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The Importance of Cultural Competence in Medical Practice

David Acosta, M.D., associate dean of multicultural affairs at the University of Washington School of Medicine, discusses the significance of cultural competence, his role as a medical educator, and his practice in family medicine.

Eric Weissman: Thank you for joining us for the AAMC Aspiringdocs.org Podcast. I'm Eric Weissman with the Association of American Medical Colleges. Today's podcast, we'll explore a career in family medicine with Dr. David Acosta. Dr. Acosta is the Associate Dean for Multi-Cultural Affairs at the University of Washington School of Medicine and Clinical Associate Professor in the Department of Family Medicine. He has been a Board Certified family practice physician for 24 years. Dr. Acosta, thank you for joining us.

Dr. David Acosta: Thanks for having me, Eric.

Eric Weissman: So, let's begin with a very broad question. Why do you think diversity in medicine matters?

Dr. David Acosta: I think that's a great question and it can probably be answered in many different ways and let me answer it in a couple of ways for you.

Number one, I think as a physician it becomes exceedingly important, at least from my background and my experience and what I've seen in the patients that I've taken care of who come from a diverse background, backgrounds that essentially make up many racial and ethnic population groups, many patients come from disadvantaged backgrounds, especially

social economic disadvantaged backgrounds. I think it becomes really critical that knowing the patient population that I'm going, that I was taking care of at that time, if I knew that in medical school I probably would have pursued more opportunities to know how to be more culturally responsive. I think I learned that over time. Being Latino myself, you know, I could bring some of that to the table. A lot of things I learned from my own family, my own culture, heritage, my customs, my traditions and at least that I grew up with, especially as they relate to health, but also more importantly to family. You know, that was very instrumental and it helped me I think in taking care of my patients in a culturally responsive way. But I also found that there was a big void of other things that I was very unaware with, especially with families that came from, came from backgrounds that I was not as familiar with. And I think over time, I kind of changed my way of thinking. I've tried to understand, instead of trying to understand every culture realizing that it was pretty impossible, I realized that there was a better way to approach it more from a general fashion.

The other way I'd answer it is while, is the fact that, you know, when you have a diverse student body, I think it really captures for you a much more rich educational environment that you can learn what you need to learn to take care of different populations like this. If you have a diverse set of people that are at the table when you're discussing a case and you're learning everybody's different perspectives based on their own experiences where they came from related to this patient care case. From that I think we have a lot to offer each other. And again rather than coming from a homo genius environment, I think having a more diverse

one really adds and enriches that teaching. And I'm seeing that right now where I'm at, at the University of Washington, is that, that's something that you can't learn in the classroom by ultimately having that mix plays a big role I think in learning as much as you can in this area.

And then lastly, just from a demographic standpoint, you know, we're changing. We're changing dramatically. Looking the demographic trends that are going to happen in the next ten to thirty years, they are going to be so dramatic that we need to be prepared. I don't think we have a choice anymore. I think it is really critical that anybody coming out of medical school, anybody coming out of any health profession, I think really needs to appreciate that.

Eric Weissman: You say we don't have a choice anymore. That implies that there's a risk or something is at risk. What's that risk?

Dr. David Acosta: Well, that risk has been really well publicized and I think what sparked that was the studies that came out of the Institute of Medicine that told us that ultimately there is clearly health care disparities that are being experienced by certain populations, especially the racial and ethic populations in our country. Disparities have always been there but I think for the first time it came to light back in 2003 was now we had over 600 published studies that have now shown and has come to the forefront that, you know, this stuff is real and we have to pay attention to it. And when I say that we don't have a choice, it's that we don't have a choice because the demographics are changing so much that there's no guarantee anymore that when you open that door and go see that next

patient that they're going to be from a homo genius group that you're used to taking care of. Going through that door with all, with the different racial ethnic populations that we are now experiencing in the U.S., me as a Latino, I feel that I am pretty well prepared for it. But I think even if you weren't from a minority population, I think we're all going to be up against the same challenges that come that way. And I think it's a decision I think we have to pay attention to those health care disparities and try as best we can to try to reduce and eliminate them. One in that way is to try and diversify our training in medical school and residency to see if that'll effect it.

Eric Weissman: Much earlier on you used the term culturally responsive. I'm wondering if you can tell me what you mean by culturally responsive and if maybe you can even think of an example where an actual medical case that you looked at had an outcome that was favorably impacted by a culturally responsive approach?

Dr. David Acosta: Sure. What I mean by a cultural responsive approach , I use that now only because I really don't like the term cultural competence. Cultural competency is kind of a new buzz word that's been around for the last several years or so and what it implies is that you reach this particular state of equilibrium, that you've learned everything you needed to know and you're competent in this area of knowing how to approach and how to understand differences and similarities between other differences in groups. And I don't think that is just so – I think the reality is we're learning everyday. Every day there's never an encounter that I don't have

in any given week, any given day, that I’m not learning something new about a different type of group.

What being culturally responsive really means is that I’ve taken into account, I’ve approached an encounter with a patient in such a way that I try to approach it with humility in a sense that I’m going to be very open to the differences that maybe we’ve both come to the table with if I have a patient who’s from a total different culture than I am. It’s that ability to be humble and say, “You know something? I don’t know much about your culture but I want to know because that’s really going to impact on how we get along. It’s going to impact our relationship, but it’s also going to impact some decisions that we make down the line as I begin to take care of you.” So it’s really important for me to understand the perspective of what you think about the illness. Why do you think this happened to you? What do you think caused it? How is it impacting you but also, how is it impacting your family? How is it impacting others around you? Have you tried other folk medicine remedies that maybe have been passed down from tradition to tradition to your family that you use but now they’re not? Or maybe they’re conflicting with maybe a medication that I want to prescribe to you? I want you to feel very comfortable that you can talk to me about that. I want to know if you’re seeing a traditional healer then. I need to know that so we can work in conjunction with each other, not against each other, and I’m very open to know that. I also want to know that based on maybe some religious values you have or other family values you have that maybe what I’m asking you to do in changing your lifestyle or go through a certain treatment modality that maybe it is

against, against the grain of that. And so it becomes really important that we become partners in approaching someone's condition or illness, their treatment and the only way to do that is I think is trying to be as culturally responsive as we can. So that's kind of a summary of that.

Eric Weissman: Right. And can you think of, you know, of a specific event, a case where, you know, asking someone whether they had sought a traditional remedy or if there was a religious issue where it really did change the outcome?

Dr. David Acosta: Sure. I can share an example of a case that I actually shared with a couple of my medical students just this last week and it's of an elderly Hispanic woman that I was taking care of. And again mind you, being Latino I come to the table with some pretty good understanding of cultural values and norms. But it was a patient that I was taking care of for a couple of years or so. She was from Nicaragua. My family is from Southern Mexico so there are some differences in our customs but some similarities along that line. At any rate, I felt that we had had a very good relationship but one of the things that I had been noticing is that she had diabetes. I prescribed a standard of medicine, the particular medications that most diabetes were non-insulin dependent with her. But I also realized, you know, she just wasn't getting better and things going through my mind was she's either not taking her medication, she can't afford the medication, the medication is making her ill that she doesn't want to tell me that they are or something else is going on that I'm not really aware of sort of. At any rate, during our interchange, I speak Spanish fluently and so, she also spoke Spanish, and so I thought I had

asked her every question and asked her some of these open-ended questions that I had learned along the way to try to see if there was any other reason why her diabetes wasn't getting better. Then I had an idea. The idea that I had was maybe I should bring in a medical interpreter because I knew that Spanish was one of her native languages but it was not her indigenous language. And so we found an interpreter that knew the indigenous language that she knew from Nicaragua and here I thought, again, taking care of her for two years that I have known pretty much everything and I asked her all these questions. What came out of that was just a revelation of things that I did not know at all. I learned that ultimately she had decreased her dosage of medication because she had also learned from another friend and a woman that is known as an Abwella who is an elderly woman who knows a lot of the healing traditions in the community and had started some both herbal remedies, but it also started some foods known as [inaudible 11:13] which are just, it's a flat cactus from [inaudible 11:17]. She had learned that that helped sugar and ultimately knew that if she started eating these things and taking the herbs that that would help her diabetes. She also learned that she needed to decrease her medicine because she knew some other people in her community that had lowered their blood sugar too much by staying on the same medications, same level of it, while doing this other therapy. And she said that she had respected me so much that she didn't want to tell me because she thought I would be very upset and so we talked about that because out of respect we would never have talked that well. And then I also learned one other very interesting thing is that when

I asked her the question and it was interpreted by the interpreter of how to ask those questions, “So what do you think caused your diabetes” sorts of things, I was kind of expecting the usual things that runs in my family, the things that I eat and I’m overweight. Those sort of things. She had had, she relayed a whole different story and the story was relating to me of about a frightening experience that she had had with witnessing one of her relatives being murdered. There’s a condition called, at least in my family known as Susto, which is such a great fright that essentially it’s so great that it either, it scares the spirit out of you or it scares the soul out of you sort of thing. And there’s certain ways that when Susto happens, it creates a number of symptoms and many of the symptoms of what she had that I had been treating as anxiety, depression, those sorts of things but in her mind she also knew from the community that she grew up is that she needed more than an allopathic physician to help take care of the diabetes as it was related to the Susto. And Susto usually required a traditional healer that had a certain approach, a ritual approach to it in order to bring the spirit back, bring her spirit and her back together in one. So a lesson for me was I knew a lot about Susto. I knew about traditional healers and that, but I think the lesson for me was even though I may know the native language and we speak the same language, sometimes people may not be able to emote properly or find the right words if it’s not their indigenous language that they can tell that with. Our relationship changed dramatically. She felt still very comfortable in speaking Spanish with me and English, but I think we both learned that when we got to the point of having to talk about something that may be a little bit more

deeper down than maybe having the interpreter available was something that was really going to change our approaches.

Eric Weissman: So you're, in addition to being a practicing physician, you're an educator as well? You teach medical students?

Dr. David Acosta: That's correct.

Eric Weissman: How do you teach this to medical students? Or let me ask more broadly. How do medical students learn this? Do they learn this or is this something that they discover when they're out in the field practicing medicine?

Dr. David Acosta: I'd probably say all of the above. I think it really depends on the institution that you're at. And I think that the faculty that they get exposed to. I think over the years of doing this, I think one of the things I think is the first place is to have students to be at least, whether they are residents or whether they're medical students, I think one of the most critical things is getting their attention, getting their awareness. And I think what I've learned over time being a physician now for 26 years or so, the reality is that, you know, the gift of story, the narration of stories like the one I just told you is a powerful thing. Because it's not something that I think I can have a class on this, Hispanic 101, let me tell you all the things you need to know about. You can certainly learn generalizations about certain cultures. But it's nearly impossible with all the cultures that we have, that it's nearly impossible to know every single nuance and detail about that. And so I think there's a couple of ways. I think by narrative story but I

think number two is basically I can teach medical students and residents of how to approach somebody with humility. There is a set of, a number of, a set of questions that you can ask in an open-ended way to get people to talk. I think a third way is also, more than anything else, is that teaching medical students and residents how to gain trust because I think a lot of patients come to the table or come to meet you with some distrust in the sense of how they've experienced the medical system or the health system outside of you. And so they bring that to the table and they kind of, they would lump us all together and I think part of it is breaking through those barriers as best that we can. And I think you can teach that through better cross-cultural communication skills, learning about mistrust, learning about conflict resolution, how do you break through those barriers. And that's what we're actively doing right now as best as we can. Is it successful? Tough to say. You know, ultimately we hope that it is. I think the best way, we really don't have, there's not, kind of an evaluator monitor that we look at. I think what we really look at is just patient satisfaction, adherence to modalities that you recommend, adherence to coming back and seeing you and the, last but not least, the ability for them to have deeper conversations with you because they trust you, especially in tenable situations as all patients are in.

Eric Weissman: So let's go back one more life stage from the medical student to someone who's considering a career in medicine. What's one piece of advice or one thing that you'd like to plant in the mind of someone who is seriously considering going into medicine and hasn't decided that he or she is really going to do it at this point?

Dr. David Acosta: You know, I think probably the most important thing is making sure it's the right calling for you. I think you have to deeply reflect on, you know, why is it you want to go into medicine? What's the calling about? What is it you want to do with it? What is your outcome? And are you passionate about it? It all starts with some form of idealism. I mean we've all started in that place. But I think part of it is also validating that idealism by going out and seeking opportunities to shadow physicians to see what they're really doing. But not just physicians. I would also say any, really any healthcare professional. I think it's equally important to see what a nurse, see what a social worker does, a pharmacist does. Just realizing that, you know, the health system is bigger than just being a physician. And the only way that I feel you can really validate your feelings that physician hood is pretty much something that I want to achieve is by checking out the other things around it. We do work as an interdisciplinary team but it's very important that understanding that a physician plays a different role. Everybody has their own role on that team as you approach a patient because you can't do it alone, but there are clerical things that stand out. So I think make sure you're passionate about it, validate it, I think is very important as well. And the last piece is probably conviction and what I mean by that is that the reality of how we're trained it does take a considerable amount of time. As I tell students, a couple of things I think are very important and that is I think there comes a time in which you have to really ask yourself are you ready. Have you experienced life in such a way that you've gotten a lot of that stimulus that you need to kind of keep you going? You know, is it out? Is it done? Have you experienced

other people's life and different frameworks? Have you experienced death with somebody? Have you experienced happiness with somebody? Have you been around people who have been sick all the time and do you thrive at that? Have you been around people, have you been in situations that actually forced you to make some difficult decisions? You know, I tell my students a lot that as they come to me as pre-meds, I'll ask them a lot of those same questions and again I don't go by age necessarily. There's a lot of people that have many, many different experiences just from growing up that I think some mature a lot faster than others. But I think invariably across the line what I see is that those that go out and live independently, can make it, get those life experiences, actually will make better physicians. I think they have to ask themselves, you've got to remember is that, people are going to base their trust in you based on what life experiences or how you approach them. People can tell that within that first five minutes of just being with you of where you've been, how you think, how open are you and do you really understand the path and the journey that I've had that's led me to this burden of illness. And if you can't answer that, you may want to think and wait a little bit. But I think it's very important.

Eric Weissman: Well, Dr. Acosta, thank you very much for joining us today.

Dr. David Acosta: Thank you, Eric, for having me. Appreciate it.

Eric Weissman: For the AAMC, I'm Eric Weissman.