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Beyond Professional Licensure: A Statement of Principle on Culturally-Responsive Healthcare

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Abstract

This work calls on healthcare institutions and organizations to move toward inclusive recognition and representation of healthcare practitioners whose credibility is established both inside and outside of professional licensure mechanisms. Despite professional licensure's advantages, this credentialing mechanism has in many cases served to reinforce unjust sociocultural power relations in relation to ethnicity and race, class and gender. To foster health equity and the delivery of culturally-responsive care, it is essential that mechanisms other than licensure be recognized as legitimate pathways for community accountability, safety and quality assurance. Such mechanisms include certification with non-statutory occupational bodies, as well as community-based recognition pathways such as those engaged for Community Health Workers (including *Promotores de Salud*) and Indigenous healing practitioners. Implementation of this vision will require interdisciplinary dialogue and reconciliation, constructive collaboration, and shared decision making between healthcare institutions and organizations, practitioners and the communities they serve.

Keywords

Delivery of health care, interprofessional relations, complementary medicine, traditional medicine, health services, indigenous, community health workers, culturally-congruent care

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We are a diverse group of healthcare practitioners and scholars who collaborate on work related to equity, diversity, and inclusion in healthcare. We share a vision of safe and effective healthcare that is accessible, affordable, and culturally-responsive. Our equity-focused vision centralizes the social, structural, and ecological determinants of health; respects the healthcare preferences and choices of individuals and communities; and, aims to end inequities in access to health and healthcare for members of marginalized groups. It emphasizes wellbeing and prevention alongside care for acute and chronic conditions, as well as disabilities. Our vision also seeks to transform the root causes of many marginalized communities' distrust of dominant conventional biomedical healthcare.[1]

At the heart of this vision is a belief that the inclusion of a range of healthcare practitioners from distinct therapeutic systems is necessary for optimal, equitable care. As the World Health Organization (WHO) observes, many traditional, Indigenous and complementary medicine approaches represent "culturally

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acceptable and trusted" approaches to care for "many millions of people" worldwide, including in industrialized nations.[2] Aligned with WHO recommendations, such approaches are becoming increasingly integrated into primary healthcare across many countries. Within biomedically-dominant health systems around the world, however, occupational hierarchies persist which privilege biomedical forms of practice and licensure-focused forms of professional organization. These hierarchies, we argue, inequitably privilege particular groups of patients. To achieve the WHO's aims, which align with our shared vision, this must change.

Statement of Principle

We believe that optimal healthcare includes licensed providers of physical and mental healthcare, non-licensed practitioners including community health workers, and traditional and Indigenous healers who are recognized and trusted within their communities.

Professional Licensure May Reinforce Health Inequities

Statutory regulation (licensure) is one way of recognizing that a healthcare practitioner is qualified to deliver safe, effective, ethical healthcare. Licensure provides a recourse mechanism for patients who have concerns about their care or practitioner. Across industrialized countries, a wide range of biomedical professionals, including allied health and mental health professionals (eg, physical therapists, social workers) are licensed. Some traditional/complementary healthcare occupations (eg, chiropractic, naturopathic medicine, massage therapy, acupuncture/Chinese medicine, midwifery) also have attained professional licensure in a number of jurisdictions.[2] Depending on the jurisdiction, care provided by various regulated health professionals may or may not be reimbursed by public and/or private health insurance plans – which contributes to their accessibility or lack thereof.

Professional licensure represents an authoritative claim over a particular type of knowledge and practice.[3] It clearly delineates who is 'acceptable' (or 'unacceptable') as a healthcare provider. However, it does not necessarily foster health equity. This is in part because the high costs of training and licensure can make professional entry inaccessible for people from marginalized groups; and, where care is not reimbursed by publicly funded health systems, may lead licensed practitioners to serve higher-income patients in order to pay off education-related debt.[4]

In addition, professional licensure is an approach to legitimation with European cultural roots,[3] and capitalist,[5] colonialist[3] affiliations. As such, it may reproduce unjust power relations. Gendered power differentials remain between licensed professionals (eg, medical doctors vs. nurses,[6] obstetricians vs. midwives[7]). There are also many examples of licensure being unjustly used to exclude qualified and experienced ethnic minority practitioners who deliver skilled, culturally-responsive care within marginalized communities (eg, immigrant and African-American midwives,[8] Chinese medicine practitioners with limited English proficiency[9]).

Innovative policy strategies may have the potential to reduce some of the inequitable outcomes associated with health professional licensure.[9] However, some of the central features of contemporary professionalization structures—such as occupational standardization and the formal institutionalization of training—have inherent limitations that make them unsuitable for some approaches to healthcare practice.[3] Although health professional licensure has become the norm in many places worldwide, it is not always the most appropriate way of identifying skilled—and culturally-responsive–healthcare practitioners.

A Place for Unlicensed Practitioners

Non-licensed certification/registration is another important model used to identify professionals who are qualified to deliver quality healthcare. In some cases, third-party certification models are structurally similar to those used in professional licensure. In other words, they may implement standardization of educational requirements, and accreditation of training programs, but have not (yet) earned government's stamp of approval. In the United States, the National Ayurvedic Medical Association and International Association of Yoga Therapists exemplify this certification strategy. Nevertheless, while the preservation of dominant modes of professional recognition within such certification structures may serve to advance the sociocultural standing of the groups that use them,[10] such structures also carry the potential to reproduce the barriers associated with biomedical professional licensure models.

In other cases, practitioners such as mindfulness educators may present training from organizations or institutions that represent specific lineages or approaches. Despite emerging evidence of clinical effectiveness with respect to mindfulness practices,[11] standardization across diverse approaches is not necessarily understood as an occupational best practice although some training programs carry considerable reputational prestige. In addition, some mindfulness educator programs charge fees reaching $1000 USD or more beyond the cost of training for their own 'certifications' and 'qualifications'.[12,13] Such private fees contrast notably to third-party occupational certification fees for Ayurveda, yoga therapy and clinical herbalism in the United States,

which–in the range of $150–$350 USD—[14–16] fall below the cost of health professional licensure and may represent a reduced economic barrier to occupational entry. Further, some mindfulness educator programs have been elsewhere critiqued as exemplifying a colonialist, capitalist logic that divorces mindfulness practices from their Buddhist roots while 'selling' ideas of wellness that set aside considerations of social injustice.[17]

In yet other instances, models of health practitioner accreditation deliberately diverge from conventional approaches. For example, the American Herbalists Guild (AHG) voluntarily registers professional herbal medicine clinicians on the basis of a peer reviewed application process that explicitly recognizes: (a) diverse approaches to practice (eg, using plants from different bioregions, and diagnostic and treatment models from various traditions); and (b) diverse routes to expertise (eg, formal education, apprenticeship, oral tradition, self-study).[18] The AHG has made clear that while it recognizes excellence and emphasizes safety in therapeutic herbal care, its membership neither seeks professional licensure, nor aims to outlaw or marginalize non-member practitioners.

The Importance of Community-Based Recognition

Community-based recognition pathways represent another vital approach to distinguishing skilled, credible healthcare providers, and honoring the knowledge they carry and preserve. In the United States, practitioners of this type include Community Health Workers, a public health occupation recognized by the US Centers for Disease Control and Prevention (CDC).[19] As the CDC notes, such frontline healthcare workers (eg, *Promotores de Salud*) are trusted as cultural insiders within communities they serve, and act "as a bridge between communities, healthcare systems, and state health departments". However, such healthcare practitioners may experience marginalization within dominant health systems. For example, while Community Health Workers/*promotores* and doulas have secured public insurance reimbursement for their work in several American states, many critique the low reimbursement rates provided to them as compared with licensed practitioners.[20]

Indigenous healing practitioners (eg, Curandero/as, Elders or other traditional healers) represent another type of informally-recognized healthcare provider. Like Community Health Workers, such healers may be recognized and trusted to support physical, mental and spiritual wellbeing within their particular ethnocultural communities. Again, the practitioner's credibility and authority to practice may be recognized by their community's trust and support, or within community-based organizational structures, rather than through a formal institutional accreditation.

Indigenous healers increasingly work in hospitals, community healthcare settings and prisons, where they provide important culturally-rooted care.[21] Many such practitioners also play a vital role in protecting traditional/Indigenous medical knowledges at risk of loss, a point recognized by the World Health Organization.[2]

A growing body of evidence demonstrates that unlicensed practitioners, including Community Health Workers and Indigenous healers, may contribute to the reduction of health disparities and enhance efforts to promote health equity within marginalized communities in high-income (as well as low- and medium-income) countries.[22] Such practitioners may also foster improved delivery of safe healthcare across the lifespan,[23] and in some cases contribute to notable cost savings for healthcare systems.[24]

Finally, it is important to recognize the diverse ways in which community members may gather together to share their own knowledge, resource, skills and wisdom to improve health, wellbeing and resilience without exclusively relying on dominant conventional healthcare systems.[25,26]

Call to Action

We call on healthcare institutions and organizations to move toward inclusive recognition and representation of healthcare practitioners whose credibility and safety are established either inside or outside of professional licensure and credentialing models. This inclusive approach stands against segregation and lifts up culturally-responsive and culturally-rooted care, and is essential for transforming dominant health systems towards health equity. To differentially privilege licensed health professions (and those seeking licensure) reinforces problematic historical power relations that deepen distrust and promote further marginalization of people historically oppressed within these systems.

Affirming Credibility and Safety

Practitioner credibility and safety remain a vital component of our healthcare vision. How to best affirm the 'validity' or 'credibility' of unlicensed health practitioners' respected knowledge and expertise will require insights from cultural insiders within such practitioners' communities.

Alongside physical safety, mental/emotional safety and community accountability, we furthermore emphasize *cultural* safety as a central healthcare focus.[27] Aimed at health equity, cultural safety requires cultural humility[28] from practitioners, mutual respect and trust

between practitioners and those being served,[29] as well as strategic efforts to transform the social and structural conditions that limit and erode health and wellbeing for all.[27] Significant work remains to determine how these forms of safety may be best achieved across both licensed and non-licensed health practitioner communities.

A Commitment to Dialogue and Collaboration

Our vision of health equity includes inter-disciplinary dialogue and reconciliation, constructive collaboration – and ultimately, shared decision-making between diverse groups of healthcare practitioners as well as the communities they serve. We humbly recognize that implementation of this vision will take time, and that community stakeholders and organizations may be at different stages in their engagement with the principles we have outlined here. We commit to working in partnership with community members, healthcare practitioners and organizations, researchers, and policy makers in pursuit of this vision; and, welcome respectful dialogue toward this end.

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