The Impact of Cultural Humility in Prehospital Healthcare Delivery and Education
The NAEMSE Cultural Competence Committee

Introduction

EMS personnel in the U.S. continue to be overwhelmingly Caucasian and male, with 75% being male and 85% identifying as nonminority ("National Registry Data Dashboard," 2018).   While the population of the United States becomes more diverse in ethnicity, religion, and race, the EMS workforce remains largely homogenous and does not reflect the diversity of the population it serves. Given the growing diversity across the country, EMS personnel will increasingly be responding to calls for service involving patients with different cultural backgrounds than their own. This growing gap between providers and the population they serve may exacerbate already existing disparities in care.

The Role of EMS Educators

EMS Educators play a significant role as gatekeepers to our profession and directly influence who enters it. Acting in this critical role, they impact the provision of culturally competent, equitable, and medically appropriate prehospital care to the general public.

The National Association of EMS Educators (NAEMSE) believes ensuring the availability of consistently safe and equal care to all is a core responsibility of EMS Educators. To fulfill this responsibility, EMS Educators must continually work to improve the ability of their learners to meet this expectation.

As our country becomes increasingly diverse (Vespa, 2018), EMS Educators must work to match this diversity in their student population. This paper provides the background and rationale for these positions as well as tools and best practices for EMS Educators to implement in service of these goals.

NAEMSE has adopted the following recommendations on cultural competency, cultural humility, cultural competency education, and the role of EMS educators in the promotion of cultural competency and humility in EMS.

Recommendations

1: All members of our society, regardless of race, gender, ethnicity, age, national origin, native language, religion, socioeconomic status, cultural background or sexual orientation have equal access to EMS education.

2: All members of our society should have access to, and receive, identical high-quality, and evidence-based care.

3: EMS educators should acquire, utilize and teach the ideals of cultural competency and humility.

4: A diverse EMS workforce, representative of the patients it serves, is crucial to promote understanding among EMTs and Paramedics, patients and other providers in the healthcare system, and to eliminate disparities in care experienced by minority patients.

5: EMS training programs should increase efforts to recruit, enroll, and retain minority students.

6: EMS employers should increase efforts to recruit, hire, and retain minority providers.

These positions align with content in EMS Agenda 2050 pertaining to socially equitable care that is consistent and focused on patient outcomes (TEP, 2019).

Background

EMS Agenda 2050 (TEP, 2019) recognized the importance of socially equitable care as a principle of the future of EMS. Socially equitable care is patient care in which the quality of care and outcomes are not impacted by the location in which care is provided (TEP, 2019). More so, EMS has a responsibility to provide identical care to individuals regardless of their health status, demographics, or social factors (TEP, 2019). Achieving this will require an EMS workforce educated on biases, social-cultural determinants of healthcare, and cultural humility.

The Institute of Medicine recognizes nine classifications of patients in healthcare susceptible to disparities:
- Racial/ethnicity identity
- Socioeconomic status
- Gender
- Age
- Disability
- Rural residency
- Inner-city residency
- Sexual orientation
- Religion

Given this susceptibility, it is important for EMS providers and Educators to work to address and mitigate these tendencies in healthcare.

Cultural Awareness, Competency, and Humility Definitions

It is critical for EMS Educators to recognize that cultural competency exists on a continuum with awareness on one side of the spectrum and humility on the other with the ability to improve throughout one's lifetime. In order to facilitate open communication and a common understanding of relevant terms, NAEMSE has adopted the following definitions:

Cultural awareness: The National Center for Cultural Competence at Georgetown University defines Cultural Awareness as *"being cognizant, observant, and conscious of similarities and differences among and between cultural groups"* (Goode, 2001, revised 2006).

Cultural competence: *"the ability of providers to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients (Betancourt, Green, & Carillo, 2002). A culturally competent health care system can help improve health outcomes and quality of care and can contribute to the elimination of health disparities (Betancourt et al., 2002). Cultural competence describes how providers can work effectively and consistently across different cultures (Institute of Medicine [IOM], 2001).*

Cultural humility: *"Cultural humility is a process of inquisitiveness, self-reflection, critiquing, and lifelong learning. In contrast to the idea of cultural competence, cultural humility is never mastered-it is an ongoing process, shaped by every encounter we have with every person, as long as we maintain an open mind and heart." (Lippincott, 2019).*

An organization or individual exhibits cultural competency by respecting and being responsive to cultural differences in an attempt to ameliorate inequities (Hanley, 1999). The ability to be aware of self and to experience other cultures are the two most important conditions to successfully develop cultural competence (Hanley, 1999). Six stages have been identified to achieve cultural competence culminating in cultural humility (Bennett, 1986, 1993, 2004, 2013, 2014). There are several stages of an individual's journey as they evolve from an ethnocentric to an ethnorelative perspective. Ethnocentric refers to people employing their own cultural values to evaluate other cultures while ethnorelative takes into account different values and beliefs. The six stages include:

1. **Denial-** people are unaware that there are differences in culture.
2. **Defense-** people acknowledge differences and feel threatened by those who have different values and respond with feelings of denigration, and superiority.
3. **Minimization-** at this point, people are aware of differences and minimize the difference between cultures.
4. **Acceptance-** people now not only recognize but value different cultures in a non-judgmental manner.
5. **Adaptation-** involves the ability to adapt behavior to cultural differences and can work within another culture effectively.
6. **Integration-** allows people to move freely and comfortably between a variety of cultures.

Cultural humility refers to the stage where people become aware that they can never be truly competent however, they can enhance their ability to work with people of diverse backgrounds.

Hidden Bias/Implicit Prejudice

Addressing the ideas of hidden bias and implicit prejudice is often unsettling. It is important to note that while many attach a negative connotation to these words, they are not personal indictments, nor are they something unique to a few individuals. The human brain works in such a way that humans cannot avoid developing these "hidden" concepts. Whether we choose to acknowledge that some of these bias/prejudices are negative and can influence our professional and personal lives is what will separate individuals.

Just as we can never "know it all", we can never become totally culturally competent, but we can continuously evolve, learn and grow. Our prior influences, feelings, perceptions, and attitudes, as well as stereotypes developed as our brain categorizes information all facilitate the development of implicit bias in humans (Devine, Austin, & Cos, 2012 p. 1267-1268). According to Hardin and Banaji "we now know that the operation of prejudice and stereotyping in social judgment and behavior does not require personal animus, hostility, or even awareness. In fact, prejudice is often "implicit"-that is, unwitting, unintentional, and uncontrollable-even among the most well-intentioned people" (Hardin & Banaji, 2013, p. 13-14). While animus need not be present, implicit bias can produce discriminatory behavior, influencing interactions of all types.

Hardin and Banaji cite 3 characteristics of implicit prejudice: "(a) operates unintentionally and outside awareness, (b) is empirically distinct from explicit prejudice, and (c) uniquely predicts consequential social judgement and behavior" (Hardin & Banaji, 2013 p. 14). Given that implicit prejudice is not a conscious choice made by an individual, mitigation of the effects of implicit prejudice becomes a significant challenge. Research has shown that it is difficult for individuals to "control or fake" implicit prejudice (Hardin & Banaji, 2013, p. 16).

The Kirwan Institute for the Study of Race and Ethnicity defines implicit bias thus "refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner" (Kirwan Institute, n.d.). Larry Purnell believes that it is "essential for health professionals to take time to think about themselves, their behaviors, and their communication styles in relation to their perceptions of different cultures" (Purnell, 2009, p. 2). Purnell also states "health professionals must first address their own personal and professional knowledge, values, beliefs, ethics, and life experiences in a manner that optimizes assessment of and interactions with clients who come from a culture different from that of the health-care provider." (Purnell, 2009, p. 2).

These thoughts reinforce the fact that becoming culturally competent is a process; one should picture a journey, not a sprint.

Ultimately, the desired outcome is to mitigate the impact of our hidden bias and implicit prejudice upon the communities we serve. Research demonstrates that this outcome is difficult to achieve. Tropp and Godsil state, "Simply making people aware that they have the potential to be biased is not enough; people require specific and tailored forms of intervention" (Tropp & Godsil, 2015.). They outline a five step process intended to help navigate through our humanness and overcome these particular obstacles:

- Exposing people to counter-stereotypic examples of group members.
- Consciously contrasting negative stereotypes with specific counter-examples.
- Rather than aim to be color-blind, the goal should be to "individuate" by seeking specific information about members of other racial groups.
- Assume the perspective of an outgroup member
- Making more of an effort to encounter and engage in positive interactions with members of other racial and ethnic groups.

(Tropp & Godsil, 2015.)

In addition to these efforts, actively incorporating procedures designed to mitigate negative impacts must become part of our decision-making process.

Benefits and Attributes of Culturally Competent Providers

It is interesting to note that many public service entities, such as fire service and law enforcement, work to promote diversity in order to reflect the community that they serve (Coffey Consulting & American Institute of Research [Coffey Consulting & AIR], 2016). Arguably this enhances the agency's ability to meet community needs.

A culturally competent provider has several characteristics that will improve care and therefore outcomes (Minnesota Public Health Association's Immigrant Health Task Force, 2000). These attributes include:
● The ability to complete an accurate assessment while taking into account the patient's culture.
● The ability to convey information and develop a treatment plan in a manner that respects the patient's culture.
● Willingness to integrate healthcare delivery from numerous cultures.

Barriers to Achieving Workforce Diversity

The U.S. Department of Transportation (2016) report discusses increasing the diversity of first responders. However, it neglects to address barriers to recruiting and retaining a culturally diverse workforce specifically in EMS. If EMS agencies are to become more diverse it is critical that the culture of the organization change to value diversity starting from the executive administration (Coffey Consulting & AIR, 2016).

Can Cultural Competence Improve Patient Outcomes?

Significant evidence suggests that minority patients experience substantial healthcare disparities (Minnesota Public Health Association's Immigrant Health Task Force, 2000). Until recently, little of that evidence was specific to prehospital medicine. However, there is now evidence showing these disparities exist even in the prehospital world, and we must do more to address them. Multiple EMS-specific studies have shown worse care being provided to minority patients than to similarly situated Anglo patients (Lord, 2019). Since culture influences everything from behavior to medical treatment it is essential that providers and agencies become more culturally competent.

These disparities result in limited access to care and a lower quality of care (Lord, 2019). EMS's presence within the community provides a unique opportunity to identify and manage these disparities. As a provider of healthcare EMS has a responsibility to the public to work to reduce disparities.

Achieving Cultural Competency in Healthcare

The Minnesota Immigrant Task Force Report has identified several steps that EMS agencies can utilize to assist susceptible populations within their communities:
1. Involve immigrants in their own healthcare.
2. Learn more about culture, starting with my own.
3. Speak the language or use a trained interpreter.
4. Ask the right questions and look for answers.
5. Pay attention to financial issues.
6. Find resources and form partnerships.

Counterarguments

There is resistance within the EMS community to discussing these topics or even to viewing them as important enough to be addressed (NAEMSE Cultural Awareness Survey 2016). This is not a particularly surprising result, as many people don't understand the importance of these topics. There are some common arguments against discussing these topics. We have included some of those arguments below, and suggested responses to each.

1. There are too many cultures in the US and world. It is impossible to learn everything about all of them.
● There are indeed many cultures in America. Many of the cultural classifications overlap. Cultural competence does not demand in-depth knowledge of all cultures. It demands awareness of the potential for cultural differences to affect interactions and the willingness to work consciously to recognize and overcome barriers to education and medical care.

2. People who have examined their preconceptions about the various cultures in their service area and changed some of their thoughts may now feel culturally competent to deal with any person who might appear in their service.
● Cultural humility is not a static state. It is a constant process of awareness, learning and adapting to the all the possible cultures a health care provider may encounter.

3. A person may believe their own diversity, be it ethnicity, gender or disability, has taught them what it means to be culturally sensitive. They may feel they do not need any special training on how to become culturally competent.

- Since each of us represents multiple aspects of culture, it is possible to be culturally aware in one area but still be insensitive to other cultures.

4. An organization that already has significant diversity may feel that there is nothing left to be done.
- Every organization represents multiple cultures. As with society as a whole, these cultures will change with time. Cultural humility is not a static state. It is a constant process of awareness, learning and adapting to the all the possible cultures members of an organization may encounter.

5. People feel the need for a more concrete way to achieve cultural competence. This process is too "touchy feely" in asking them to become more aware. How do they become aware? How will that make a difference in their journey towards cultural competence?
- Awareness (knowledge of the existence of a thing, place, idea, etc) begins with the willingness to learn. The professional's first step toward cultural competence in handling a situation is to become aware that they <u>might</u> have stereotypes or preconceptions about the person before them. Awareness is a complex skill gained over time. Only with greater cultural awareness can a person reject or avoid acting on the preconceived thoughts, obtain new individualized information and resolve the case with cultural awareness.

6. There are only a couple of cultures that are different from the dominant (American) culture in the community.
- Culture is not defined exclusively by race and ethnicity, but includes a broad spectrum of identities. Regardless of the perceived diversity or lack of diversity in one's community, every person encounters people in on a daily basis with cultural experiences that differ from their own. Using a process to practice cultural competence routinely in every case can help a person ensure fair and equal treatment of every person who comes before them for assistance.

7. People feel that diversity equals preferential treatment for others, and doesn't do anything to benefit themselves or others in the majority.
- Diversity is the collective mixture of differences and similarities among all individuals in an organization. Diversity pertains to every one of us, and therefore, an effective program should be inclusive-enabling everyone to have an equal voice and an equal opportunity to utilize their talents.

8. People may have already attended all those legal "don't do" trainings such as discrimination training, sexual harassment training, and disability rights training. So they know what the law says you can and cannot do.
● It is not about the law. It is about how each individual interacts with others. It is about behaviors and actions that improve a person's ability to effectively and authentically communicate and interact with people perceived to be different. Cultural competency is about what you can do to improve the services and outcomes of people who come to you for assistance.

Paraphrased from National Council on Disability; *Common Myths About Diversity And Cultural Competency*; https://ncd.gov/publications/2006/june2006 Downloaded 5-7-2019.

References

Vespa, Jonathan, David M. Armstrong, and Lauren Medina, "Demographic Turning Points for the United States: Population Projections for 2020 to 2060," Current Population Reports, P25-1144, U.S. Census Bureau, Washington, DC, 2018. https://www.census.gov/content/dam/Census/library/publications/2018/demo/P25_1144.pdf

The National Registry Data Dashboard. (2017, April 13). In *The National Registry*. Retrieved 25 May 2019, from www.nremt.org/rwd/public/data/maps

American College of Physicians. Racial and Ethnic Disparities in Health Care, Updated 2010. Philadelphia: American College of Physicians; 2010: Policy Paper. (Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.)
https://www.acponline.org/acp_policy/policies/racial_ethnic_disparities_2010.pdf

Betancourt, J. R., Green, A. R., & Carillo, J. E. (2002). *Cultural competence in healthcare: Emerging frameworks and practical approaches.* New York: The Commonwealth Fund.

Coffey Consulting & American Institute of Research. (2016). *Promising practices for increasing diversity among first responders*. Bethesda, MD: Coffey Consulting. Hanley, J. H. (1999). Beyond the tip of the iceberg: Five stages toward cultural competence. *Reaching Today's Youth*, *3*(2), 9-12.

Institute of Medicine. (2001). *Committee on Quality of Healthcare in America*. Washington DC: National Academies Press.

Minnesota Public Health Association's Immigrant Health Task Force. (2000). *Six steps toward cultural competence: How to meet the health care needs of immigrants and refugees*. Minneapolis, MN: Minnesota Department of Health.

National Registry data, dashboard, & maps. (2018). Retrieved June 13, 2018, from https://www.nremt.org/rwd/public/data/maps

EMS Agenda 2050 Technical Expert Panel. *EMS agenda 2050: a people-centered vision for the future of emergency medical services*. Report No. DOT HS 812 664. Washington, DC: National Highway Traffic Safety Administration; 2019. https://www.ems.gov/pdf/EMS-Agenda-2050.pdf.

Devine, P. G., Austin, A. J., & Cox, W. T. (2012). Long-term reduction in implicit race bias: A prejudice habit breaking intervention. Journal of Experimental Social Psychology, 48, 1267-1278.

Hardin, C. D., & Banaji, M. (2013). The behavioral foundations of public health (E. Shafir, Ed.). Princeton, NJ: Princeton University Press.

Kirwan Institute (Ed.). (n.d.). State of the science: Implicit bias review 2015. Retrieved April 13, 2018, from The Ohio State University Kirwan Institute website: http://kirwaninstitute.osu.edu/research/understanding-implicit-bias/

Purnell, L. D. (2009). Guide to culturally competent health care (2nd ed.). Philadelphia, PA: F.A. Davis Company.

Tropp, L. R., & Godsil, R. D. (2015, January 23). Overcoming implicit bias and racial anxiety [Blog post]. Retrieved from https://www.psychologytoday.com/us/blog/sound-science-sound-policy/201501/overcoming-implicit-bias-and-racial-anxiety

Lord, B., & Khalsa, S. (2019). Influence of patient race on administration of analgesia by student paramedics. BMC Emergency Medicine,19(1). doi:10.1186/s12873-019-0 245-2 https://bmcemergmed.biomedcentral.com/articles/10.1186/s12873-019-0245-2

Cultural Awareness Definition, National Center for Cultural Competence, Georgetown University, retreived from: https://nccc.georgetown.edu/curricula/awareness/index.html