Ensuring Culturally Effective Pediatric Care: Implications for Education and Health Policy

ABSTRACT. This policy statement defines culturally effective health care and describes its importance for pediatrics and the health of children. The statement also defines cultural effectiveness, cultural sensitivity, and cultural competence and describes the importance of these concepts for training in medical school, residency, and continuing medical education. This statement is based on the conviction that culturally effective health care is vital and a critical social value and that the knowledge and skills necessary for providing culturally effective health care can be taught and acquired through focused curricula throughout the spectrum of lifelong learning, from premedical education and medical school through residency and continuing medical education. The American Academy of Pediatrics also believes that these educational efforts must be supported through health policy and advocacy activities that promote the delivery of culturally effective pediatric care. *Pediatrics* 2004;114:1677–1685; *culture*, *cultural competence*, *cultural sensitivity*, *culturally effective care*, *diversity*, *ethnicity*, *health literacy*, *minorities*, *pediatric*, *racial*.

ABBREVIATIONS. AAP, American Academy of Pediatrics; AMA, American Medical Association; CME, continuing medical education; APA, Ambulatory Pediatric Association.

INTRODUCTION

The mission of the American Academy of Pediatrics (AAP) is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To this end, the AAP recognizes that the increasing cultural diversity of the patient population has implications for the provision of pediatric health services and for conducting child advocacy, health policy, and health services research.

Over time, the cultural attributes of children and families, including but not limited to race, ethnicity, language, religion, sexual orientation, gender, disability, and socioeconomic status, will likely continue to be different from those of the individual pediatrician or child health professional. Indeed, the most recent data from the US Census Bureau project that by the year 2020, 44.5% of American children 0 to 19 years of age will belong to a racial or ethnic minority group.\(^1\) Consideration of cultural attributes in addition to race and ethnicity would greatly increase this projection of diversity. As the Future of Pediatric Education II Task Force noted, “These changing demographics are likely to have implications for the utilization of medical services, as well as for the acceptance of interventions by caregivers. In addition, other special populations—including homeless children, children in migrant families, and children in foster care—will reflect even more cultural and ethnic diversity and will require sensitive attention from the pediatricians and other child health professionals who provide care for them.”\(^2\)(p173)

The disparity in cultural attributes between health care professionals and their patients and patients’ families or guardians will require educational interventions to ensure that pediatricians and other health care professionals are able to provide culturally effective care to a diverse patient population.\(^3\) The AAP, therefore, reaffirms the importance of establishing and promoting an organizational policy on the provision of culturally effective pediatric health care, which it regards as vital and a critical social value.

Throughout this statement, the term “pediatricians” refers not only to general pediatricians but also to pediatric subspecialists and pediatric surgical specialists. The AAP continues to embrace the concept of the pediatric health care team and recognizes the need for all health care professionals to deliver culturally effective care. However, the scope of this statement is limited to addressing this issue from a pediatrician perspective, providing a key reference point for this discourse. The AAP encourages child health care professionals other than pediatricians to embrace the concepts presented here and implement them accordingly, because this topic concerns the health and well-being of children, regardless of the individual providing health care services.

Culturally effective pediatric health care can be defined as the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of all cultural distinctions leading to optimal health outcomes. For the purposes of this policy statement, the term “culture” is used to signify the full spectrum of values, behaviors, customs, language, race, ethnicity, gender, sexual orientation, religious beliefs, socioeconomic status, and other distinct attributes of population groups. Given the com-

\(^1\)Most recent data from the US Census Bureau project that 44.5% of American children 0 to 19 years of age will belong to a racial or ethnic minority group.


\(^3\)AAP, American Academy of Pediatrics.
plexities of the term “culture,” a complete analysis of the specific effect of each aspect is beyond the scope of this statement. Rather, the focus remains on strategies, whether universally applicable or specifically targeted, that can be applied to one or all of the components of culture to improve the delivery of culturally effective care. Additionally, significant emphasis is placed on barriers to access to care that can be related to a low level of health literacy or unique health care needs, along with considerations of the traditional aspects of culture.

Because several terms have been used in the medical community to denote the concepts embodied by “culturally effective health care,” some initial clarification of terminology is required. The American Medical Association (AMA) considers “cultural competence” and “culturally effective health care” synonymous terms but has retained use of the term “cultural competence” because of its widespread use and acceptance in the literature. Over time, the scope of cultural competence has been expanded beyond the traditional realms of race and ethnicity to incorporate a wider range of personal attributes, health care services, and definitions of health, well-being, and illness. The literature and recent national mandates, for instance, demonstrate that there is great interest in expanding the concept of cultural competence to include access to interpreter services in health care settings and consideration of individual health and illness experiences as well as mechanisms to ensure the right to respectful and nondiscriminatory care. The AAP believes, however, that “culturally effective pediatric care” is a more inclusive term than “cultural competence,” because it encompasses the values of competence but more importantly focuses on the outcomes of the physician-patient or physician-family interaction.

At the level of the individual pediatrician, culturally effective health care requires acquisition of knowledge, development of skills, and demonstration of behaviors and attitudes that are appropriate to care for patients and families with a wide variety of cultural attributes. In addition, physician self-reflection, self-knowledge, and self-critique have been identified as critical components of competence. Along with requiring these knowledge bases, skills, behaviors, and attitudes, commonly referred to as cultural competence and cultural sensitivity, culturally effective health care emphasizes the need for continued monitoring and documentation of measurable outcomes.

To promote the provision of culturally effective health care to pediatric patients, the AAP reaffirms its commitment to participate in the development and implementation of educational materials and courses. As such, the AAP maintains that culturally effective health care should be promoted through health policy and education at all levels, from premedical education and medical school through residency education and continuing medical education (CME). At every level of education, child health professionals must be able to interact effectively and respectfully with patients and their families regardless of the cultural differences that may exist between them. These educational efforts should enhance the knowledge and understanding of pediatricians and child health care professionals other than pediatricians about the cultures of their patients and their families and increase their ability to provide care in a manner that is responsive to the individual needs of each patient. Educational programs must focus also on the enhancement of interpersonal and communication skills, which are essential to nurturing the pediatrician-patient or pediatrician-family relationship and optimizing the health status of patients.

The focus of this policy statement remains on strategies that can significantly improve patient outcomes for all infants, children, adolescents, and young adults in a diverse nation. Having defined the key terms to be used throughout the statement, some background information is provided on the scope of cultural distinctions and describes the current educational landscape regarding cultural education. After this, the statement outlines educational imperatives to expand on the current system and provides specific AAP recommendations for improving culturally effective care through educational and health policy reform.

**BACKGROUND**

**Innate Cultural Attributes**

In its 1994 report, the AAP Task Force on Minority Children’s Access to Pediatric Care expressed concern that the health services provided by many institutions in the United States reflect the values of the racial and ethnic majority culture (ie, white European). Patients and families that have different cultural attributes may experience difficulties in their interactions with health care professionals, and these difficulties may have an adverse effect on the delivery of health care. This is a concern for racial and ethnic minority children, for example, because according to standard indicators of child health status (including low birth weight, infant mortality, and immunization rates), these children are, in general, less healthy than are white children. The task force’s report identified potential barriers to quality health care services for racial and ethnic minority children, including poverty, geographic factors, lack of provider cultural sensitivity, racism, and other forms of prejudice.

In the years since the 1994 report, discussions of health disparities among other minority patient populations and their families have emerged and expanded the discussion of culturally effective health care. In particular, sexual orientation, socioeconomic status, religion, and gender have been identified as cultural factors that affect the delivery of health care. Although a comprehensive overview of how each aspect affects individuals cannot be provided here, there has been increasing recognition of the unique health and wellness concerns and potential barriers to access to quality health care for certain groups of individuals. For example, gay, lesbian, and transgendered youth are disproportionately affected by human immunodeficiency virus infection, suicide, substance use, and violence. Varying socio-
economic circumstances present their own concerns that have been proven to have detrimental effects on the well-being of adolescents and children well into adulthood.12 Similarly, religious issues challenge the pediatrician, as illustrated by a study13 that describes the practical implications of Islamic ethical and moral norms in pediatric clinical practice. Another attribute that has proven to affect health care is gender, as a study14 recounts the influence it has on patient-physician communication and consequently on health care.

Regardless of their background, all patients and their families have culturally based concepts about health, disease, and illness. At the same time, the cultural attributes of the pediatrician may differ from that of the patient or family or the pediatrician’s colleagues. Given this variation, and because miscommunication between health care professionals as attributable to cultural differences may also lead to poorer health outcomes, the AAP previously addressed the need to enhance the diversity of the pediatric workforce as a strategy to improve patient care outcomes.15 These differing cultural attributes are especially significant when they affect patients’ and their families’ beliefs about health, illness, and treatments and conflict with the pediatrician’s diagnosis or management plan. In this scenario, cultural differences may become barriers to access to care or the provision of optimal pediatric health care services.

Communication and Language

In addition to innate cultural distinctions, there is an inherent imbalance of power in all physician-patient relationships as the patient and/or the patient’s family seeks advice or care from a pediatrician in his or her role as an expert or consultant. This imbalance may be even more pronounced when patients and their families are from minority groups, because they may experience “communication anxiety” when dealing with people in expert roles.16 Failure to appreciate this imbalance may lead to miscommunication, posing an even greater barrier to health care services.

Cultural variations in verbal and nonverbal communication can be a major barrier to effective pediatric care. Although the role of culturally linked behaviors that may influence the physician-patient interaction, including eye contact, body language, and communication styles, has not been fully explored,17 language barriers have been shown to have a major effect on health care. Parents and their children in the United States increasingly speak a language other than English at home and/or have limited English proficiency. In addition, communication with families dependent on the use of American Sign Language and/or lip reading may pose significant challenges. When the pediatrician and his or her patient and patient’s family do not speak the same language with fluency, there is a potential for misunderstandings such as an inaccurate history, misunderstanding of therapies, and deferred medical visits.18,19 This barrier could be addressed through the use of medical interpreters or bilingual pediatricians and other pediatric health care professionals to meet the needs of children whose parents are not proficient enough to interact with members of the health care system in English.20 Some pediatricians, medical educators, and policy makers have identified concerns with the use of medical interpreters, including concerns about the lack of required or standardized training. Translation errors, ranging from omission to substitution to editorialization, have implications for patient safety as well as potential clinical consequences.18,19 An alternative to this personnel-intensive effort is the burgeoning use of technology in the medical sector. Because many times an interpreter is not available, technology can enable use of an off-site translator who interprets and relays through headphones to both the physician and the patient. Video and telecommunication may become prominent in the future as alternatives to on-site interpreters.

The US Department of Health and Human Services, in its March 2001 National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report,7 established 14 national standards, several of which concern services for individuals with limited English proficiency. Standard 4 states that “health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.” Although the AAP supports this and other efforts to provide culturally effective pediatric health care, the AAP is opposed to unfunded mandates such as those pertaining to interpreter and/or translation services that will further erode the beleaguered health care delivery system and lead to access problems for Medicaid patients, most of whom are children.21 Government mandates to improve the provision of culturally effective health care must be accompanied by the funding and infrastructure necessary to implement these programs and achieve the identified outcomes. The AAP opposes the use of children and adolescents as medical interpreters for their parents and family members and calls for adequate funding to defray the cost of using professionally trained medical interpreters and/or translation services.

Health Literacy

Another facet of the relationship between language and culturally effective pediatric care is health literacy. Healthy People 2010 defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”22 Although this is a particular problem for individuals with low or marginal literacy skills, health literacy can also affect patients and families with adequate language literacy. Many individuals find the complex wording of insurance statements, benefits coverage, hospital admissions forms, prescription drug information sheets, and similar documents to be confusing. Low health literacy for pediatric patients and their families, similar
to limited English proficiency, is a barrier to the provision of optimal pediatric health care. A number of AAP policies ranging from hearing detection\textsuperscript{23} to Medicaid\textsuperscript{24} have addressed these issues and call for materials to be produced in languages other than English for patients and families of diverse cultures and for consumers with low literacy. There is, however, no current AAP policy that specifically addresses low health literacy for patients and their families in all cultures. The AAP is currently and will continue addressing this topic through research, education, and other appropriate venues.

Although health literacy may not be a distinct cultural attribute, language and health literacy are greatly affected by cultural distinctions and, if low, directly contribute to unfavorable patient outcomes among minority groups. Background on these issues was provided to demonstrate how addressing these topics will improve cultural effectiveness of health care.

**CURRENT STATUS OF EDUCATIONAL EFFORTS**

To provide culturally effective health care for pediatric patients, education and training are needed for pediatricians and child health professionals at all levels and stages of careers and in all practice settings. The AAP recognizes the value of educational tools and programs and calls for their development and incorporation at all levels of pediatric education and child advocacy: medical school, residency training, and CME. A variety of programs, seminars, workshops, and residency curricula already exist across the country with great variation in educational content, focus, priorities, faculty support, and availability and with limited and/or variable descriptions of outcome measures.

**Medical Student Education**

The literature pertaining to teaching multicultural issues to medical students is robust, although many medical educators believe that training physicians to provide culturally effective care should begin earlier as part of undergraduate premedical curricula. Some medical educators have suggested that these educational endeavors should focus less on individual attitudes and the characteristics of minority groups and more on discussions pertaining to social barriers and inequities at the institutional or systems level.\textsuperscript{25,26} Others have raised concerns about the model of addressing multiculturalism and cultural competence through lectures and occasional workshops and have argued for the incorporation of these topics as a continuum throughout medical school. The most prominent options for the latter approach include finding space in existing courses on patient-physician relationships and medical interviewing, for example, and developing “thoughtfully prepared instructional material throughout the four-year curriculum.”\textsuperscript{26,27} Drouin and Rivet support the premise that “communication in health care delivery is usually enhanced when the professional speaks in the patient’s mother tongue and is familiar with the patient’s culture and context.”\textsuperscript{28} The development of a communications skills laboratory within the medical school is one strategy to allow acquisition of language skills in a controlled environment, using simulated patients who provide feedback to students regarding their perceptions of the quality of the communication during the encounter.\textsuperscript{28} The need for practical experience, mentoring, role models, and, in particular, evaluation tools has been stressed.\textsuperscript{29,30}

Several specialties, including internal medicine and family medicine, have developed cross-cultural or multicultural curricula.\textsuperscript{31–33} As a joint effort, the Council on Medical Student Education in Pediatrics and the Ambulatory Pediatric Association (APA) developed in 1995 the “General Pediatric Clerkship Curriculum and Resource Manual” for clerkship directors to encourage the use of formal curricular goals and objectives. The manual, which was revised in February 2002, cites cultural sensitivity and tolerance of difference among the important personal characteristics that are essential foundations for the medical student. This manual also outlines learning objectives and competencies for medical students that relate to the provision of culturally effective health care, with reference to cultural, ethnic, and socioeconomic factors.\textsuperscript{34}

**Residency Education**

The program requirements for residency education in pediatrics developed by the Pediatric Residency Review Committee call for structured educational experiences that prepare residents for the role of child health advocate within the community and inclusion of the multicultural dimensions of health care in the curriculum.\textsuperscript{35} To prepare residents to fulfill the needs of all their patients, the Future of Pediatric Education II Task Force recommended that all pediatric residents design and implement an individualized professional education (CME) plan by the third year of residency training that incorporates anticipated needs for their future practice.\textsuperscript{2}

In 1995, the APA published its “Educational Guidelines for Residency Training in General Pediatrics,”\textsuperscript{36} which soon became an essential tool for educators of pediatric residents. The APA began the revision of this important document in 2002, with a particular emphasis on tailoring the guidelines to support and mirror the 6 core competencies for residency education in all specialties established by the Accreditation Council for Graduate Medical Education. The APA adopted these 6 competencies of patient care: medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice. Under these competencies, the APA included considerable language related to the provision of culturally effective pediatric care. For example, the guidelines define professionalism as “demonstrat[ing] a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to diversity,” which includes “demonstrat[ing] sensitivity and responsiveness to patients’ and colleagues’ gender, age, culture, disabilities, ethnicity, and sexual orientation.”\textsuperscript{36} Language on culturally effective care also appears in the
sections on patient care and interpersonal communication skills.

CME

Beyond residency training, pediatricians and other child health professionals can benefit from CME to enhance the provision of culturally effective health care. The AAP incorporates culturally effective pediatric care into its CME programming primarily, at this point, through the SuperCME, an activity serving more than 700 practicing general pediatricians. SuperCME will serve as a culturally effective care model for future AAP CME activities, demonstrating how the topic of culturally effective pediatric care can be infused into overall programming and specifically how to incorporate dimensions of culturally effective pediatric care into clinical presentations. In support of the latter component, the AAP Committee on Continuing Medical Education is engaged in the creation of CME guidelines that will assist physician volunteer CME program planners in including culturally effective pediatric care within the program design and CME faculty in preparing their materials and learning how they, too, might incorporate this topic through individual presentations. The goal is to raise awareness of the multifaceted dimensions of culturally effective pediatric care by ensuring that this topic is incorporated into CME activities appropriately.

Pediatricians, moreover, should become knowledgeable about the resources available to their patients and families within their institutions (offices, hospitals), health maintenance organizations, and communities. Pediatricians therefore should find opportunities to partner with institutions such as third-party payers, hospitals, health departments, and education departments to advocate for the culturally specific needs of their patients and, thereby, increase patient satisfaction and quality of health care. Although Medicaid and other public insurers are placing increased emphasis on “cultural competence” and quality care, few tools exist for health care payers to measure the outcomes of processes implemented to ensure culturally effective care. The use of patient-satisfaction scoring systems that assess shared decision-making, mutual respect, trust, and other culturally sensitive parameters should be encouraged. Survey instruments should use quality measures that are within the scope of responsibility of the health care professional, and the results of these surveys should be used to identify priorities for continuing education. When carefully designed to reflect the health and wellness values of the specific community being surveyed, such outcomes-driven efforts will allow greater focus on the effectiveness of interventions designed to monitor and ensure quality care.

EDUCATIONAL STRATEGIES AND RESOURCES

The medical literature on cultural competence and sensitivity provides guidance for enhancing cultural effectiveness in pediatrics. In addition, other resources exist that may be helpful in identifying important components for educational activities. For example, Delivering Culturally Competent Health Care for Adolescents: A Guide for Primary Health Care Providers discusses how to assess cultural factors within a health history and also how to modify patient management plans to accommodate cultural influences.

Educational programs may include a component that allows the individual participant to analyze personal beliefs and values. Programs may focus on the communication aspects of providing culturally effective health care by exploring how assumptions and stereotypes influence interactions between health care professionals and patients or their families as well as between health care professionals. Programs need not be all-inclusive or completely group-specific to discuss variations in the values and communication styles of various cultural groups. Indeed, training in the provision of culturally effective care may include teaching physician skills that are applicable to interacting with many cultural groups as well as those that are targeted at providing care to a specific cultural group. Because individuals are influenced by their own personal experiences and may or may not subscribe to group assumed norms, individuals who share the same cultural background may think and act quite differently. For this reason, it is important that programs intended to address the cultural values and practices of specific groups not perpetuate stereotypes. Also, culture is not static; changes occur over time. An appreciation of cultural change and the significance of intracultural diversity (variation among individuals within the same culture) helps to prevent cultural stereotyping. Programs aimed at enhancing the provision of culturally effective health care should be tailored to the demographics of the pediatric population or community the pediatrician serves.

Many patient populations and communities suffer from poorer health compared with other populations. Reliable data have shown that patients who belong to racial, ethnic, linguistic, or other minority groups tend to have greater morbidity than do white, English-speaking patients. The reasons for these health disparities are numerous, including cultural beliefs about health care and healing, dietary deficiency, insufficient exercise, barriers to access to health care resources, financial indigence, inadequate insurance coverage, and inability to communicate with English-speaking health care professionals. None of these reasons is exclusive; health outcomes can be more greatly affected by the additive effects of more than one of these factors. In particular, varying levels of health literacy may present considerable barriers to improving one’s health. Strategies to overcome these barriers to eliminating health disparities are complex and often costly. However, the education of pediatricians has the potential to improve the provision of culturally effective care. At the medical school and residency levels, for example, institutions and programs are encouraged to set an example by supporting and, if possible, offering incentives for students and residents to demonstrate medical proficiency in a second language before graduation, possibly corresponding to a substantial underserved pa-
tient population that they anticipate serving. It is recognized that such a suggestion, although popular in some venues, is also problematic and therefore requires additional monitoring and discussion before achieving the status of a recommendation or mandate. Another educational endeavor that merits institutional and program support is teaching students and residents how to use their best advantage (and how to evaluate) professional medical interpreters and translation services. At a minimum, medical school curricula and pediatric residency education programs should include educational components that identify the implications of low English proficiency, low literacy, and low health literacy on pediatric health care and offer strategies for remediating these problems.

At the CME level, new programs emphasizing skills needed to care for an increasingly diverse patient population and address health disparities are already being offered. The AAP has established a diversity track at its SuperCME, and the APA offers special-interest group workshops on serving the underserved; culture, ethnicity, and health care; and race and medicine, which seek to teach pediatricians how to meet the unique health care needs of patients of ethnic minority groups. In addition, the Henry J. Kaiser Family Foundation and the Robert Wood Johnson Foundation, in collaboration with other key groups, have launched the Initiative to Engage Physicians in Dialogue About Racial/Ethnic Disparities in Medical Care to raise awareness among physicians about health disparities, starting with cardiac conditions among African American individuals, and to teach them to take a leadership role in addressing health disparities among patient populations at greater risk. The Objectives for Improving Health in Healthy People 2010 identify strategies for addressing language barriers, including health literacy, and call for the development of materials for individuals with low literacy. The report also calls on organizations, community groups, schools, and others to offer programs that target skill improvement for individuals with low literacy and limited English proficiency. Programs that provide multilingual prescription or drug information are needed. The AMA Foundation has been working to raise awareness of health literacy within the health care community and has awarded funds to state and county medical societies, along with several medical specialty societies, including the AAP. The AMA has also developed a Health Literacy Educational Kit and train-the-trainers sessions, in which AAP members have participated.

Education and training to enhance the provision of culturally effective health care must be integrated into lifelong learning for pediatricians and other child health professionals and include didactic and experiential components. Toolboxes, such as the one developed by the University of California, San Francisco Center for the Health Professions, provide a concrete curriculum with defined objectives for learning and application in clinical care and other professional activities. The AAP has also developed a Web page devoted to the provision of culturally effective pediatric care that provides a variety of educational resources, policy, and data on this issue. Using such modalities, current and future pediatricians and other child health professionals can become better prepared to meet the needs of children from culturally diverse backgrounds, including racial and ethnic minority groups.

HEALTH POLICY IMPLICATIONS

Full participation by the pediatric community is critical to the delivery of culturally effective pediatric care. However, pediatricians will not be able to provide care without the financial and infrastructure support of the health care system. Recent years have seen a noteworthy increase in the number of federal, state, national, and county organizations/agencies that are generating reports, guidelines, and strategies to address various facets of culturally effective health care delivery.

Although mandates from government agencies and regulatory bodies have served as important policy leverage or motivation to promote the provision of culturally effective care, these mandates have been largely unfunded, implying that academic institutions, hospitals, pediatricians, and other physicians must defray the costs of their implementation. Decreasing reimbursement to physician practices for clinical care and decreasing hospital operating margins have rendered these mandates largely unpalatable. Additionally, financial and other incentives from insurers, government agencies, and other payers to reward physicians and hospitals for delivering culturally effective care have been meager and have not supplied the impetus and support to encourage fundamental systemic changes, which are often costly.

In an era when cost containment is an urgent priority for the health care community, research has a pivotal role in changing the societal value of culturally effective health care. The AAP regards culturally effective pediatric care as vital and a critical social value. However, many health care payers, employers, institutions, and others fear exacerbating current financial pressures and hardship when trying to provide such care. Reliable and timely data to demonstrate long-term decreases in health care costs, appropriate use of health care services, and improved patient health outcome measures would provide a solid foundation for addressing valid concerns about the financial implications of providing culturally effective care. To this end, culturally effective knowledge and skills need to be applied to research development and implementation. From a quality-of-care perspective, moreover, this research would allow policy makers to identify patient populations at risk and to develop strategies to address health disparities at national, regional, state, and local levels.

Indeed, because the delivery of health care services in the United States is regulated and directed by many entities at many levels, the provision of culturally effective pediatric care will depend on a coordinated effort by all stakeholders in child health. The development of sound and responsible health policy
will have to address the aforementioned issues and others that act as barriers to optimal pediatric care.

Pediatricians are not alone in seeking solutions to improve the delivery of pediatric health care. Pediatricians, other health care professionals, community groups, health care payers and insurers, regulatory and accrediting bodies, legislators, and others have significant roles to play in ensuring culturally effective pediatric care and will have to participate in health policy deliberations on this topic. Broad-based participation will ensure that a pediatric focus and perspective are brought to bear on decisions that have a direct effect on the quality of care that is delivered to children. In particular, stakeholders will have to advocate for the necessary financial, regulatory, and other support among decision-makers to implement necessary changes to the US health care delivery system. Of prime importance will be advocacy for patient access to care using key parameters such as scope of services and benefits available; convenience of service organization; patient satisfaction; geographic, temporal, cultural, and language accessibility; and out-of-pocket costs. It is critical that the needs and perspectives of the pediatric population and their parents, families, and caregivers be represented in all such policy development and regulatory action. The AAP, on behalf of the pediatric community, must actively participate at the national and chapter levels in these wider health policy deliberations and initiatives that seek to address issues pertinent to the provision of culturally effective care.

CONCLUSIONS

Since adoption of the Report of the AAP Task Force on Minority Children's Access to Pediatric Care, the AAP has strengthened its commitment to ensure that all infants, children, adolescents, and young adults have access to optimal and culturally effective pediatric care, ideally through a medical home. Additionally, the AAP acknowledges that culturally effective pediatric care is multifaceted, complex, and often costly. The AAP believes that the education of pediatricians about cultural attributes and about the importance of implementing culturally effective practices and policies is essential. Because pediatricians are committed to lifelong learning, education that will enhance the provision of such care must be available at all levels, from premedical education and medical school through residency education and CME. This policy statement describes some of the approaches that are available. One approach is not endorsed in lieu of another. It is noteworthy that new ideas and tools are being generated at a rapid rate. The AAP hopes that this policy statement will serve as a springboard to foster ongoing discussion, in many forums, about the application and efficacy of existing and new educational methods.

The individual pediatrician needs educational tools; the pediatric community needs the results of outcomes research to bolster, validate, and sustain their effort; institutions need support and encouragement to provide appropriate and effective education and training; foundations and other organizations need to have a pediatric perspective in all health care and policy development considerations; and the legislative arena, including federal and state agencies, needs to provide the funding and infrastructure necessary to implement and evaluate mandates. The AAP has played and must continue to play a pivotal role in all these important health policy deliberations.

The AAP is committed to advocating for pediatric patients and families by participating in public policy deliberations pertaining to the delivery of culturally effective health care. To promote the provision of culturally effective health care to pediatric patients, the AAP recommends the following:

1. The AAP, along with health care organizations at all levels, should continue to participate in the development and evaluation of curricular programs, such as toolboxes, that teach health care professionals to be supportive of cultural diversity and sensitive to cultural differences and behavior. These curricular programs also should teach health care professionals to understand their own cultural norms and how they relate to patient care activities. Programs should be tailored to the unique needs of the learner at each stage within the spectrum of lifelong learning from premedical education and medical school through residency and CME. The curricula should address issues including but not limited to cultural beliefs, values, behaviors, customs, language (including health literacy), sexual orientation, religious beliefs, disability, socioeconomic status, and other distinct attributes.

2. Recognizing that institutional commitment is necessary to ensure the provision of culturally effective care, pediatricians must work with hospitals, offices, managed care organizations, and commercial and government insurance payers to develop policies and plans that address identified community needs and support community health efforts. Such policies and processes should include considerations of disparities between the diversity profiles of physicians and other caregivers and that of patients and families being served.

3. Government mandates to improve the provision of culturally effective health care must be accompanied by the funding and infrastructure necessary to implement these programs and achieve the identified outcomes. Health care payers and health care professionals should not be mandated to defray the costs of these programs out of their own pockets at a time when reimbursement for health care services is declining and weakening the financial viability of health care systems.

4. Federal and state incentive programs should be established to encourage the implementation of national and community-based programs to improve the delivery of culturally effective health care. These programs should contain an evaluative component to measure improved health care access and outcomes through the generation and dissemination of reliable data. Third-party payers, health care organizations, industry, and charitable foundations should be encouraged to establish
incentive programs that reward physicians for demonstrating improved outcomes in providing culturally effective health care. Public and private incentive programs should be considered as a strategy for encouraging physicians to practice in medically underserved areas, in which are large numbers of patients from minority (eg, racial, ethnic, cultural, linguistic) groups.

5. Medical students and residents should be encouraged to demonstrate proficiency in a second language in clinical settings corresponding to that of a substantial percentage of the patient population being served before graduation and should be rewarded for doing so as a strategy to improve the provision of culturally effective health care.

6. Pediatricians should assume a leadership role in advocating for culturally effective health care for all infants, children, adolescents, and young adults by ensuring that all public policy on these issues is in consonance with the best interests of pediatric patients and their families.

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