REVIEW

Cultural competence for the 21st century dermatologist practicing in the United States

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Significant health disparities exist among under-represented minorities in the Unites States, which can partially be accounted for by the quality of patient-physician interaction. A distinguishing factor of this interaction is the ability of the provider to demonstrate cultural competence, or address the social, cultural, and community influences on healthcare behaviors and incorporate these elements into patient care. However, this practice has yet to be universally implemented in our healthcare system. These factors become even more important as the racial, ethnic and cultural distribution of the United States population changes. Multiple studies have suggested that cultural competence of the health care provider and staff leads to improved patient adherence, satisfaction, and ultimately, health outcome. Cultural competence in the workplace also leads to efficient and cost-effective healthcare and better community integration into healthcare systems. The purpose of this review is to help dermatologists understand the benefits of culturally competent care for their patients and themselves and identify methods and resources to achieve this goal. (J Am Acad Dermatol http://dx.doi.org/10.1016/j.jaad.2017.07.057.)

Key words: cross-cultural training; cultural competence; cultural efficacy; effective clinical encounters; health disparities; quality of care; sociocultural barriers to care.

Dermatologists practicing in the United States today must be aware of changing demographics of the population and associated health care disparities based on sex, race, ethnicity, socioeconomic status, disability, religion, and sexual orientation. This issue is not limited to the United States, because similar changes are occurring in other countries around the world. Dermatology as a specialty requires particular attention, because it has the dubious

Abbreviations used:

UIM: underrepresented in medicine
URM: underrepresented minorities

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distinction of being second only to orthopedics as the medical specialty with the smallest percentage of underrepresented minorities (URMs) in the United States,* specifically those who are underrepresented in medicine (UIM),† in its workforce.[1-10] In 2015, African American and Hispanic dermatologists comprised only 4.1% and 4.7%, respectively, of the US dermatology workforce, which poorly reflected the racial and ethnic profile of the US population at that time (14.3% African American and 17.4% Hispanic).[3-5,11-13] The situation does not appear to be improving, because only 1.6% of African American, 1.4% of Hispanic, and 0% of American Indian medical school graduates reported dermatology as their specialty of choice in 2011.[14]

With the increasingly diverse patient population in the United States, there is an ever-growing need for physicians and other health care providers to improve health care delivery beyond having exceptional clinical skills and successfully achieving system-wide quality measures; cultural competency should also be considered in this process. Culture is distinct from race and applies to all forms of diversity. For example, many multiracial Hispanic populations in the United States share the same culture. A patient's cultural view of health care may be unrelated to race. Cultural competence requires the health care provider to be inquisitive, accepting, and flexible in order to integrate a patient's beliefs into their care. Culturally competent care is a patient-centered approach that includes establishing rapport and engaging in shared decision-making between the patient and physician in a manner that is respectful of a patient's values, goals, health needs, and cultural background. This improves patient satisfaction, and, ultimately, health outcome (Fig 1).[15-18]

CAPSULE SUMMARY

- Cultural competence is underused although it is important for providing quality health care to diverse populations.
- This review helps readers understand cultural competence, its significance, and how to adopt it in the workplace.
- Cultural competence provides diverse benefits for patients, communities, and health care systems, including improved outcomes and patient satisfaction.

WHAT IS CULTURAL COMPETENCE?

To more clearly define cultural competence, we will first highlight the definitions of associated terms, including race, ethnicity, and culture. Racial categorization divides individuals into groups based on physical characteristics, most commonly relating to shared ancestry. For example, individuals can be assigned to a racial group based on skin color and facial features. Ethnicity, however, is a term that groups individuals based on their sociocultural context, and therefore encompasses more than physical traits. Individuals of the same ethnicity usually have a common group history, such as shared language, genealogy, or religion.

*URMs were formerly defined by the Association of American Medical Colleges, Council on Graduate Medical Education, and Department of Health and Human Services as racial and ethnic groups who are represented in lower proportions in health professions than in the US population as a whole. These races/ethnicities include: African American, Mexican American, Native Americans (American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans. The National Institute of Health has expanded this definition to specifically include Pacific Islanders, which is reported by the US Census Bureau/-Office of Management and Budget under the race "Native Hawaiian or Other Pacific Islander."

The 2010 US Census Bureau defined black or African American as a person having origins in any of the black racial groups of Africa. This includes respondents who reported entries such as African American, sub-Saharan African, and Afro-Caribbean. For consistency, the term African American is used in this article.

The 2010 US Census defined Hispanic or Latino origin as a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race. Individuals answering the 2010 US Census were asked to answer both race and ethnicity, with ethnicity defined as "Hispanic, Latino, or Spanish origin" or "not of Hispanic, Latino, or Spanish origin." In the 2010 US Census report on the overview of race and Hispanic origin, the terms Hispanic or Latino are used interchangeably. For consistency, the term Hispanic is used in this article.

†In June 2003, the Association of American Medical Colleges Executive Council adopted the following definition of UIM: "[UIM] means those racial and ethnic populations that are underrepresented in the medical profession relative to their numbers in the general population." This article refers to medical providers who are underrepresented in the medical profession as UIM. The term was revised by the Association of American Medical Colleges from URM to UIM to include underrepresented groups based on changing demographics of society and the medical profession, rather than on race/-ethnicity alone. Available at: https://www.aamc.org/download/54278/data/urm.pdf.