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Developing Cultural Competence in Clinical Practice

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Abstract: Cultural competence in clinical practice is essential. Much discussed and reviewed in the literature, training in and learning cultural competence is an important aspect of professional development. There are pitfalls, however, to a learned behavior or practice that may wrongly be assumed by clinical staff to be essential in all clinical encounters to the exclusion of conversation that explores personal beliefs of self, culture and religion. One such example is to assume that all Muslims refrain from alcohol, or that all Israelis have served in the army. Surely, it would be better to ask and explore than assume what is essentially a stereotype.

The following account reviews some of the evidence behind developing cultural competence and discusses the importance of coming to terms with our own personality traits, prejudices and perceptions in order to overcome them and understand our patients so that we can communicate on the same wavelength with our patients. Our assertion is that it is communicating on the same wavelength that is the prerequisite to sincere communication, mutual understanding and developing trust essential to clinical care — especially in an emergency and critical care setting.

Key words: culture, cultural competence, language, communication

1. Introduction

1.1 The Importance of Cultural Competence

There is no doubt that culture plays a large role in shaping an individual's health-related values, beliefs, behaviour and situational judgment in general (Anderson, 2003). In the workplace, poorly handled cross-cultural communication often results in negative social and clinical consequences, an environment of uncertainty or misunderstanding, bewilderment for the patient (and family), the ordering of unnecessary investigations, patient non-compliance, delays in obtaining informed consent and an inferior quality of care (American College of Physicians, 2010; Betancourt, 2005; Richardson, 2010). Cultural competence is, therefore, fundamental to clinical care; it is central to professionalism and, not unlike empathy, an element of care that, if not spontaneously forthcoming in every health professional, may, at least, be learned (Anderson, 2003).

In the following account we discuss how cultural competence may be acquired. We discuss the notion of encountering diverse minority cultures within a dominant culture and suggest that with globalization, the traditional model of a single dominant culture that becomes diluted may not last in the modern world. We take the definition of cultural competence and try to see how this fits in a multi-cultural society that may be integrated to

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variable extents and discuss why the concept of individuality may be more important in delivering patient-centered care. As Napier et al. (2014) state in their article about the Lancet Commission on culture and health "in clinical settings, a tendency to standardize human nature can be, paradoxically, driven by both an absence of awareness of the diversity with which wellbeing is contextualized and a commitment to express both patient needs and care giver obligations in understandable terms".

1.2 Defining Cultural Competence

Cultural competence goes beyond a sensitivity or awareness of another culture. It engenders a respect for another culture and individual, and a willingness to behave or take action that is appropriate in cultural context (Weaver, 2004). By definition, this embodies a range of skills healthcare professionals have depending very much on individual context rather than broad judgments of how to interact with a patient of a particular faith or from a particular region of the world.

Betancourt defines a culturally competent healthcare system as one that "acknowledges and incorporates — at all levels — the importance of culture, assessment of cross-cultural relations, vigilance toward the dynamics that result from cultural differences, expansion of cultural knowledge, and adaptation of services to meet culturally unique needs." He goes on to explain that "a culturally competent system is also built on an awareness of the integration and interaction of health beliefs and behaviours, disease prevalence and incidence, and treatment outcomes for different patient populations."

Our assertion is that accepting that cultural differences and similarities exist, we need to keep our focus on the *individual* in each patient interaction.

1.3 The Dominant Culture

The dominant culture is traditionally the majority culture in a society in terms of language, dialect, politics, custom, expectation, behaviour and even religion; for most of us, our perception is that globalization has resulted in the entry of subjects with foreign cultures into *our* dominant culture. We discuss whether this perception really stands up in the healthcare environment later, but, as globalization continues, for healthcare professionals looking after patients in our rapidly changing societies, cultural awareness is becoming a major healthcare issue and a significant challenge (Koehn, 2006).

2. Assumptions

Our principal assumptions rest on a belief that cultural differences have more impact on interactions than similarities, immigrant cultures themselves are homogeneous, and the fact that, across cultures, language presents the most significant barrier. How much do we really try to find out about our patients as individuals and how much do we need to know in order to treat them optimally to achieve the best clinical outcome for them, and an experience that enables us to trust each other? What do we know about our patients' previous experiences of healthcare workers? How does this affect their experience with us while they are ill, vulnerable and effectively in our care?

In the UK, until the 1990's it was common to assume that all Asian immigrants (immigrants from the Indian sub-continent) had shared family values, common gender issues and similar attitudes towards education and economic prosperity; the only differences seemed to exist amongst religions: Hindus, Muslims and perhaps Sikhs. With time it became more obvious that the societies within the Indian sub-continent are far more diverse in culture,

religion and behaviour, and with assimilation, we learned that it is, indeed, safer to think of individuals rather than cultures in terms of diversity. Assumptions that all “Asians” speak English outside the house and indigenous languages at home are becoming dispelled as familiarity with individuals overtakes stereotyping.

We know from living in multi-cultural societies, therefore, that there *are* no real cultural characteristics (stereotypes) and that people originating from the same regions of the world may actually be very different. Indeed, the strength of a multi-cultural society is that individuals from different parts of a country or the world represent only themselves. A true test of cultural competence is the sensitivity and ability to pick up on individual characteristics, personality and expectations and engage with that individual **personally**, rather than to assume that a person is a representative of a particular culture and communicating with him or her requires a particular adjustment in outward behaviour of the health professional who represents the dominant culture. Culturally competent healthcare surely rests on the basis that healthcare workers make it their business as individuals to be aware of cultural diversity and have an open and exploratory mind when it comes to dealing with their patients and discovering their concerns and beliefs. Napier and colleagues (2014) recommend “a broad view of culture that embraces not only social systems of belief as cultural, but also presumptions of objectivity that permeate views of local and global health, healthcare, and healthcare delivery”.

Our assumptions are by no means confined to our interactions with ethnically diverse patients. Aneez Esmail, gives a historical account of Asian doctors who settled in the UK and their contribution to the National Health Service. It is clear that their role in society and the attitudes towards foreign healthcare workers has also evolved and will, of course, continue to do so. We cannot ignore that as health professionals, *we* also represent diverse cultures rather that a single dominant culture of the state in which we practice.

The following account, therefore, focuses on how **individual** healthcare workers can engage effectively with their patients as **individuals**. We take Betancourt’s definition of cultural competence and ask how individuals can put assumptions to rest and deal with individuals.

2.1 Cultural Competence Skills

Cultural competence may involve **inclusive** skills where prior knowledge, effective communication skills, and sympathetic behaviour enables a person or a programme to work effectively by understanding, appreciating, and respecting differences *and* similarities in beliefs, values and practices within and between cultures (Glossary-Health Check, 2012), empowering patients and fostering an environment where patients feel involved in their care and participate in clinical decisions. It is this mutual understanding and the development of shared ideas and values that forms the basis of shared decision making in clinical care and, indeed, true informed consent (Meisal, 1996). Without cultural understanding, this co-operation is impossible and barriers remain to essential communication. Alternatively, cultural competence, may embody **learned** behaviour and skills that facilitate effective cross-cultural interaction, an example is in the use of language in communication.

2.2 Language

An appreciation of language and colloquialisms, using interpreters effectively, including bilingual family members trusted by the patient in communication, or even support groups, mitigates misunderstanding on both sides and builds trust. Much has been written about the perils of using informal interpreters or bilingual family members (Gerrish, 2004; Meyer, 2010). The two solutions seem to be to plan conversations (by appointment, if necessary) in advance so that trained interpreters are present at the right time and to hire interpreter services in collaboration with other institutions so that costs do not become prohibitive.

Translating words from one language to another may not be enough, however. An interpreter does more than translate words. In the book by Jhumpa Lahiri (2000) *The Interpreter of Maladies* an Indian intellectual "translates" the complaints of the Indian patients to the English doctor. However, the interpreter knows that he must embellish the word translation with cultural references so that the physician can offer culturally acceptable remedies to the ailing. Dryly translating word for word the symptoms of the Indian patients to the English doctor does not accurately convey how the patients are affected by their symptoms. In turn, when the doctor offers treatment to the Indian patients, the interpreter enhances the explanation in cultural context so to the patients fully comprehend and accept treatment.

2.3 Physical Interaction

Non-verbal communication is also important. No one would disagree that the very intrusive contact incumbent in physical examination is entirely inappropriate between strangers, but within the context of a healthcare team caring for a patient, this physical contact is not simply accepted, but tacitly expected, sometimes with a minimum of verbal communication. Context is, therefore, crucial, and non-verbal cues that promote understanding are not to be dismissed. Here, again, it is not simply clinical contact that counts, everyday gestures also convey meaning and can influence the professional relationship between the healthcare team and the patient. Informal contact in Western culture may be perceived as rude and offensive in other cultures; body language may seem overly familiar or intrusive. In China and Japan, for example, kissing is not a usual greeting. In many parts of the world, kissing in public is common-place and, indeed, the norm for members of the same sex greeting each other, especially in the Middle East. The biggest cultural differences in physical communication exist in relation to territorial space, eye contact, touch frequency and insult gestures (Storti, 2004). Awareness of these subtle nuances in physical communication is arguably critical in building rapport and partnerships between healthcare workers and patients and their families. While cultural norms are important, however, individuals vary in their adherence to "their own" cultural norms: some people like to be touched; others not.

3. Developing Cultural Competence

Becoming culturally competent is a developmental process (Wu, 2004) that rests on three factors: personal attributes, knowledge and skills. Personal attributes and prior knowledge contribute to situational awareness while sound interpersonal skills promote effective communication and build understanding. All of these together foster trust and build confidence in relationships. Developing cultural awareness is, therefore, dependent on individual factors, the healthcare institution and wider social complexities.

3.1 Individual Factors

While knowledge and skills may be taught (LaFromboise, 1993; Wu, 2004) what can healthcare workers do about their own personalities in order to become culturally competent? Firstly, **healthcare workers should possess a strong personal identity; know who they are, their values, their motivations and acknowledge their strengths and weaknesses** (LaFromboise, 1993; Wu, 2004). Secondly, we have to acquire a working knowledge of the cultures and religions around us. This can be done by asking questions and reading literature; culture, however, is more effectively experienced and absorbed rather than learned. Thirdly, we must display sensitivity towards other cultures: have an open mind; be prepared to listen; watch interactions and be prepared to discuss with patients and their families openly "how do you do this in your culture/at home". Fourthly, we should

try to communicate clearly in the "language" of the given cultural group. This does not necessarily involve speaking a different language, it is better described as being on the same wavelength. Fundamental to this, is the *endeavour* of establishing what wavelength the patient is on. Simply trying goes a long way, builds bridges and allows us, on both sides, to forgive small faux-pas. Finally, we should strive to possess an awareness of the social norms in our own culture as well as the other cultures that we most frequently encounter, so that adjustment to cultural nuances becomes second nature and we seek to put anyone we meet at their ease.

Efforts to be culturally competent include an individual's ability to step outside his or her cultural boundary, to make the strange familiar and the familiar strange, and to act on that change of perspective (Earley, 2003). Eurocentric values have dominated the sciences and have been propagated as a universal culture. This model does not always lead to successful patient encounters, however, and, as an example, a Norwegian study found that the ICU staff were culturally challenged when dealing with migrant families when offering support, giving information and providing bedside care. The author concluded that there exists a "conflict between professional nursing practice and family cultural traditions" (Høye, 2010). This conflict results in an inevitable clash between behaviours of a dominant and a non-dominant culture. The distinction between dominant and non-dominant cultures often represents a point of friction between systems (and the professionals therein) and patients and their families (Mason, 1996). As discussed earlier, the effect of a dominant culture may be diminished, however, as people become culturally competent and stop using their own culture as the **benchmark** in measuring *all* behavior (Krajewski-Jaime, 1996) and develop more flexible frames of reference that are more inclusive.

3.2 Institutional Factors

Krajic et al. (2005) evaluated the acceptability of ethnocultural training courses in the workplace, their feasibility, cost-effectiveness, quality and sustainability in hospitals in eight European countries in an effort to improve cultural competence as part of the "Migrant friendly Hospitals" project. Key findings amongst healthcare staff were that cultural competence training was easy to implement and its success was dependent on the support of management; convincing staff of the importance of training; addressing real cross-cultural rather than hypothetical problems; a skills-oriented approach; the recruitment of competent trainers; and, inclusion into normal hospital quality improvement routines with continuous professional development.

In a systematic review of 34 studies from 1980 to 2003, Beach et al. (2005) found that there is good evidence that cultural competence training improves the knowledge, skills and attitudes of healthcare professionals.

With the global financial burden can we afford training courses in cultural competence? Is cultural competence so integral to quality and safety that funding of training should be guaranteed or is it incumbent on individual healthcare workers to make themselves culturally competent? Clearly, it is self-awareness that is crucial and personal behaviour that shapes patient interaction. Why should we fund these? The answer, of course, lies in the fact that we know that most unsuccessful patient encounters and complaints arise due to poor communication and that we simply do not try hard enough to communicate well. Though, a pervasive problem for some healthcare workers, most clinicians in contact with patients are aware that effective communication is vital to patient-centered care and that cultural awareness is a pre-requisite for effective communication and effective clinical care, not to mention advocacy for our patients (Brown, 2006)

3.3 A Patient Based Approach to Cultural Competence

How can we accelerate the cultural competence process? One of the ways is to embrace a patient-based approach to cross-cultural care (Betancourt, 2006) from the outset. Nurses should use their assessment skills to

discover the core cross-cultural issues in the care of each patient by using the following techniques: exploration of the meaning of the illness to the patient; determination of the social context in which the patient lives; engagement in negotiation with the patient to encourage effective communication and adherence to treatment; and, exploration of their perceptions of the treatment they receive. Addressing compliance with treatment is a particularly challenging issue, the determinants of which are multifactorial. The ESFT (explanatory/social/fears/treatment) model, derived from the patient-based approach (Betancourt, 2006) is a tool that identifies barriers to treatment and provides strategies to address these. The following example shows how a healthcare worker can adapt to a situation in real time provided they have a degree of self-awareness:

I was explaining the implications of testing positive to Hepatitis C to my Ethiopian patient. We discussed treatment options and when I asked her if she had any questions, she asked "how does the virus you found in my blood affect my liver? How does the blood get to the liver?"

I had to stop and think: perhaps her question is based on her knowledge of how the body works? Perhaps the basis of this question is cultural? I then asked her to tell me what she understood of the circulation of blood, including its flow through the liver. From her response I understood that she was unaware that blood flows through the liver or that the circulatory system connects all the organs in her body. I, therefore, explained to her with diagrams how the virus had travelled in her bloodstream to the liver and what the implications of hepatitis were for her health and long term wellbeing. We were then able to discuss the cultural implications together.

It is obviously impossible for every physician or nurse to learn everything about every culture and that should not be expected. Instead, we should learn about the communities we care for. More importantly, **we should have a framework that allows us to provide appropriate care for *any* patient**, one that deals with issues of effective communication, comfort and adherence to treatment as cultural competence outcomes, regardless of the patient's race, ethnicity or cultural background (Betancourt, 2006).

What other outcomes of cultural competence should we expect? Wear (2003) suggests that cultural competence far exceeds proficiency in cultural sensitivity, cross-cultural skills and an understanding of multi-culturalism. Stewart (1995) reviewed 21 studies investigating the effects of the quality of doctor-patient communication from 1983 to 1993 and demonstrated the correlation between effective communication and improved health outcomes. Culturally competent healthcare providers overcome language and cultural barriers to communication and are more knowledgeable about their patients' backgrounds. They have more positive attitudes towards their patients and practice a patient-centered approach to their clinical work. All these factors lead to the provision of better care for patients (US Department of Health and Human Services, 2004).

4. Summary

In this 21st century of diversity and globalization, cultural competence is a pre-requisite for providing optimal care. Being a culturally competent healthcare worker, in all situations, is, however, not easy. We must first come to terms with our own personality traits, prejudices and perceptions in order to then overcome them. As healthcare workers we can learn to identify cultural issues, assess our own level of understanding, seek help when we need it and aim to be on the same wavelength as our patients not simply to talk to them, but to really understand them, build trust and compliance and work together for better health for individuals, and healthcare advocacy for vulnerable communities.

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