited, ageism can develop. In pharmacoeconomic analyses, preference is given to younger individuals when using quality-adjusted life-years, a value that is greatest for the longest life expectancy after a given intervention. The "fair innings" argument would require all patients to live a threshold number of years.[67] Productivity ageism would also result in more health care resources given to younger working individuals.[68] However, this approach does not account for senior work from volunteerism or grandparenting.[63] About half of U.S. and Canadian seniors have experienced ageism in health care. The assumption that symptoms are related to aging could alter work-up decisions.[69] Although socioeconomic status has been independently associated with health status, it intersects with race and ethnicity to affect health status.[2, 13] Excluding women and minorities from research before federal mandates in 1993 also contributed to gender and ethnic health disparities. In reference to physical abilities, adults with developmental disabilities were 7 times as likely to report being in fair or poor health as adults without disabilities.[1] Persons with disabilities were also far less likely to receive breast and cervical cancer screening, and oral health care.

A paucity of literature, confounded by methodologic issues, exists in the area of lesbian, gay, bisexual, or transgender (LGBT) health disparities.[4, 15–17] In fact, one of the greatest threats to the health of the LGBT population is the lack of scientific information about their health.[17] Further, one's LGBT identity is inextricable from other issues of identity. For a black, gay man without health insurance, it is difficult to discern which aspect of his cultural identity is associated with specific health desires, outcomes, and disparities. Some patients who are LGBT may be at higher risk for disease because of potentially risky behaviors (e.g., anal intercourse among gay, bisexual, or transgendered men) or higher disease prevalence (e.g., smoking, obesity, and alcohol or drug use).[15] Lesbians and bisexual women younger than age 50 years are more likely than heterosexual women to smoke cigarettes and consume large amounts of alcohol.[70] Nonheterosexual women receive health screenings less frequently (e.g., lipid profiles, mammograms, and Pap smears), delay treatment (e.g., for breast cancer), and are less likely to have a regular primary care provider.[4, 40] The link between LGBT youth (or youth questioning their orientation) and suicide has been explored.[4, 71] Rates of serious suicide attempts among LGBT adolescents have been reported to be as much as 4 times those of heterosexual-identified youth.[71] Thus, sexual health and rights should be included with other key social determinants of health.[72] Further research with improved methodology is essential to better understand the relationship among sexual orientation, minority status, and health disparities and outcomes.

Health disparities are expected to grow as the minority populations, disadvantaged cultures, and financial differences among groups in the United States grow, unless significant changes in health care occur. Certain groups are already responding to this need, such as the American Heart Association, which contributed to the development of a comprehensive public health strategy entitled *A Public Health Action Plan to Prevent Heart Disease and Stroke* (available from http://www.cdc.gov/DHDSP/library/action_plan/index.htm).[73] Thus, the future of health care in the United States will be influenced substantially by its success in improving health for all. Improving cultural competence will decrease health disparities; however, eliminating social injustices is also important.

Health Care Disparity Policies

Over time, the U.S. government is increasing its efforts through policy, guidelines, and sponsored research to identify and eliminate health care disparities. These initiatives partly explain the focus on delivery of health care services to ethnic and racial minorities in cross-cultural situations. Some of the major policies and government programs are listed in Table 4.[21, 38, 74–89] Former President Bill Clinton also passed legislation to eliminate racial disparities by

Table 4. Key Health Disparity Policies

Year	Policy	Comments
1964	Title VI of the Civil Rights Act	Prohibition against national origin discrimination as it affects person with limited English proficiency.[74, 75]
1977	Race and Ethnic Standards for Federal Statistics and Administrative Reporting	Data now collected for four races (American Indian or Alaskan Native, Asian or Pacific Islander, black, and white) and two ethnic backgrounds (Hispanic or non-Hispanic).[86]
1985	Department of Health and Human Services, Office of Minority Health	Office tries to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities. They advise the U.S. Secretary and the Office of Public Health and Science. The Office of Minority Health Resource Center was established in 1987.[76, 77]
1990	Americans with Disabilities Act	Increased access and function for Americans with a disability.[78]
1990	National Institutes of Health, Office of Research on Women's Health	Advises National Institutes of Health director, increases and supports women's health research, increases women's participation in trials, increases and supports women in biomedical careers.[79]
1993	National Institutes of Health, Revitalization Act	Enrollment of minorities and women required in clinical trials.[80, 87]
1994	Food and Drug Administration, Office of Women's Health	Monitors and increases women's participation in clinical trials.[88]
1995	Center for the Linguistic and Cultural Competence in Health	National standards for culturally and linguistically appropriate services were developed as part of their responsibilities.[21, 81–84]
2000	Healthy People 2010	Standards related to minority health were included. Some topic areas are cancer, cardiovascular disease, infant mortality, diabetes, human immunodeficiency virus or acquired immunodeficiency syndrome, and child and adult immunizations.[76, 85]
2002	Institute of Medicine	Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care report released.[38]
2006	Joint Commission on Accreditation of Healthcare Organizations	Requirements related to the provision of culturally and linguistically appropriate health care.[89]

2010.[76] This initiative to eliminate racial and ethnic disparities in health that began in 1998 wants to eliminate disparities in infant mortality, cancer screening and management, cardiovascular disease, diabetes, human immunodeficiency virus or acquired immunodeficiency syndrome, and child and adult immunizations.

Some professional organizations have created organizational policies, statements, and committees. A few examples are provided. In 1991, the American Nursing Association published a statement on cultural diversity in nursing practice.[90] In 1999, the American Medical Association published the *Cultural Competence Compendium*.[91] The American Academy of Pediatrics has also been actively involved in implementing cultural competence for pediatric care[92, 93] and creating an ethnically diverse workforce.[93] The U.S. Public Health Service, Bureau of Health Professions, Division of Medicine established the Promoting, Reinforcing, and Improving Medical Education (PRIME) project, which facilitates diversity education within medical school curricula.[94, 95] In 2002, the American College of Clinical Pharmacy had cultural competence as its theme and created a task force on cultural competence. This task force developed some components of this five-part article series and drafted the initial recommendations for their organization as well as the entire pharmacy profession. The American Society of Health-System Pharmacists established an Ad Hoc Committee on Ethnic Diversity and Cultural Competence to study the ethnic pharmacist workforce and to help eliminate health disparities.[96] The American Pharmacists Association adopted policies in 2005 to facilitate access to resources to achieve cultural competence and encourage pharmacists to achieve and develop cultural awareness, sensitivity, and cultural competence. In 2006, adopted policies included expanding culturally competent health care services in all communities. Cultural competence was the theme for the American Pharmacists Association's Student Pharmacist Academy in 2005–2006. At the 2006 interim meeting of the American Association of Colleges of Pharmacy, the theme was Cultural Competence: Closing Gaps and Expanding Access.

Cultural Competence and Morality

The commonality of our ethical and moral values concerning health care is being questioned as we enhance our understanding and practices in a multicultural and especially multifaith country. In a multicultural society, challenges exist when moral truths are different between patient and health care provider, which could create an actual or potential conflict between them. Four aspects of Western moral theory exist and are helpful in understanding the relationship between cultural competence and morality.[97] Some moral truths are independent of culture (absolutism or realism), whereas some are shared between cultures (fundamentalism or principlism). Some morals will differ between cultures (multiculturism or relativism), and postmodern or deconstruction theories would say all these views have equal worth, principle, or power.

Standards of practice and laws exist to resolve some but not all the conflicts from differing cultural moral beliefs. Recent examples include controversies over emergency contraception (morning-after pill), use of prayer versus drugs, clitorectomy (female circumcision), and ending a terminal illness. Within the pharmacy profession, pharmacists in most states are not required to dispense the emergency contraception pill if this act violates their own sense of ethical values. In such a case, however, the pharmacist must still respect the patient's moral beliefs by referring the patient to another pharmacist or pharmacy that will provide such services in a timely manner to effectively and safely achieve drug therapy outcomes. Practicing with full respect for the patient resolves the conflict. Pharmacists could also choose a pharmacy position such as a pharmacy benefit manager or in an institutional or pharmacy industry setting, where direct patient contact is limited and pharmacists might not face as many challenges to their personal beliefs.

Some parents with a religious belief in prayer as the source of healing (e.g., Christian Science) have opted not to give their children drug therapy such as insulin or chemotherapy. In this case, frequently the legal system is engaged to either force the parents to give the children the drug therapy or to place the children in social services.[98] In some cases, however, the legal system has respected the religious belief of no drug therapy for the children. In contrast, almost all health care providers in the United States and the American public believe clitorectomy to be a form of mutilation that violates women's health and rights. Most health care providers in the United States would therefore opt not to perform these services regardless of the patient's or the family's cultural beliefs.

In terms of end of life, at least four major areas are influenced by culture: communication of terminal illness, locus of decision making, use of advance directives and hospice care, and transition to next phase (i.e., pain-penance-cleansing before death, heaven, reincarnation, etc.).[99, 100] The U.S. legal system allows people to designate advance directives and assign a power of attorney for end-of-life care consistent with their cultural beliefs; however, some cultures do not complete these forms.

In the United States, common morality is related to four principles of medical ethics: autonomy, beneficence, nonmaleficence, and justice.[101] However, this common morality does not apply to all cultures. For example, the Navajo Indian and Arab cultures expect the family, not the patient, to be told about a terminal disease. Thus, family members are considered the primary decision makers for health care choices. Another example is when cultures see suffering as a natural part of human existence, thus opting for no pain relief agents. In such cases, whose definition of reason provides the gold standard for normative adjudication?[101] Other health care areas with cultural variability include fertility, birth, contraceptive methods, pregnancy, organ transplantation and donation, blood products, and life-sustaining measures (Figure 1).[46] Especially in these areas, the health care provider must not be ethnocentric but must first acknowledge and respect the cultural differences and then minimize the negative consequences of these cultural differences.[97, 101]

Stages To Become Culturally Proficient

Models, frameworks, and reports have been developed that provide descriptions of the process by which individuals and/or practice settings or organizations can become culturally proficient.[9, 10, 20–22, 32, 34, 38, 40, 75, 76, 81, 82] Two models will be presented.[9, 22–24, 83] In some ways, these cultural proficiency models are similar in that they progress from a stage in which individuals or practices have deficiencies in understanding cultural differences to later stages in which they have acquired greater understanding and capacity. The final two steps in both models are

similar in their descriptions of cultural competence and cultural proficiency. They view these latter steps as higher level processes of adapting services and care to the needs of various cultures (competence) and developing studies and quality improvement projects that address the needs of culturally diverse communities (proficiency). Although both models assume that practitioners and practices will strive toward the highest level (i.e., cultural proficiency), they have clear differences in assumptions and intermediate steps.

Cultural Competence Continuum Model

This model was developed by the National Center for Cultural Competence at Georgetown University.[9, 23, 24, 83] It suggests six stages on the path toward cultural proficiency:

- Stage 1. Cultural destructiveness: providers or organizations show bigotry, exploitation, and other dehumanizing policies and practices toward persons of different cultures.
- Stage 2. Cultural incapacity: providers or organizations are ethnocentric and paternal, and do not offer programs or services oriented to help other cultures.
- Stage 3. Cultural blindness: providers or organizations treat all people the same regardless of skin color and culture and might not recognize differences that exist in cultures.
- Stage 4. Cultural precompetence: providers or organizations recognize differences that exist in culture, have a few goals, and implement a few activities to address cultural issues and disparities.
- Stage 5. Cultural competence: providers or organizations accept, value, and respect differences within and between cultures. They have services to enhance care of different cultures.
- Stage 6. Cultural proficiency: providers or organizations recognize the value and positive impact of cultures on health outcomes, conduct research to identify and resolve disparities, and disseminate and publish the findings.

Underlying this model is the assumption that patient health care improves and that disparities are less at the higher stages. The first stage of the model assumes that individuals lacking cultural competence actively behave in culturally destructive ways. Stage 3 is consistent with viewing the United States as a melting pot. The fifth stage, cultural competence, assumes that individuals and practices that have accepted, value, and are respectful of cultural differences do provide or strive to provide culturally competent care and work to eliminate disparities. This stage is consistent with a multicultural view of the United States as a mosaic or tapestry.[101] Perception supports these concepts with additional research further documenting the value of culturally competent care. This continuum model describes the stages with little guidance on how to make the transition to the higher stages, but it provides the framework for others to develop programs for transitions.

Stages 5 and 6 emphasize the importance of valuing cultural diversity. To value diversity, practitioners, practices, and health agencies must recognize themselves as cultural entities. The concept of valuing diversity is related to the concept of caring, which must be central to all health care practices. Caring has been described as attitudes, judgments, and actions that show support and professional skill.[28] Attitudes and actions that fail to respect outside cultures are not consistent with providing care and are not consistent with the Pharmacy Code of Ethics.[102]

Cultural Development Model

This second cultural proficiency model also has six stages, as follows[22]:

- Stage 1. Cultural incompetence: do nothing to increase knowledge of different cultures.
- Stage 2. Cultural knowledge: learn facts about cultures, especially related to health and health behaviors.
- Stage 3. Cultural awareness: understand implications of culture on health behaviors.
- Stage 4. Cultural sensitivity: combine knowledge and awareness into individual and institutional behaviors.
- Stage 5. Cultural competence: routinely employ culturally appropriate health care interventions and practices.
- Stage 6. Cultural proficiency: practice with cultural competence and integrate it into one's research and scholarship activities.

Unlike the cultural competence continuum model, this model does not begin with overt behaviors of cultural insensitivity as a starting point in the cultural proficiency continuum. The cultural development model adopts a more cognitive approach at the onset. It starts with individuals and/or practices that lack knowledge about other cultures and moves to discussing

culturally sensitive behaviors in the latter part of the model. Knowledge of the extrinsic and intrinsic values, attitudes, and behaviors associated with a culture is critical to ensuring a competent practice. Extrinsic or material culture includes those aspects of culture that are easily observed and frequently shared with outsiders such as mode of dress, language, and gestures. Intrinsic or nonmaterial culture includes the values, mores, and beliefs that are more commonly shared only within the culture or in intimate settings.[43]

Knowledge of the extrinsic aspects of diverse cultures can help practitioners identify cross-cultural interactions. Awareness of the extrinsic differences in culture could also facilitate communication in cross-cultural settings (e.g., no direct eye contact). Nonetheless, barriers to care that can arise from unstated or intrinsic cultural differences must be recognized and overcome (e.g., touch by the opposite sex). Knowledge of these intrinsic aspects of culture is important for delivering culturally competent care. Stereotypes based on knowledge of extrinsic and intrinsic aspects of culture might lead to inappropriate or unsuccessful actions if patient-specific beliefs are not determined. Specific cultural skills required for delivery of care to individual members of a given culture could determine success or failure in recognizing, preventing, or treating a drug-related problem.

In the third stage of the cultural development model, individuals and practices use the knowledge they acquired in the second stage to become aware of how culture can affect health behaviors. Cultural awareness will come from undertaking a self-examination process to recognize the distinct attitudes, values, language, and perceptions that shape our individual and collective cultures. This process of shifting attitudes toward valuing diversity and gaining cultural awareness will reduce both conscious and unconscious ethnocentrism.

The latter half of the cultural development model assumes that the individual and/or practices will incorporate the knowledge and

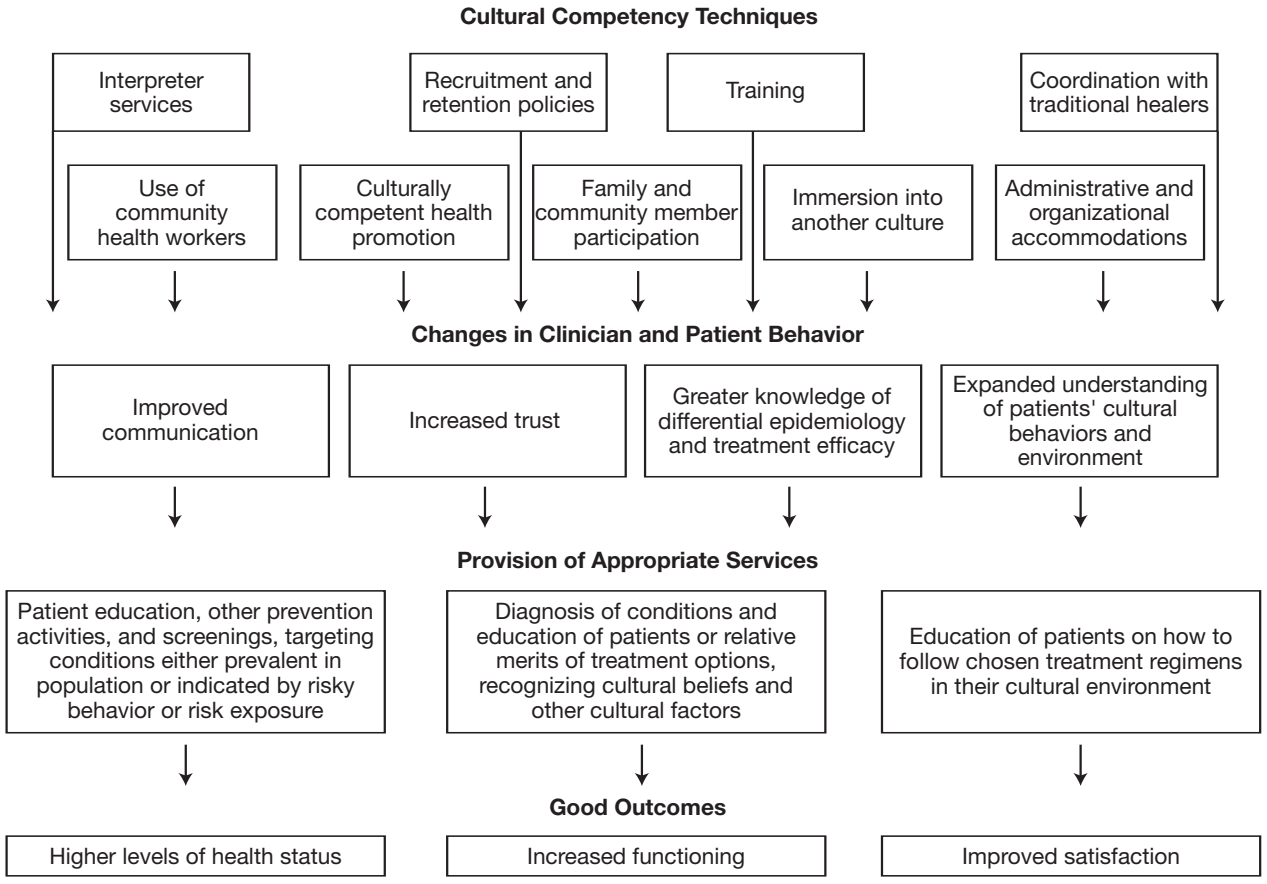

Figure 2. Conceptual model of how nine cultural competency techniques could reduce health disparities. (From reference 20 with permission.)

awareness acquired in the first part of the model into culturally sensitive behaviors.[28] Dissemination of cultural knowledge and skills, as well as advocacy, are final elements of a culturally proficient practice. In this case, advocacy involves not only recognition of racism, prejudice, and ethnocentrism, but also actions to reverse them. Dissemination of cultural knowledge and skills in addition to intolerance of racism, bigotry, or other forms of bias is a determinant of a successful health care system. Stages 4 and 5 differ mainly in that individuals and practice settings in stage 5 apply culturally sensitive behaviors more frequently and to more groups than do those individuals and health systems in stage 4.

Frameworks to Achieve Cultural Competence in Organizations

Cultural proficiency within institutions and practices is a rapidly evolving field of change and research. Seven domains have been identified to help focus assessment and change within organizations.[103] These domains are organizational values, governance, planning and monitoring or evaluation, communication, staff development, organizational infrastructure, and services or interventions.

Two frameworks provide ways of conceptualizing how organizations might incorporate various cultural proficiency techniques to reduce health disparities and assess the outcomes of these interventions. Within the first framework depicted in Figure 2, nine cultural competence techniques are thought to lead to reduced health disparities.[20] These techniques include interpreter services, recruitment and retention policies, training, coordination with traditional healers, use of community health workers, culturally competent health promotion, family and community member participation, immersion into another culture, and administrative and organizational accommodations. The second framework (Figure 3) links cultural competence

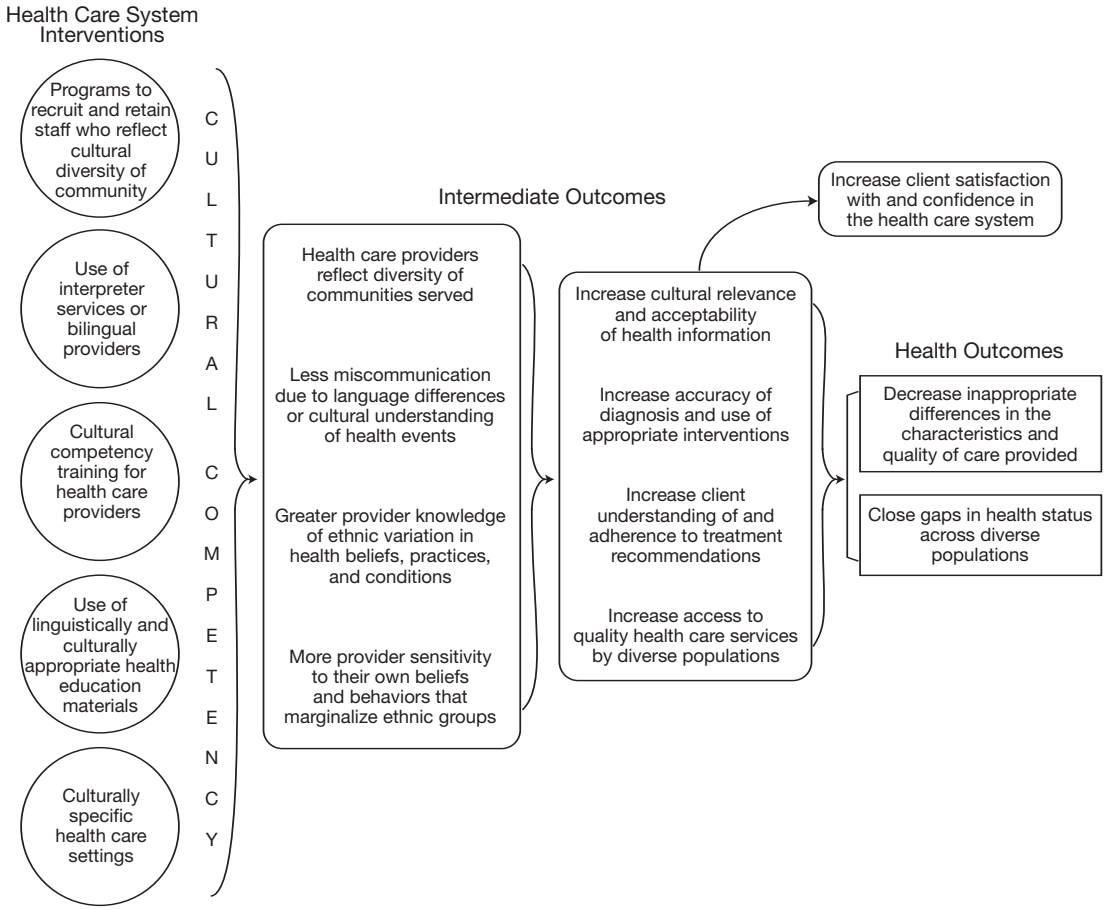

Figure 3. Framework combining interventions with intermediate and health outcomes for evaluating, improving, or designing health care systems with culturally diverse patients and staff. (From reference 21 with permission.)

Table 5. Key Web Sites for Cultural Competence

Resources	Web Address[a]	Comments
Government resources		
Agency for Healthcare Research and Quality	www.ahrq.gov	Initiatives addressing racial and ethnic disparities in health care; measurement of quality of care in vulnerable populations and translating this research into practice; disparity reports and information on health literacy and cultural competence; information on former President Clinton's initiative to eliminate racial and ethnic disparities in health
Department of Health and Human Services, Office of Minority Health	www.omhrc.gov	Publications such as Setting the Agenda for Research on Cultural Competency in Health Care (2004), National Standards for Culturally and Linguistically Appropriate Services in Health Care (2001), and Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes Focused Research Agenda (1999); information on African-Americans, American Indians and Alaskan Natives, Hispanics and Latinos, Asian-Americans, and Native Hawaiians or other Pacific Islanders; section on cultural competence
	www.thinkculturalhealth. org	Web-based training module (0.3 continuing education unit) for pharmacists, program entitled "A family physician's practical guide to cultural competent care," extensive publications, tools, and links
Health Resources and Services Administration	www.hrsa.gov	Cultural and linguistic competence resources, training curricula and technical assistance, assessment tools, some ethnic- and culture-specific information, compendium of innovative and successful cultural competence practices; health disparities collaborative measures for research; health literacy information; research grants on racial disparities in health outcomes
National Center for Health Statistics	www.cdc.gov/nchs	State and federal databases with health and delivery statistics
Census Bureau	www.census.gov	Information on race, age, income, education, housing, insurance, and more
Pharmacy resources		
American Association of Colleges of Pharmacy	www.aacp.org	Curricular resource center has materials for underserved populations and women, both contain cultural competence resources and links
National Pharmaceutical Association and Student National Pharmaceutical Association	www.npha.net www.snpha.com	Pharmacy professional and student associations concerned with the views, ideas, and needs of minority pharmacists, increasing the standards of pharmaceutical care, and lack of minority representation in pharmacy and other health professions (of note, other culturally oriented pharmacy organizations also exist)
Health care, academia, and other organizations		
Diversity RX	www.diversityrx.org	Information resource on how to meet the language and cultural needs of minorities, immigrants, refugees, and other diverse populations seeking health care; holds annual convention
Ethnomed, University of Washington	www.ethnomed.org	Culture profiles, cultural pearls, patient education materials in other languages, immigration information
Gay and Lesbian Medical Association	www.glma.org/	Two documents provide valuable information to improve care and communications: Healthy People 2010 Companion Document for Lesbian, Gay, Bisexual and Transgender (LGBT) Health; and Guidelines for Care of Lesbian, Gay, Bisexual, and Transgender Patients
National Center for Cultural Competence, Georgetown University	gucchd.georgetown.edu/nccc	Mission to increase the capacity of health care and mental health programs to design, implement, and evaluate culturally and linguistically competent care delivery systems; curriculum enhancement information, assessment tools, and extensive free publications including policy briefs
Program for Multicultural Health, University of Michigan	www.med.umich.edu/multicultural/ccp/culcomp.htm	Extensive Web site with sections on cultural competence, culture specifics, discipline specific (including pharmacy practice), and government; many Web-based learning modules

Table 5. Key Web Sites for Cultural Competence (continued)

Resources	Web Address[a]	Comments
Institute of Medicine	www.iom.edu	Brief reports and slides on unequal treatment, confronting racial and ethnic disparities in health care; sections on aging, minority health, and women
Health care, academia, and other organizations (continued)		
Joint Commission on Accreditation of Healthcare Organizations	www.jointcommission.org/HLC/hlc_facts.htm www.jointcommission.org/HLC/compiled_list.htm www.jointcommission.org/HLC/Source_Links.htm	Hospitals, language, and culture section; information on their organization's 30-mo project to assess hospitals' capacity to address issues of language and culture that affect quality and safety of care; resource list includes tool kits, standards, and training
Kaiser Family Foundation	www.kff.org/minorityhealth/index.cfm	Publications and resources related to minority health, prescription drugs, women's health, and uninsured people; Race, Ethnicity and Medical Care report from 2003
Kaiser Health Disparities Report	www.kaisernetwork.org/disparitiesreport	Weekly e-news devoted to race, ethnicity, and health; sections with links to articles and audios are science and medicine, politics and policy, health in community, culture-based care, initiatives, recent releases, and opinions; free weekly e-mail
National Association of Social Workers	www.socialworkers.org	Guidelines for cultural competence in social work practice as well as other pages relevant to interacting with diverse populations
Physicians for Human Rights	www.phrusa.org	Global and domestic perspectives; The Right to Equal Treatment report has 24 policy and 11 research recommendations; extensive abstracts for cultural competence articles

[a]Web sites accessed October 2006.

to intermediate and health outcomes, thus helping to identify the value of new programs, training, skills, and attitudes.[21]

To achieve cultural proficiency, an organization must identify and overcome three categories of sociocultural barriers: organizational, structural, and clinical.[32] Within the organizational category, the leadership and workforce need to include people from diverse backgrounds that reflect the populations being served. The attainment of a culturally diverse staff can facilitate greater collaboration between practitioners and patients. People from the community should participate in decision making and strategic planning.

From a structural perspective, communication with patients needs to be improved through increased availability and use of interpreters, and clinical training on how to best use interpreters and to work with patients with limited English proficiency. The system should also guarantee equal access to referrals and coordination of care with traditional healers.

Within the clinical category, areas of improvement would include valuing and accepting diversity, increasing knowledge of different cultures, and providing cross-cultural training. Information about creating these changes within the pharmacy profession and practices will be found in a subsequent article of this series.

Cultural Competence Resources

Early steps on the path toward cultural competence and proficiency begin with knowledge. One cannot know all cultures in the United States, but increased awareness and the ability to access resources can be a first step toward cultural competence. The Joint Commission on Accreditation of Healthcare Organizations has created a cultural and linguistic competence bibliography and links to many good Web sites.[104, 105] Table 5 contains select key cultural competence Web sites that can guide pharmacists and other individuals working in the profession toward cultural competence and proficiency. New Web sites that provide lists of cultural resources continue to be developed. Recently, the Kaiser Family Foundation created a weekly newspage listing articles and audios related to

race, ethnicity, and health (available from http://kaisernetwork.org/disparitiesreport). The weekly report can be e-mailed free to subscribers. Some additional resources will be listed in the second article of this series.

Conclusion

The United States is becoming a more diverse society. Today, health disparities in terms of access and quality exist for all cultural diversities, which include age, gender, disability, race, ethnicity, socioeconomic status, religion, and sexual orientation. Over the past few decades, policies, resources, models, and frameworks have been and are still being developed to enable health care providers, staff, administrators, and organizations to provide culturally appropriate and sensitive health care to all patients in all health care settings. The first step to becoming culturally competent requires everyone to be self-aware and to eliminate ethnocentrism. With an attitude of respect, lifelong learning about other cultures, and a desire to provide the best care to all, one can become culturally competent. Based on preliminary data, some evidence supports the assumption that culturally competent health care providers will improve outcomes and decrease health care expenditures.

The next articles in the cultural competence series will address the specific development of cultural competence within pharmacy and pharmacy education and research and will end with recommendations for moving the pharmacy profession as a whole toward cultural proficiency.

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