Cultural Competency Programs:

Decreasing Health Disparities Resulting from Implicit Biases

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WRTG 3020

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 America’s demographic population has changed dramatically over time. Projections of what America will look like in 2040 and 2060 support the fact that non-Hispanic Whites will become the minority (Lombard). In fact, the percentage of non-Hispanic Whites in 2016 was 61.3% and is predicted to be at 43.6% in 2060; that’s almost a 20% decrease in the non-Hispanic White population of America (Kolko). Despite the growing percentage of minority groups, such as blacks, Hispanics, Native Americans, and Asian Americans, these groups experience a 7 year difference in life expectancy than non-Hispanic White Americans (“Creating the Healthiest Nation: Advancing Health Equity”). Differences between racial and ethnic groups can be caused by genetics, income, and the availability of healthcare. However, the American Public Health Association is one of many organizations that includes racism and discrimination as a social determinant of health. An example of discrimination in healthcare is the significant difference in deaths in childbirth between black and white mothers, with black mothers dying at three times the rate of white mothers (“Creating the Healthiest Nation: Advancing Health Equity”). Both explicit and implicit biases and associations of a racial or ethnic population can influence the quality of care. How can health professionals address health disparities and differences in quality of care stemming from discrimination?

 Guidelines, accreditation standards, and training approaches have been provided by well-known professional institutions in attempts to increase cultural competency across the nation and in medical schools (“Cultural Competence in Health Care: Is It Important for People with Chronic Conditions?”). The Institute for Diversity in Health Management, amongst other institutions, know that cultural competency programs aim to “provide care to patients with diverse values, beliefs and behaviors, tailoring health and delivery to meet patients’ social, cultural, and linguistic needs'' (“Becoming a Culturally Competent Health Care Organization: AHA”). Most research that has tested the effects of these cultural competency programs states the positive outcomes of having an increased education of diverse cultures, which is offered in cultural competency programs (“Becoming a Culturally Competent Health Care Organization: AHA”). Even if this research has proven helpful in understanding useful ways to become more culturally competent, cultural competency programs are only required in a few states, and is not always a requirement for medical school graduation (“Cultural Competence Training for Health Care Professionals”).

 I would like to suggest that a regional-specific cultural competency program for working healthcare professionals, in addition to a required Implicit Association Test and more diversity training in medical schools, will substantially decrease health disparities resulting from implicit bias and increase the quality of care for racial and ethnic groups.

**What is implicit bias and its role in healthcare?**

 Oftentimes, Americans that believe race relations have improved in America are referring to the end of Jim Crow laws and the passing of progressive legislation, such as the Civil Rights Act of 1964, which ended segregation in public places. However, the General Social Survey (GSS) taken in 1990 and 2010 shows negative associations, biases, and even levels of racism continue to exist in America. In fact, only 1 in 5 (or fewer) whites agreed that African Americans are intelligent. Further, the GSS also found an increased association of words such as “lazy, violent, dangerous, and unintelligent” with African Americans (“Becoming a Culturally Competent Health Care Organization: AHA”). Many people can reflect on this survey and claim they do not believe these things, or would never act on these clearly stereotypical explicit biases. Some physicians may even make this claim. But, implicit biases are unconscious and are not exclusive of physicians, judges, and other professionals who claim to be unbiased (“Understanding Implicit Bias”). Negative words, images, or teachings of racial and ethnic groups can lead to implicit bias, and can conflict with a professional’s strive to deliver impartial care. The process of diagnosing and treating a patient can differ based on these biases, overall affecting the quality of care a health professional provides.

 There is evidence that African Americans, Hispanics, and Native Americans experience health inequities due to a low income and little to no access to healthcare. A 2003 study by the Institute of Medicine concluded that “even after differences in income and in access to health care and health insurance are controlled for, racial and ethnic minorities still experience a lower quality of health care services” (“Unequal Treatment”). In *Unequal Treatment*, the behavior and attitudes of the evaluated health professionals were taken into consideration. This points to the fact that these racial groups are receiving a lower quality of health care due to their race/ethnicity. The implicit bias of these health care professionals reduces the standard of care provided. The differences in treatment that lead to health disparities are addressed in the book and suggestions to “improve patient-provider communication and integrate cross-cultural learning within the health professions” are made (“Unequal Treatment”). Cross-cultural education and diversity training are essential parts of cultural competency programs, and *Unequal Treatment* outlined multiple ways to improve communication, such as “availability of language translation [and] community-based care” (“Unequal Treatment”).

 The Implicit Association Test was developed as a way to measure “attitudes that are introspectively unidentified” (White-Means). There are many different tests one can take, including associations of religions, genders, weight, and race. The IAT measures implicit associations between differences in one of the categories above. For example, the race IAT will measure an unconscious preference for Whites over Blacks. Looking at results from the race IAT test in 2004, more than 75% of whites have an implicit preference for whites over blacks (White-Means). Another report published in 2017 focused on physicians that had taken this test. The results are similar, with the majority of the tests proving an “implicit bias for White patients, especially among white physicians” (Horowitz). These results encompass only the physicians that are already practicing. What if these tests were required in medical school, so a future physician is aware of their biases and can better work to resolve them?

**Can IAT results change behavior?**

 Some argue that taking the Implicit Association Test may not influence the explicit attitudes or behaviors that result from these biases. A meta-analysis published in the Journal of Personality and Social Psychology concludes that “changes in implicit measures did not mediate changes in explicit measures or behavior” (Forscher). It would be hoped that explicit behaviors (we can refer to these as openly racist actions) would be punished in healthcare professions. On the other hand, implicit biases can be changed through the right measures and certain unbiasing techniques, as noted by the Kirwan Institute for the Study of Race and Ethnicity at Ohio State University (“Understanding Implicit Bias”). Even in the meta-analysis, it was found that implicit associations can be changed, though minimal. Regardless, the research suggests procedures that could have larger effects on implicit behaviors, including the association of sets of concepts (Forscher). Knowing one’s biases can lead to self-awareness, and in the case of doctors, who are supposed to prevent harm and distribute resources justly, IAT results would allow for self-reflection.

**Designing a Beneficial Cultural Competency Program**

 As we know, implicit biases, as well as a lack of diversity training, are two factors that affect the quality of care provided for racial and ethnic groups. Lack of diversity training can decrease “the ability to engage and educate patients” (“Becoming a Culturally Competent Health Care Organization: AHA”). This alone can prevent a physician from providing the best quality of care possible. The American Hospital Association published an article in 2013 that provides multiple ways in which becoming a culturally competent organization has social, health, and business benefits (“Becoming a Culturally Competent Health Care Organization: AHA”). On top of “increased respect...from patients,” an organization can also see decreased costs while decreasing the number of health inequities in their community (“Becoming a Culturally Competent Health Care Organization: AHA”).



Reasoning for a region-specific program is based on the racial and ethnic group that is most represented in that area. For example, there are more Hispanics along the Southern border, with 91.8% of the population of McAllen, Texas identifying as Hispanic; 49.0% identifying as Black in Jackson, Mississippi; and 41.7% identifying as Asian in Honolulu, Hawaii (Kolko). Because of the different racial and ethnic populations that occupy different parts of our country, requiring the attendance and completion of a regional-specific cultural competency program would provide the most benefit to health care professionals. Including the community around a hospital or other institution would result in better education provided to professionals that would align with the specific needs of the demographic population (“Becoming a Culturally Competent Health Care Organization: AHA”). It’s important that “hospitals and care systems seek advice from individuals and groups in the communities they serve” (White-Means). It would also be responsible for a regional-specific program to consider the many differences within a population. The Latino population includes a variety of different groups that vary in age, citizenship status, and even nationality that lead to different ideas of health and different habits affecting health (“Cultural Competence in Health Care: Is It Important for People with Chronic Conditions?”).

While cultural competency programs include diversity training amongst working physicians, requiring an Implicit Association Test earlier on in medical training can provide a better conscious understanding of a physician’s bias. One suggestion of cultural competence studies states the acknowledgement of such biases and “deliberately practicing perspective-taking and individualization” is important in building better doctor-patient relationships and improving communication (Williams). Taking an IAT would benefit a physician who is interested in providing a standard quality of care to all patients. By identifying the biases which could hinder this standard of care, medical students and physicians could better educate themselves during a cultural competency program and outside of training.

African Americans, Native Americans, Asian Americans, and other racial and ethnic minority groups are oftentimes at the blunt end of implicit biases and cultural incompetency. Given the demographic changes we’re seeing as a country, professionals and policy-makers need to discuss what programs would provide the right tools for a professional to give the best quality of care to these groups. A health professional’s duty is to treat a patient fairly and provide a standard of care that doesn’t vary based on the color of a person’s skin. By undergoing a cultural competency program and understanding what implicit biases one might have, health disparities will decrease, leaving a healthier and happier majority population in our future. Health care professionals should strive to decrease health disparities resulting in implicit bias and increase their quality of care by becoming more culturally competent.

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