Cultural Competency Training
Course: AA 2877

Cultural competence is a term used for the ability of people of one culture to understand and feel comfortable with the cultures of other people. The term is fairly recent but is becoming widely used in the field of education and healthcare regulatory compliance within the United States, to discuss acceptance of persons from a wide array of diverse backgrounds and cultures.

Cultural competency is a measurable construct against which individuals and organizations can be assessed. Training (through a non defect approach) of persons or systems can then be implemented to improve cultural acceptance. Cultural Competence can also denote a state of Cultural Health.

The United States in its earliest history had a culture influenced heavily by its Northern European population, primarily from the British Isles, who originally settled in the original British Colonies. While the indigenous peoples, known as Indians, were the largest population of North America, they were slowly pushed away from the Eastern Seaboard into the interior of North America during the 1600s, 1700s, and 1800s. During this period, people from the British Isles (England and Scotland primarily) brought the culture and religion of the British Isles with them to the United States and became the dominant political and cultural group along the Eastern Seaboard of North America.
During the 1800s, immigration from other populations both within Western Europe and Asia as well as the results of the Atlantic slave trade during the 1700s, which brought a large population of Africans to North America especially in the Southern United States, began the process of diversifying the population of the United States though the majority of the population were White immigrants from England and Scotland and those White immigrants maintained most of the power, social and economic, of the nation.

During the 1900s, large numbers of immigrants from through out the world came to the United States bringing with them their cultural heritages.

During the early part of the 1900s, Jewish, Irish, and Italian immigrants and their descendants began accumulating social and economic power. While these immigrants were faced with prejudice, the fact that they were light-skinned and shared a similar culture with the existing peoples assisted them in easier assimilation into the nation[citation needed]. Descendants of African slaves an*d immigrants fa*ced a much more difficult challenge due to their skin color and cultural differences enforced by legal systems, such as the Jim Crow laws in the United States. During the Civil Rights Movement of the 1940s, 1950s, and 1960s, African Americans were able to achieve a number of social and political gains, allowing them to more fully participate in the mainstream society of the United States.

Since the 1960s, African Americans as well as other minority groups such as Mexican Americans have gained greater social and economic status and power. They have also become larger segments of society, such that one can roughly divide the population of the United States into three large pieces (White - predominantly North European 60%, African American 15%, and Mexican American 15%) with a fourth, smaller piece composed primarily of Asian Americans (Chinese, Japanese, Vietnamese, Indian) and Native Americans.

Lia Lee was a three-month-old Hmong child with epilepsy. Her doctors prescribed a complex regimen of medication designed to control her seizures. However, her parents felt that the epilepsy was a result of Lia "losing her soul" and did not give her medication as indicated because of the complexity of the drug therapy and the adverse side effects. Instead, they did everything logical in terms of their Hmong beliefs to help her. They took her to a clan leader and

shaman, sacrificed animals and bought expensive amulets to guide her soul's return. Lia's doctors felt her parents were endangering her life by not giving her the medication so they called Child Protective Services and Lia was placed in foster care. Lia was a victim of a misunderstanding between these two cultures that were both intent on saving her. The results were disastrous: a close family was separated and Hmong community faith in Western doctors was shaken.1

How can physicians-in-training prepare for situations like Lia's? People wanting the best for her and her health surrounded Lia. Unfortunately, the involved parties disagreed on the best treatment because they understood her epilepsy differently. The separate cultures of Lia's caretakers had different concepts of health and illness.1 To ensure good care for diverse patients, physicians-in-training must address cultural issues in medicine.

By the year 2000, almost 50 million people in the U.S. will be ethnically diverse. Immigration contributes to the growing diversity of the U.S. In 1940, 70% of immigrants were from Europe. By 1992, the pool of immigrants had changed so that 15% came from Europe, 37% came from Asia and 44% came from Latin America and the Caribbean. The U.S. attracts two thirds of the world's immigration and 85% of American immigrants come from Central and South America. Generalist physicians can expect more than 40% of their patients to be from minority cultures.

Culture is defined as "the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group."

WHAT DOES IT MEAN TO BE CULTURALLY COMPETENT?

Cultural competency is "a set of academic and personal skills that allow us to increase our understanding and appreciation of cultural differences between groups." Becoming culturally competent is a developmental process. Terry Cross describes the cultural competence continuum with six stages, each delineated by an attitude and associated action or nonaction.

Culture is a predominant force in shaping behavior, values and institutions. Not only do cultural differences exist, but they also impact health care delivery. Culturally competent providers appreciate family ties and realize that they are defined differently for each culture8 Rather than being insulted by another culture's perspective, culturally competent providers welcome collaboration and cooperation. For example, a culturally competent physician who had been taking care of a Native American family for about five years noticed that the wife was depressed. The wife slowly revealed that her uncle had sexually assaulted her when she was young. The doctor started her on psychotherapy and antidepressants, which helped but did not resolve the underlying problems. After consulting with a Native American medicine man, who then met with the family, the physician and the patient learned that the woman had acquired a bad spirit from the incest. A traditional purification ceremony was performed that released the woman of the spirit and her depression.

How are traditional healers different from Western-educated physicians?

How can I work with traditional healers without compromising my beliefs?

How do I provide "culturally competent" care if that means sometimes letting patients continue with, in my opinion, less than optimal treatment?

What are some examples of how a lack of cultural competency can affect medical care?

What are common problem areas in dealing with multicultural populations?

What are some of the unique problems in servicing your specific community?

What can the provider do to make treating a minority patient more culturally competent?

GOALS OF CULTURALLY COMPETENT CARE

CULTURAL AWARENESS: Appreciating and accepting differences.

CULTURAL KNOWLEDGE: Deliberately seeking out various worldviews and explanatory models of disease. Knowledge can help promote understanding between cultures.

CULTURAL SKILL: Learning how to culturally assess a patient to avoid relying only on written "facts;" explaining an issue from another's perspective; reducing resistance and defensiveness; and acknowledging interactive mistakes that may hinder the desire to communicate.

CULTURAL ENCOUNTERS: Meeting and working with people of a different culture will help dispel stereotypes and may contradict academic knowledge. Although it is crucial to gather cultural knowledge, it is an equally important, but sometimes neglected, culturally competent skill to be humble enough to let go of the security of stereotypes and remain open to the individuality of each patient.

DEFINITIONS

Acculturation: The process of adapting to another culture; to acquire the majority group's culture.
Cultural group: The integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.
Ethnic: Belonging to a common group; often linked by race, nationality and language with a common cultural heritage and/or derivation.
Minority Group: Globally, non-Caucasians constitute a majority, thus the term is used to refer to a variety of groups who have been disadvantaged in one way or another.5
Race: A socially defined population that is derived from distinguishable physical characteristics that are genetically transmitted.
Stereotype: The notion that all people from a given group are the same.

WHY ARE THERE CULTURAL CLASHES? We are all part of a cultural group that has its own beliefs, practices, customs and rituals. These include definitions of health and illness; the superiority of technology; prevention through annual exams; compliance; procedure; and systematic approaches. Medical students engage in customs of professionalism and courtesy and have rituals like the physical exam, visiting hours and surgical procedures. Medical school teaches students scientific rationality and an emphasis on objectivity. Medical students value numeric measurement and physicochemical data and tend to separate the mind and body. Medical students reduce patients to individual diseases and body parts without seeing the patient as a part of a family or community. In this way, physicians in training represent an ethnocentric culture--one that values its own culture above others. This inevitably leads to conflicts with the patient's culture.

Medical students must have the capacity to assess themselves, to determine their own inherent culture's biases as well as their medical culture's biases. The realization of the influence that their own culture has on medical student's everyday behavior can help them understand the magnitude of cultural influences on their patient's lives and health behavior.

AREAS OF DISSONANCE

Historical Distrust Past injustices may cause minority patients to distrust their providers. For example, some "illegal aliens" may be hesitant to fill out forms because of deportation fears. Taking time to establish a rapport and explain why the forms are needed and who sees the forms may alleviate these fears.

Interpretations of Disability Physicians have many ideas about disability. For example, doctors feel that treatment should include intervention and that biological anomalies should be corrected. However, some cultures believe that the "disability" is spiritual rather than physical or that the "disability" itself is a blessing or reward for ancestral tribulations.

Concepts of Family Structure and Family Identity For patients, family often extends beyond the sphere of the traditional nuclear family. Because patient decision-making may include members of the extended family and the community, providers should consider familial influence on treatment decisions.

Communication Styles and Views of Professional Roles Westerners tend to separate professional and personal identity. The need for objectivity depersonalizes communication style.

However, many cultures value personal relationships that use both roles.

Incompatibility of Explanatory Models An explanatory model explains the epidemiology of the illness.16 If patients' and providers' ideas differ about the structure and function of the body, for example, causes of diseases being bacteria, virus or the environment versus the "evil eye," "loss of soul" or "curses," it will be difficult to get patients to comply with treatment. Is health merely physical or a moral/social balance as well?

Disease Without Illness Physicians are well indoctrinated about the dangers of "invisible" diseases like hypertension, high cholesterol and HIV infection, but people in other cultures are not as willing to intervene when there are no symptoms.

Illness without Disease The existence of the folk illness may be an area of disagreement between patient and provider. A folk illness is when a patient feels that he or she has an illness that is not defined by biomedicine. Physicians need to be aware of common folk illnesses that may affect members of a cultural community. "Some may see a medical doctor for relief of symptoms while also going to a folk doctor or traditional healer to be rid of the cause of the illness." In addition, although a few practices may be harmful (or misinterpreted as abuse), most folk medical beliefs and practices are not harmful and do not interfere with biomedical therapy.17 Providers should not try to change patients' benign beliefs but should educate them on the importance of biomedicine as complementary. A combination of the two forms of therapy may increase patient compliance because this is within the ethno cultural ideals of the patient. For example, a Puerto Rican mother might believe that her child is suffering from empacho, a folk illness caused by food "sticking" to the inside of the stomach and causing pain. The physician diagnoses viral gastroenteritis and prescribes medication, but also tells the mother to rub her child's stomach. This is not harmful and it fits the cultural beliefs of the patient, possibly increasing compliance.

Misunderstandings of terminology, language or body language Monolingual providers who encounter patients who do not speak their language cite this as a barrier to health care. Body language can be misinterpreted between cultures. For example, the firm handshake in Anglo-American culture is a symbol of strong character, but in some Native American groups, a limp hand is a symbol of humility and respect. Two people from these cultures would leave this encounter with completely inaccurate assessments of each other.

Listed below are some common Anglo-American values and some representative differences that other cultures may hold. (Please note that Anglo-American values are interpreted as those closest to the medical provider culture). Recognizing some of these values as those of the medical provider and seeing the discrepancy between the two will begin to remedy cultural clashes.

HOW DO PHYSICIANS-IN-TRAINING BECOME CULTURALLY COMPETENT?

Listen with sympathy and understanding to the patient's perception of the problem

Explain your perceptions of the problem and your strategy for treatment.

Acknowledge and discuss the differences and similarities between these perceptions.

Recommend treatment while remembering the patient's cultural parameters.

Negotiate agreement. It is important to understand the patient's explanatory model so that medical treatment fits in their cultural framework.

In some cases, it may be impossible to resolve an ethical dilemma. For example, a western doctor may regard female circumcision as wrong while it is often a cultural imperative with some African tribes. To resolve these cases, both provider and patient must be regarded as having equally important ethical concerns in making decisions. "It is reasonable to suppose that cultures that have provided the horizon of meaning for large numbers of human beings of diverse characters and temperaments over a long period of time. . . are almost certain to have something

that deserves our admiration and respect. . . . it would take a supreme arrogance to discount this possibility a priori."

SOME GUIDELINES FOR HOW TO USE AN INTERPRETER[33]

Unless you are thoroughly effective and fluent in the target language, always use an interpreter.
Try to use an interpreter of the same sex as the client but avoid using family members as interpreters.
Learn basic words and sentences in the target language; emphasize by repetition and speak slowly, not loudly.
Be patient. Careful interpretation often requires that long explanatory phrases be used.
Address the patient directly: do not direct commentary to or through the interpreter as if the patient did not exist.
Return to an issue if you suspect a problem and get a negative response. Be sure the interpreter knows what you want.
Provide instructions in LIST format and have patients repeat their understanding of the medical therapy.
Use short questions and comments; avoid technical terminology and professional jargon, like "workup."
Use language that the interpreter can handle; avoid abstractions, idiomatic expressions, similes and metaphors.
Plan what to say ahead of time. Do not confuse the interpreter by backing up rephrasing or hesitating.

TIPS FOR IMPROVING THE CAREGIVER/PATIENT RELATIONSHIP ACROSS CULTURES

Do not treat the patient in the same manner you would want to be treated. Culture determines the roles for polite, caring behavior and will formulate the patient's concept of a satisfactory relationship.
Begin by being more formal with patients who were born in another culture. In most countries, a greater distance between caregiver and patient is maintained through the relationship. Except when treating children or very young adults, it is best to use the patient's last name when addressing him or her.
Do not be insulted if the patient fails to look you in the eye or ask questions about treatment. In many cultures, it is disrespectful to look directly at another person (especially one in authority) or to make someone "lose face" by asking him or her questions.
Do not make any assumptions about the patient's ideas about the ways to maintain health, the cause of illness or the means to prevent or cure it. Adopt a line of questioning that will help determine some of the patient's central beliefs about health/illness/illness prevention.
Allow the patient to be open and honest. Do not discount beliefs that are not held by Western biomedicine. Often, patients are afraid to tell Western caregivers that they are visiting a folk healer or are taking an alternative medicine concurrently with Western treatment because in the past they have experienced ridicule.
Do not discount the possible effects of beliefs in the supernatural effects on the patient's health. If the patient believes that the illness has been caused by embrujado (bewitchment), the evil eye, or punishment, the patient is not likely to take any responsibility for his or her cure. Belief in the supernatural may result in his or her failure to either follow medical advice or comply with the treatment plan.
Inquire indirectly about the patient's belief in the supernatural or use of nontraditional cures. Say something like, "Many of my patients from ___ believe, do, or visit___. Do you?"
Try to ascertain the value of involving the entire family in the treatment. In many cultures, the immediate family or the extended family makes medical decisions. If the family can be involved in the decision-making process and the treatment plan, there is a greater likelihood of gaining the patient's compliance with the course of treatment.
Be restrained in relating bad news or explaining in detail complications that may result from a particular course of treatment. "The need to know" is a unique American trait. In many cultures,

placing oneself in the doctor's hands represents an act of trust and a desire to transfer the responsibility for treatment to the physician. Watch for and respect signs that the patient has learned as much as he or she is able to deal with.
Whenever possible, incorporate into the treatment plan the patient's folk medication and folk beliefs that are not specifically contradicted. This will encourage the patient to develop trust in the treatment and will help assure that the treatment plan is followed.

The Cultural Assessment The cultural assessment is a tool to help providers understand where patients derive their ideas about disease and illness. Assessments help to determine beliefs, values and practices that might have an effect on patient care and health behaviors. Although a completely accurate assessment currently is underdeveloped, there are several areas to consider when doing an assessment. They include:
level of ethnic identity
use of informal network and supportive institutions in the ethnic/cultural community values orientation
language and communication process
migration experience
self concept and self esteem
influence of religion/spirituality on the belief system and behavior patterns
views and concerns about discrimination and institutional racism
views about the role that ethnicity plays
educational level and employment experiences
habits, customs, beliefs
importance and impact associated with physical characteristics
cultural health beliefs and practices
current socioeconomic status
LANGUAGE BARRIERS Language often is cited as a barrier to health care. 12% of the U.S. population (32 million people) speaks a language other than English. Physicians will inevitably treat people with limited or no English proficiency. Both law (Title VI of the Civil Rights Act of 1964) and good medicine require that physicians make the best attempt at communicating with these patients. Furthermore, the federal government requires any health care provider who receives federal funding from the Department of Health and Human Services to communicate with patients effectively or risk losing that money.
There are several strategies for working through a language barrier. Becoming a bicultural/ bilingual provider should be the main goal, especially if medical students plan to work in an environment with a large population of non-English speaking patients, such as in states like California, Florida, New York and Texas. Because this cannot be immediately accomplished, consider employee language banks. Language banks are an ad-hoc system that uses the bilingual skills of unofficial volunteer interpreters who happen to work in the hospital or clinic. Although they are sometimes the only option, language banks are fraught with many problems, including time strain on the employee's "real" duties. Unlike official interpreters, hospital and clinic employees tend to be untrained and therefore may incorporate bias into their interpretations.28
Another option is the AT&T language line--a phone interpreter service that has interpreters for more than 140 different languages.24 Call (800) 752-0093 or check out <http:/www.att.com/languageline/> for information. This service is offered for subscription (frequent usage-about 20 minutes/month), membership (15 minutes/year) or personal (incidental usage) interpretation and charges set-up and per-minute fees.
Ideally, a professional medical interpreter is the best choice. Medical interpreters can take on a variety of roles, depending on the needs of the provider and the patient. Straight interpretation with no additions, omissions or rephrasing is the basic interpreter role. But in situations where there may be cultural misunderstandings, a knowledgeable interpreter can be a valuable "culture broker," someone who knows about the cultures of both provider and patient and explains when cultural differences that may cause confusion. It is up to the provider, patient and interpreter to

determine what kind of interpreter is needed. Ultimately, the provider should always watch the interaction between the interpreter and the patient. The interpreter should always be completely attentive to the patient.

Though the expense of professional interpreters is often cited as an obstacle, organizations should think of the more expensive monetary and ethical consequences. Poor communication can lead to worse health or liability costs. A provider in Washington, D.C., was sued for $11 million when, due to miscommunication, an abortion was performed on a non-English speaking woman who only wanted contraception.

A special note on the use of family members, especially children, as interpreters: not only is this role stressful for a child, but adult patients may lie or be reluctant to talk about sexual concerns or life-threatening illnesses when speaking through the child. Family members, like ad-hoc interpreters, may incorporate bias into their interpretations. Also, there may be a disruption of family dynamics when children are consulted for their adult family member's medical problems.

Finally, community members and traditional healers like shamans, curanderos and herbalists may be used to act as cultural brokers/interpreters. They are aware of the cultural differences between provider and patient and most believe in Western medicine in adjunct with traditional methods. Also, patients are more likely to stick with a treatment plan that incorporates their beliefs.

There are, however, some clients who have limited English skills and an interpreter is not readily available. In this case, there are several things that providers can do to improve communication:

Communicate thoughts in organized way

Simplify the language

If using preprinted pamphlets, underline or highlight important passages

Print in longhand and use both upper and lower case letters (not all caps); do not use abbreviations

Ask patients to repeat instructions

Make the instructions relevant to the patient's life; for example, ask the patient when she expects to take her medicine (after breakfast, before feeding the baby, after work, etc.)

Invest in a small cassette recorder and blank tapes; record the diagnosis and any advice while interacting with the patient. Let him or her have the tape for referral.31

CASE STUDIES

Case 1: Re-evaluating Ethics and Values from a Different Cultural Perspective An adolescent, unmarried girl in Saudi Arabia was brought to a hospital for an unrelated spinal problem when her American doctors discovered that she was pregnant. Two of the doctors, familiar with the gender expectations of young women, knew that the pregnancy would bring great dishonor to the family and that punishment could bring death to the girl. They arranged for her to have an abortion in a neighboring country. They told her parents that treatment for the spinal problem was only available in this other country. A third doctor, who had only been in Saudi Arabia a short time, felt that he could not be a part of this deception. The other two doctors urgently convinced the third doctor that the girl would be in serious danger if her pregnancy were revealed to her family. The third doctor reluctantly agreed to say nothing. At the last minute, as the girl started to board the plane, the doctor uncontrollably felt he could not go through with what he felt was an ethical violation of truth-telling and told the father that the girl was pregnant. The father immediately grabbed the girl and left with her. Several weeks later, the third doctor ran into the girl's brother and asked about her condition. The boy shook his head and explained that the girl was dead. The family's honor had been restored. The distraught doctor left Saudi Arabia.

What were the conflicting values about which the three physicians disagreed?

Did the third doctor make a mistake by telling the family or was he just doing what he felt was ethically imperative?

How might re-examining his ethics have helped the doctor make a better decision?

As the physician, what would you have done? How would you justify your actions?

Case 2: Family Relationships, Truth-telling Mrs. Lee was a 49-year-old Cantonese-speaking

woman who had immigrated years ago from China to the U.S. She lived with her husband and youngest son, Arnold, 22. Studies revealed that Mrs. Lee suffered from lung cancer that had metastasized to her lymph nodes and adrenal glands. Arnold did not want Mrs. Lee's diagnosis known to her. Eventually, the cancer spread to her brain. Her physician, knowing her poor prognosis, suggested a DNR to her son, who refused to even discuss the possibility with his mother. Arnold felt that his role as son and family member meant he must protect his mother from "bad news" and loss of hope. He believed telling her the dim prognosis would be cruel and cause unnecessary stress. Though futile, the son insisted that all heroic methods be used, including a ventilator, to save his mother's life. He accused the house staff and physician of racism and threatened litigation. As a family member, he considered himself, not the doctors or patient, responsible for his mother's treatment. He felt an overwhelming family responsibility to save his mother from such an early and "bad death" as well as from perceived inadequate treatment.
Had you been the physician, what would you have done?
Try and see Arnold's point of view. What might he have been thinking?
How did cultural differences in the telling of bad news, treatment limits and the role of family differ between provider and patient?
How did Mrs. Lee's age and her son's sense of responsibility to the family affect her care?
What might have been some culturally competent options for the house staff?
How do the ethics of "informed consent" and autonomy fit into the beliefs of Mrs. Lee and her family?

Case 3: Conflicts about Disability, Right to Refuse Treatment A Hmong child was born with a clubfoot. Doctors felt that the foot would cause social embarrassment and make ambulation difficult and recommended an operation to reshape the foot. The family believed that the foot was a blessing, a reward for ancestral hardships. Because the family believed "fixing" the foot would bring shame and punishment to the family and Hmong community, they refused treatment. The family went to the Supreme Court to defend their right to refuse treatment. They won.
What do you think should have happened in the court case? Why?
In this case, the operation did not involve life or death. But what if it had?