Over the 25 plus years I’ve had the privilege of teaching about cultural competency and the care of diverse populations, I have learned many lessons about what works and doesn’t work in adult education. I have also received my share of positive and negative feedback. Those of us involved in cultural competency training not infrequently receive a wide variety of comments prior to, during, and following educational programs. Here is a sampling of comments that several physicians have offered the blogosphere:

“Cultural competency sounds so good. Most physicians try to understand their patients. Cultural competency gives the sense that we will better understand our patients' needs. How do we develop a curriculum that works for all physicians? Some physicians have exposure to many Latinos. But Mexican culture differs from South American culture, which differs from Cuban culture. How do we balance all those issues? Certainly Minnesota physicians have different cultural-competency needs than Hawaiian physicians. Those in urban practice have different cultural-competency needs than rural physicians. We have a different culture in the South than in the West. How do we provide a course that really helps practice?”(1)

“I can’t help but think that there is more than a little political correctness involved. Such mandated training sounds good and is obviously easy to support politically. I believe however that all policy decisions, even seemingly benign ones, need to be made scientifically with careful weight applied to both the potential benefits and risks of such decisions.(2)

“Does anyone really think an hour of ethics CME is going to stop doctors from ripping off Medicare? No. And with some people there aren't enough hours in the day to make them behave ethically. While the overwhelming majority of doctors behave ethically every day, we'll make everyone take ethics classes and that way legislators can say they're doing something about unethical doctors. The same thing goes for cultural competency. It just makes a good sound bite for the politicians. It's hard as a medical community to put our foot down and say this is the wrong answer to the right question.”(3)

“The bottom line is that I cannot be everything to everybody. If I am perceived by a patient as not communicating well with them, for whatever reason, because I’m culturally insensitive or because I’m just not nice enough, they have the opportunity to seek care elsewhere. If I find that a whole lot of patients are doing just that, I will have to find a way to change my behavior or go out of business. That is the American way. I don't need a Cultural Competency Czar making me sit in seminars and sing Kumbaya in Norwegian to understand that basic principle of life.”(4)

Do any of these sound familiar? As cultural competency educators, we know that the subjects of cross-cultural care and human diversity often trigger strong emotional and behavioral reactions, expose various “biases” and “isms” (e.g., racism, classism, sexism, homophobia, and xenophobia to name just a few), and generate resistance and inertia which need to be managed both at the individual and organizational levels. Creating a safe environment for learning and dialogue is critical, but we also need to be mindful of our own personal reactions as well as the need to engage in appropriate interpersonal and group facilitation skills. Fortunately there are a growing number of excellent train-the-trainer and curricular resources available to guide us with these endeavors.(5)
Lest folks get disheartened, here are some more positive comments that I’ve also heard about cultural competency training:

“Cultural Competency is fine – but physicians need to be reimbursed for time and effort.”

“Cultural Competency – sensitivity training should be initiated in pre-school-kindergarten for all, and continuous through life.”

“Excellent idea, inspiring. Needs to be carried on to our institutions and communities.”

“I think that many miss the message. It’s not that we as physicians are able to fix the problems, but be aware of the problems so that we may better care for our patients. Thank you for doing a thankless job!”

I invite DiversityRX and Your Voice readers to share their own experiences relating to the following questions:

• What are some comments (“good, bad, and ugly”) you’ve heard during cultural competency training? (note: please don’t use any respondents’ real names).
• How are these comments similar or different across different health, mental health, and social service professions?
• How have you addressed or seen these comments handled during training?
• What strategies have you found helpful in dealing with resistance, inertia, disrespect, and the “isms”?
• How do you prevent “fatigue” and “burnout” in your work? Where do you get your support from?

As we continue our work together in this challenging but important area, I have found the following spiritual meditation to be helpful: “The fatal pedagogical error is to throw answers, like stones, at the heads of those who have not yet asked the questions. (Paul Tillich).

Let’s inspire further mindfulness, reflection and consciousness-raising as well as collective praxis, dedicated advocacy, and community action in increasing access, closing the disparities gap, and improving health care quality and outcomes for all!

Robert C. Like, MD, MS
Professor and Director
Center for Healthy Families and Cultural Diversity
Department of Family Medicine and Community Health
UMDNJ-Robert Wood Johnson Medical School
New Brunswick, New Jersey 08903 USA

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The “Good, Bad, and Ugly” of Cultural Competency Training: How Should We Respond to Feedback?

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