A CRASH-Course in Cultural Competence

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America is a multi-cultural society. Yet, there are cultural dimensions to the clinician-patient relationship that have not been systematically addressed in medical education or in clinical practice. Lack of diversity and lack of cross-cultural skills in the medical profession may contribute to health disparities in America. Cultural competence for the medical profession represents a core set of skills that can be learned to respectfully and effectively communicate healthcare information with diverse patient populations. The authors blended their extensive literature review with the knowledge and experience of a culturally diverse medical team to develop the CRASH-Course in Cultural Competency training program for medical professionals. CRASH is a mnemonic for the following essential components of culturally competent health care—consider **C**ulture, show **R**espect, **A**ssess/**A**ffirm differences, show **S**ensitivity and **S**elf-awareness, and do it all with **H**umility. The goal of the CRASH-Course in Cultural Competency is to build confidence and competence in the clinician's ability to communicate effectively with diverse patient populations. (*Ethn Dis.* 2006;16[suppl 3]:S3-29–S3-36)

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INTRODUCTION

Family physicians in America serve an increasingly diverse patient population.[1] Over 30% of the US population is now African American, Hispanic or Latino, Asian, or from other non-European origins, a proportion which will increase to nearly 50% by 2050.[2] Many clinical practices serve patients from dozens of different language groups.[3] However, the diversity of the health professional workforce in this country is not reflective of the diversity of the American people. While we work to increase diversity, we can also work to increase our cultural competence skills to be more effective in communicating with patients, building trust, negotiating treatment plans, and increasing adherence.[1,4–7]

There is good evidence that health professionals do not automatically have the attitudes or skills necessary to be effective in culturally diverse healthcare settings.[8] Anne Fadiman, in her award winning book, *The Spirit Catches You and You Fall Down*,[9] provides a poignant reminder that patients suffer despite all the resources of our medical system and the dogged dedication of well-intentioned Western trained providers. Her documentation of the barriers faced by an immigrant Hmong family as they deal with the seizure disorder of their young daughter is but one tragic story that undoubtedly recurs every day in America's healthcare system.

Several authors promote acronyms or mnemonics to help students and others to incorporate elements of cultural competence into their practice. For example, Berlin and Fowlkes have promoted the acronym LEARN (Listen, Explain, Acknowledge, Recommend, and Negotiate) as a framework for teaching cultural skills to medical students and residents (Table 1)[10] In a recent Home-Study monograph on ''Challenging Physician-Patient Encounters,'' Steele and Harrison put forward the PEARLS mnemonic (Partnership, Empathy, Apology, Respect, Legitimization, and Support) (Table 2).[11] Kleinman has promoted the model of asking nine essential questions to elicit the patient's own health beliefs and understanding of their own condition in a multi-cultural encounter (Table 3).[12]

The present authors have found a need for an acronym or model to emphasize core values or principles of cultural competence that underlie the more specific interview techniques presented by the LEARN model or by Kleinman's questions. These core cultural values are summarized in the acronym CRASH, a mnemonic for the following essential components of culturally competent health care—consider **C**ulture, show **R**espect, **A**ssess/**A**ffirm differences, show **S**ensitivity and **S**elf-awareness, and do it all with **H**umility (Table 4). Learning and practicing these cultural principles will not instantly confer cultural competence on anyone, but they can provide specific measurable skill sets, behaviors, and strategies for increasing one's effectiveness in providing health care for diverse populations while minimizing culturally dysfunctional behaviors. Cultural competency includes an eagerness for life-long learning about other cultures,

Table 1. LEARN model of cultural communication (Berlin and Fowlkes)

- **Listen** with sympathy and understanding to the patient's perception of the problem
- **Explain** your perceptions of the problem
- **Acknowledge** and discuss the differences and similarities
- **Recommend** treatment
- **Negotiate** agreement

Table 2. PEARLS for physician-patient communications

- **Partnership:** Working with the patient to accomplish a shared outcome
- **Empathy:** Recognizing and comprehending another's feelings or experience
- **Anology:** Being willing to acknowledge or express regret for contributing to a patient's discomfort, distress, or ill feelings
- **Respect:** Non-judgmental acceptance of each patient as a unique individual; treating others as you would have them treat you.
- **Legitimization:** Accepting patient's feelings or reactions regardless of whether or not you agree with those perceptions.
- **Support:** Expressing willingness to care and be helpful to the patient however you can.

Note: At least one author describes the S in PEARLS as representing self-efficacy.[25]

Table 3. Questions to elicit health beliefs (Kleinman)

- What do you call your problem? What name does it have?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Will it have a short or long course?
- What do you fear most about your disorder?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?

Table 4. CRASH-course in cultural competency skills

Culture: The importance of shared values, perceptions, and connections in the experience of health, health care, and the interaction between patient and professional.

Respect: Understanding that demonstrations of respect are more important than gestures of affection or shallow intimacy, and finding ways to learn how to demonstrate respect in various cultural contexts.

Assess: Understanding that there are tremendous "within-group differences," ask about cultural identity, health preferences, beliefs, and understanding of health conditions. Assess language competency, acculturation-level, and health literacy to meet the individual's needs.

Affirm: Recognizing each individual as the world's expert on his or her own experience, being ready to listen and to affirm that experience. Re-framing cultural differences, by identifying the positive values behind behaviors we perceive as "different."

Sensitivity: Developing an awareness of specific issues within each culture that might cause offence, or lead to a breakdown in trust and communication between patient and professional.

Self-Awareness: Becoming aware of our own cultural norms, values, and "hot-button" issues that lead us to mis-judge or miscommunicate with others.

Humility: Recognizing that none of us ever fully attains "cultural competence," but instead making a commitment to a lifetime of learning, of peeling back layers of the onion of our own perceptions and biases, being quick to apologize and accept responsibility for cultural mis-steps, and embracing the adventure of learning from others' first-hand accounts of their own experience.

most often directly from the patients themselves. Cultural competency must also include the capacity for self-awareness and self-examination around our own cultural values, experiences, perceptions, and sense of "norms."

THE CRASH-COURSE IN CULTURAL COMPETENCY MODEL

The purpose of the CRASH-Course in Cultural Competency is to teach public health and primary care health professionals a strategy for incorporating cross-cultural skills and values into their own practice. The CRASH-Course in Cultural Competency teaches the CRASH principles in an interactive style that includes didactic presentations, self-awareness instruments, video-vignettes, case studies, and group discussions. The CRASH-course has been taught in formats ranging from one-hour introductory sessions to full-day workshops, with sessions also conducted at a distance by videoconferencing. The curriculum contains adequate tools and resources so that it may be adapted to the unique needs of each group of participants.

The six basic concepts taught in the CRASH-course model can be presented best by offering a brief definition or description of each key word used in the acronym and then presenting specific illustrations to demonstrate their practical application in healthcare settings.

Culture

Culture is defined by the California Endowment as: "An integrated pattern of learned core values, beliefs, norms, behaviors and customs that are shared and transmitted by a specific group of people. Some aspects of culture, such as food, clothing, modes of production and behaviors, are visible. Major aspects of culture, such as values, gender role definitions, health beliefs and world-view, are not visible."

Cultural competency is defined by the US Department of Health and Human Services Workgroup in the following quote: "Cultural competence comprises behaviors, attitudes, and policies that can come together on a continuum that will ensure that a system, agency, program, or individual can function effectively and appropriately in diverse cultural interaction and settings. It ensures an understanding, appreciation, and respect of cultural differences and similarities within, among and between groups. Cultural competency is a goal that a system, agency, program or individual continually aspires to achieve."

In the words of former Surgeon General, Dr. David Satcher, **culture counts** in healthcare settings.[13,14] Recognizing the role of culture in health means an acknowledgment of the importance of shared values, perceptions, and beliefs related to health. Culture is directly related to health promotion, disease prevention, early detection, access to health care, trust and compliance.[4,6,14] The influence and expression of culture will differ for each

individual even within a specific culture based on a variety of modifying factors including innate personal characteristics such as age, birth order, gender, and sexual orientation, as well as factors that individuals develop over time, such as language, education, vocation, family roles, power/status, and degree of acculturation. These modifying factors are summarized in Figure 1.

Ilustration

A Muslim patient came to our Family Practice Center for prenatal care. Throughout her pregnancy she received care from a female attending physician. When she was in active labor, her husband brought her to the hospital, only to find out that the patient's personal physician was out of town, and only a male physician was available to examine her and to attend her delivery. The patient's husband was adamant that his wife would not be violated in this manner by a male physician. A stalemate ensued was entirely preventable, if "routine prenatal care" had included questions about the patients' values or special needs that
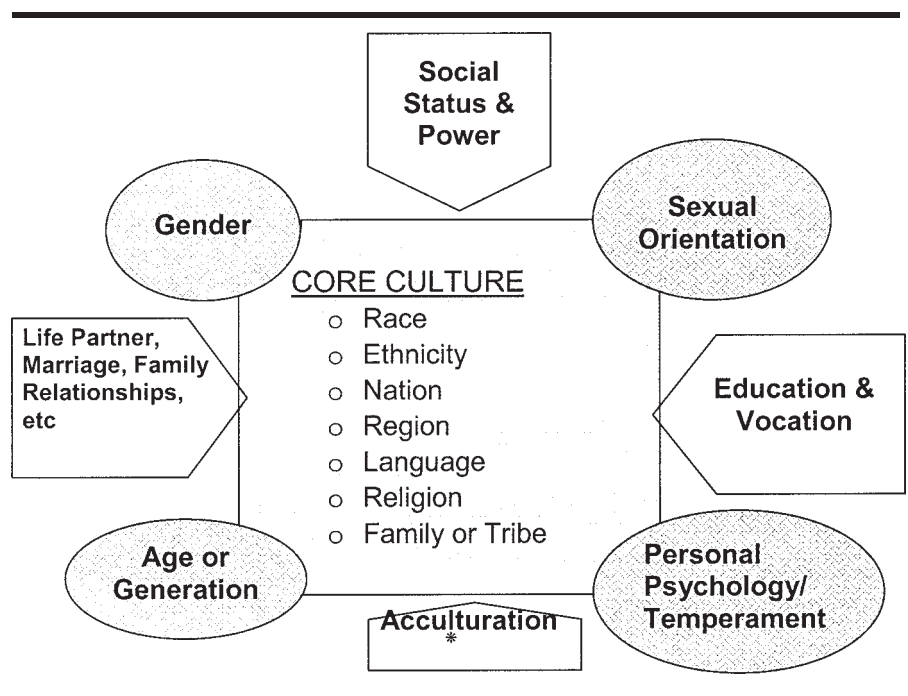

Fig 1. Factors that modify expression of core culture

might affect her birthing care, and if a discussion of call coverage arrangements had occurred in advance of the moment of crisis.

Respect

Sincere respect for individuals that comprise America's various cultures will go a long way in the clinician-patient encounter. Cultural respect does not mean merely tolerating cultures that are different, or even just respecting differences or respecting other cultures in the abstract. Respect in the CRASH-course model implies that each individual has a right to receive respect according to his or her own personal individual, family, and socio-historical perspective. We must learn to demonstrate our respect to individual patients in ways that each person will receive or perceive as being respectful.

The need for respect within the clinician-patient context is not limited to culture or race. The findings of recent surveys and focus groups, is summarized in the following statement:

All 23 grant projects found through focus groups, interviews, and surveys that most patients, regardless of their racial or ethnic identity, believe that healthcare personnel do not respect them (author's emphasis). This lack of respect is evidenced by the absence of "active" listening when patients are talking; the inappropriate use of eye contact and other nonverbal forms of communication; and the absence of basic courtesies, such as not using "Mr." or "Mrs." when addressing a patient by name. Patients also perceive that healthcare personnel are judgmental and dismissive regarding patients' customs and beliefs simply because they are different from their own.[15]

In a multi-cultural clinical setting, the health professional can easily initiate a dialogue with a patient from another culture in the following manner, "*I want to make sure I treat you respectfully.*

How would a doctor greet you in the community you grew up in? How do I make sure that you feel respected in this office?" Based on the patient's response the clinician could continue, "Would those be similar issues for other patients from your neighborhood/family/cultural group? Are there things that our doctors or staff do that make you feel *disrespected*?" Having this conversation with a patient could begin to establish a level of trust best upon mutual respect for each other.

We may each believe that we already know what constitutes showing respect, but the specific behaviors are not universal, and many of us have not received formal training in multi-cultural health care.[16] In the context of multi-cultural health care, health professionals should learn culture-specific words and behaviors to demonstrate respect to individual patients.[17–19] In other words, what can we do or say to make sure that this patient *feels respected* through the filter of their own past experience, culture, gender, occupation, and generation?

Kennedy et al documented a quantifiable relationship between disrespect for African Americans and Black and White age-adjusted mortality.[20] In this cross-sectional study using national survey data national survey, researcher found that in states where collective disrespect for Blacks was affirmed by a weighted response to a series of yes/no questions, the mortality rate for Blacks and Whites increased. This study indicates that where there is collective cultural disrespect, there is higher mortality for both the victims and the perpetrator.

In a preface to the book, *It's the Little Things: Everyday Interactions That Anger, Annoy, and Divide the Races*,[21] journalist Charlayne Hunter-Gault cites the common perception of disrespect caused by White persons automatically assuming familiarity and addressing individuals by their first name. Nathan McCall cites this same issue in his book,

Makes Me Wanna Holler: A Young Black Man in America,[22] pointing out the common experience of African Americans of high status in their own community being called only by first name by White individuals, in the same way that White families seem only to call the first names of the individuals they hire as maids, or nannies, or groundskeepers. This one behavior can call up deep feelings of resentment that will typically not be made visible to the person causing the offense.

Individual and cultural groups that have experienced oppression, consistent disrespect, or minority status may place a much higher priority on being treated with respect first, earning trust second, and only then perhaps allowing friendship or a personal relationship to develop. Often this means that the health professional should engage in a more formal style of communication than is the cultural norm for persons of White, European (non-Hispanic) background in American culture. In multi-cultural settings, it is more important to emphasize personal respect (addressing patients *and staff members* as Mr. or Mrs., sir or ma'am, etc., or using the more formal pronoun *usted* to address Spanish-speaking patients, rather than jumping presumptuously to the informal *tu*).

Illustration

In one of our CRASH-course cultural competency video vignettes, a sixty-three year-old African American female waits for a doctor in a small exam room in a neighborhood clinic. A young White male doctor enters the room without knocking, greets her by her first name ("*Hello, Bessie*!"), pats her on the shoulder, and affirms her guarded response with a patronizing "*Atta-girl*". Not being aware of the racial dynamics, this physician's efforts to appear friendly have unintentionally offended his new patient in three different ways within the first 30 seconds of their first encounter. The physician could have

engendered a much different beginning of trust and communication simply by showing respect—knocking before entering the exam room, addressing the patient by her title and last name (Mrs. Jones), asking permission before touching her ("*May I take a look?*") and avoiding the use of informal (and in this case racially offensive) language such as "attagirl" with a respected elder.

Assess

In the process of evaluating patients, we take careful medical histories, including family histories. We should also take a cultural history, however briefly, in every patient. Do not assume that someone is African American because they look or sound Black to you. Ask in a non-threatening way—"*Tell me about your family background,*" or "*Where are your parents from?*" or "*Are there cultural issues that will affect your health care?*" What will quickly be uncovered is the "within-group" heterogeneity of people perceived to be of one race. Latino individuals will most commonly identify themselves culturally with their nation of origin, not with a lumping of "Hispanics," and over time, the Anglo physician will come to expect substantial differences between their Guatemalan and their Argentinian patients, or even between Mexican patients growing up in a US-Mexico border community such as Ciudad Juarez compared with Mexican citizens from a rural state such as Chiapas (where as many as a third of rural villagers speak Mayan dialects but not Spanish).

African American individuals have tremendous within-group heterogeneity as well, including nations of origin, ie, Nigerian or Ghanaian, Caribbean or Brazilian American. Americans of African descent are lumped into the broad category of African American based on their appearance, and they may or may not be related to generations of enslaved Africans who were brought to America unwillingly. Understanding how many

generations have passed since immigration is one factor affecting a patient's level of acculturation. Other factors will influence the experience of culture as well, such as geographical roots in the South vs the North, or growing up in a rural vs an urban community. Many other dimensions of culture should be assessed as the interaction with an individual patient progresses, including health beliefs, knowledge, literacy and health seeking behaviors.

Illustration

A nurse brings an older Chinese woman back to the exam room, asking her daughter to wait in the waiting room. The physician breezes into the room, performs an examination with the nurse present, makes a diagnosis and tells the patient she must begin medication to treat her newly diagnosed high blood pressure, and hands her a prescription. The patient nods respectfully. A year later the patient is seen again and found to have dangerously high blood pressure, and it becomes clear that she has not been taking her medication. This scenario raises two key issues. The first is to understand that nodding or smiling in many cultures simply means "*I hear you and I want to show you respect.*" It does not typically mean, "*I agree with you and commit to taking the treatment you prescribe.*" Another essential point to assess is asking the patient who in their family should be included in the patient's healthcare decision making. Often times these culturally-relevant decision makers are excluded from the exam room and from discussions about the treatment plan for the patient, almost guaranteeing poor adherence and outcomes.

Affirmation

Sometimes other cultural values or behaviors challenge our comfort zone. We do not always appreciate other people's cultural differences. It is in these circumstances that we must be especially disciplined in not assuming

negative motivations or values on the part of the individual behaving against the grain of our expectations. We should instead look for ways to affirm the positive cultural values and priorities that make their behaviors and attitudes perfectly sensible and appropriate in their context. In other words, we must recognize each individual as the world's expert on his or her own experience, being ready to listen and affirm that experience. We must then re-frame cultural differences, by identifying the positive values behind behaviors we perceive as "different."

Illustration

White, non-Hispanic physicians, or physicians of any background acculturated into the US medical culture, will find it "different" or even annoying when patients or students show up "late" for an appointment. They will typically not have any awareness that their definition of "lateness" (starting within three-five minutes after the designated appointment time) is culturally-driven. Rather, they will attribute the behavior of showing up late for appointments as a characteristic of the patient's minority or immigrant culture.

When we teach health professional students or even faculty at a mostly-White, majority institution, we ask them to complete a worksheet that involves filling in the blanks in the following sentence: "*Patients who show up late for appointments _____ _____.*" Most participants will assign a negative motivation or internal characteristic to the individual who is late. Typical phrases completing the sentence include, "*don't respect my time,*" or "*are disorganized,*" or "*are rude.*" Similarly, when participants describe a person who will not make eye contact, we generate responses suggesting that such persons are dishonest, or hiding something, or perhaps of low self-esteem. In fact, individuals from other cultures may perceive American culture as being unusually or even

pathologically time-driven and task-oriented.

Illustration

For example, if a Latino individual meets their cousin on the sidewalk on the way to a clinic appointment, the values of *familismo* and *personalismo* dictate that stopping and talking to this person is a priority. The patient values the personal relationship over the task of getting to the clinic on time. In this moment of personal interaction, full attention is given to their cousin, and time is not the priority. The conversation continues for however long it takes. In many cultures, valuing people is far more important than valuing punctuality or tasks accomplished per unit time. When we understand the positive values that drive such behavior, we can affirm the individual and maybe consider adapting our practice models or our appointment systems to serve the patients as they are, rather than as we wish our patients to be.

Sensitivity

Cultural sensitivity requires us to develop an awareness of specific values, beliefs, or perceptions within cultures that might influence patient's healthcare decisions. It is important and respectful to be sensitive to expressions or gestures that might cause offense, or lead to a breakdown in trust and communication between patient and healthcare professional.

Resnicow et al make an important distinction between superficial and deep sensitivity in conducting health education. Surface structure involves matching educational materials to observable, "superficial" characteristics such as language, music, food, locations, and clothing preferred by specific cultures. Deep sensitivity involves incorporating the cultural, social, historical, environmental and psychological forces that influence health behaviors in a culture.

It is valuable and appreciated by patients when their healthcare professionals learn about their traditional health beliefs or the decision making process for disease management of their patients. When considering cultures other than our own, it is easy to focus on "differences" and to stereotype all people from other cultures or ethnic groups as having a uniform set of health beliefs or behaviors. To the contrary, each cultural group is characterized by substantial within-group variations. Most of us will tend to be highly aware of heterogeneity within our own racial or ethnic group, but tend to paint other ethnic groups with the broad brush of common characteristics.

Illustration

A Latina mother brings her infant to the emergency room with a fever. Her husband and sisters are working, and her mother and grandmother are home with the other children. After a cursory examination, the doctor (through an interpreter) tells the mother that a spinal tap is needed and asks her to sign an informed consent immediately. She hesitates, and when the doctor pressures her to sign right away, she begins to cry.

What is the problem?

This scenario is rich in cultural dynamics. The doctor is driven by his medical sense of urgency about initiating treatment, reinforced by his American sense of time-urgency and need to complete as many tasks as quickly as possible. He has just met the patient and spoke quickly and professionally but impersonally through an interpreter without taking time for building personal trust (*confianza*) or respect. The infant's mother has a strong instinct to please the doctor as an authority figure (*respeto*), but she did not grow up in a culture that so highly prizes individualism. She does not make family decisions without consulting her spouse or her mother or her sister. The doctor does not value her commitment to extended family (*familismo*), but rather assumes that she is either a poor mother

or has low self-esteem or maybe that she is afraid of her husband. ("*If she really cared about her baby, she wouldn't worry so much about what her husband or her mother thinks. She's old enough to think for herself, isn't she?*") In truth, the mother cares more about her baby than her own life, and will probably sign the form despite her personal pain and conflict. How much more positive would the dynamics be if the doctor had simply said, "*I know this is a difficult decision for any mother. Would you like to call your husband [or your mother or sister or a friend] on my cell phone? We'll have to call quickly, because the baby could get much sicker if we delay much longer. I see in your eyes your pain. I know that you and your family care about your baby very much. I want to help, by God's grace.*")

Each culture has its own set of values and health beliefs, its own concerns and sensibilities.[23] There will be significant variability within each culture depending on co-factors such as degree of acculturation, age, gender-roles, education, work-roles and professional status. Table 5 lists a few examples of behaviors that may cause offense in various cultures.

Self-Awareness

Being self-aware of our own cultural norms, values, and "hot-button" issues that lead us to anger, misjudgement or miscommunications with others is a valuable step toward cultural competency. To work effectively with persons of different cultures, we must first be aware of our own cultural background. Cross puts it this way: "Many people never acknowledge how their day-to-day behaviors have been shaped by cultural norms and values and reinforced by families, peers, and social institutions. How one defines 'family,' identify desirable life goals, view problems, and even how we say hello are all influenced by the culture in which one functions, even though we express them in unique ways that evolve as we grow."[24] Once we have taken our own self-inventory of cultural expectations and have identified

Table 5.   Cultural sensitivity: behaviors that may cause cultural "offense"

- Calling a patient by first name instead of title and surname
- Touching a patient without asking permission
- Making (or expecting the patient to make) direct eye contact
- Getting right to business (ie, taking a medical history) before establishing a personal connection
- Taking a blood or urine sample
- Patting a child on the head
- Crossing one's legs; showing the bottom of one's shoes
- Examining a patient of the opposite gender
- Making American hand gestures ("okay" sign, or thumbs-up gestures)
- Asking a spouse to wait in the waiting room
- Limiting visiting hours in the hospital

our personal filters by which we view the world, we can begin to understand and appreciate the filters from which others view us as individuals and healthcare providers.

Illustration

From time to time members of our team are asked to lead cultural workshops with a specific request to teach about specific minority ethnic groups. When the request comes from mostly White health professionals, we are frequently asked to teach on Hispanic/Latino culture or African American culture, but we have never been asked to teach on "White European-American" culture, or "doctor culture." The groups requesting the training are unconsciously saying that cultural differences represent "other people" being culturally different, or in relational terms, "*I'm normal and they're not.*" For those in a majority culture, one of the first critical steps toward cultural competence is to recognize and overcome assuming that other cultures are judged by how well they fit into "our culture." Everyone can become more culturally competent when they acknowledge their own cultural baggage.

Humility

Humility allows us the freedom to peel back layers of our own perceptions and biases. It allows us to be quick to apologize or accept responsibility for unintentional cultural missteps. Tervalon argues that cultural humility may be more important than cultural competence.[25] No one ever fully attains "cultural competence." Instead, we can make a conscious commitment to a lifetime of learning about the people we interact with on a daily basis. Learning about different cultures firsthand from people of that culture, can be a matter of just asking about their culture from the patient's own experience. We may think that we have become quite progressive, indeed "culturally competent," when suddenly a new circumstance or personal encounter causes a remnant of racism or ethnocentrism or homophobia to bubble up from deep inside us. Humility cautions that we all have cultural biases yet to cast aside. Once a mistake is made, quickly offering an apology can turn the potential disaster into a productive encounter.

One of the quickest ways to move from arrogance or self-confidence to humility is to put ourselves in the role of student, and elevate our patient to the role of teacher. Each patient is the world's expert on his or her own experience and cultural perceptions. Take advantage of their willingness to teach.

It is also appropriate for "apology" to be part of the PEARLS mnemonic,[26] just as humility is part of the CRASH-course. We need humility to say, "I'm sorry," when we unwittingly say or do something offensive or disrespectful or arrogant to persons of another culture. Asking forgiveness of a patient or a nurse's aide or from a colleague is not taught in medical school, yet humility is an essential skill in the cross-cultural doctor/patient encounter.

Illustrations

We need humility to laugh at ourselves. The lead author of this article (Rust) as a medical student once mistook round, regularly-placed suction marks on the back of an Eastern European patient for the target lesions of erythema multiforme, although he confesses that the thought "*giant squid attack*" also briefly crossed his mind. Instead, the harmless lesions were signs of the common practice of heating glass bottles and placing them on the back to create suction as they would cool, thereby removing harmful airs or vapors.

CONCLUSION

No one is "culturally competent" in the full range of possible encounters faced by clinicians caring for a culturally diverse community, but there are core values and specific skills that can help each of us be more effective healers in a multi-cultural world. Physicians, especially those who work with cultures other than their own, must recognize that cultural competency may require decades of immersion, not just in clinic but in community affairs as well. Even then, we are at best amateurs in another person's culture. A realistic goal for busy

clinicians is to learn specific behaviors and habits that will allow us to be more culturally effective. We all must continually learn ways to avoid missteps that are culturally offensive or culturally dysfunctional. We must be quick to apologize for cultural missteps and commit ourselves to a lifelong experience of learning about the variety of cultures that make up the mosaic of America.

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