Cultural Humility as a Clinical Competency in the Training of Integrated Primary Care Providers

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STATEMENT OF THE PROBLEM

Implicit biases exist toward minority populations among healthcare providers and in healthcare settings and negatively impact access to care, quality of care, and healthcare outcomes (Hall et al., 2015; Alcala et al., 2017; Hoffman, Trawalter, Axt, & Oliver, 2016; Walker, Williams, & Egede, 2016). The majority of research conducted on racial and ethnic biases demonstrate a positive implicit bias on the part of healthcare providers towards whites and a negative implicit bias towards people of color (Hall et al., 2015). According to Richeson & Nussbaum (2004), most of these biases are likely supported by both a lack of cultural knowledge and a fear of appearing racist by acknowledging that racial disparities exist. Hook, Davis, Owen, Worthington & Utsey (2013) hold that cultural humility is able to break down cultural divides that contribute to and serve to maintain healthcare disparities by embracing differences rather than dening them.

A culturally humble approach to patient care seeks to break down historical power imbalances in healthcare settings to provide better service. Yet, research reveals that implicit biases against minorities among healthcare professionals mirror those of the general population, suggesting a training need for healthcare professionals (Hall et al., 2015). Further, research suggests that the implicit racial bias of healthcare students at the beginning of training remains present, or even increases, as they matriculate through their programs (Chapman et al., 2013).

When training future healthcare providers to work in integrated primary care settings, instilling cultural humility as a clinical competency needs to be a main focus of training, both didactically and experientially, along with other skills sets unique to integrated healthcare service delivery. Models of integrating cultural humility into training of healthcare professionals are being developed, in terms of strengths, limitations, and efficacy, and the approach of a HRSA-funded behavioral health training program in integrated primary care for underserved minority populations aimed at instilling cultural humility is presented. Given the need to develop an integrated care workforce providing training to meet the needs for a culturally humble approach in training in and provision of integrated healthcare services and provides a model example via a HRSA-funded training initiative.

ASSESSMENT

- Measure to assess implicit bias of healthcare providers:
  - Color-blind Racial Attitudes Scale (Neville, Lilly, Duran, Lee & Browne, 2000). This instrument measures unawareness of racial privilege, institutional racism, and blatant racial bias. We hope to see a reduction of all of these scores in healthcare providers by the conclusion of this study.
  - Measure to assess internal and external motivations to respond without prejudice:
    - Motivation to Respond without Prejudice Scale (Plant & Devine, 1998). It will assess whether changes associated with new knowledge of institutional racism, privilege, and overt racism originate from a desire for self-actualization and improvement of the human condition or external reasons.
  - Measure to assess cultural humility:
    - The Cultural Humility Scale (Hook, Davis, Owen, Worthington & Utsey, 2013). This will be completed by patients across integrated behavioral health sites to determine whether providers’ cultural humility scores have increased or decreased from the perspective of the patient. All instruments will be administered under pre and post conditions.

TRENDS

- Emerging research from the fields of psychology and medicine have proposed and tested new approaches to reducing implicit bias across various domains (e.g., prejudice related to race, sex, age, physical health, mental health) with various stigmatized populations (e.g., people of color, LGBTQIA+, HIV+ status). From these studies, it is hoped that changes will be made at the student training, professional, and institutional levels of healthcare.
- Suggested strategies for addressing implicit bias range from increasing awareness of bias through formal assessments (e.g., IAT) and academic self-reflective exercises, to providing instruction on ways to reduce the activation of implicit associations (e.g., mindfulness), to controlling how these associations influence judgment and behavior (e.g., seeking counter-stereotypic and common identity information, perspective taking, stereotype replacement, and individuation). The use of more effective strategies (e.g., control and two-step approaches (i.e., awareness + control) are more likely to significantly impact bias.
- Beyond in-the-moment actions, research indicates the need for institutional bias reduction. Specifically, studies implore training programs and institutions to increase diversity in faculty, supervisors, and attending physicians, as well as to create opportunities for positive contact across group boundaries.

FUTURE DIRECTIONS

The IBHSP program is already practicing many of the techniques that would be ideal to utilize if hoping to practice from a culturally humble perspective. However, there are many more strategies programs and organizations could utilize to work toward increasing cultural humility. While the IBHSP promotes self-awareness and reflection, actually taking an IAT may help providers gain a more objective view of their own implicit biases. Another strategy that may be helpful would be to engage in more community activities in order to create positive contact between providers and the populations that they serve. Finally, patients should be provided with the opportunity to give feedback to their providers on perceived levels of provider cultural humility and any perceived discrimination or microaggressions that may have occurred. Not only would this give patients a voice, but it would also present the provider with the opportunity to repair any ruptures that may have occurred during the visit. Research indicates providers who repair these ruptures are rated significantly higher by their patients than those who do not address provider-patient relationship ruptures (Owen, Tao, Imel, Wampold, and Rodolfa, 2014). In an ideal world, organizations and providers would be able to implement all of these strategies. However, the capabilities of every site are unique, and they must decide for themselves how they will strive toward cultural humility.

REFERENCES

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