Cultural Competence

Culture is the widening of the mind and of the spirit  --- Jawaharlal Nehru

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The Dyson Community Pediatrics curriculum has 3 categories of competencies or focus areas on which to base resident learning:

Community Health, Cultural Competency, and Advocacy.
Workshop Goals

- Define cultural competency and discuss rational for use/learning
- Physician Culture - To explore the rich cultural backgrounds and potential biases that physicians bring to clinical encounters.
- To discuss medical culture and the hidden curriculum.
- To introduce second year residents to the cultural competency curriculum

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Norms

- One person at a time
- Respect the opinions of others - all opinions are valid
- Share depending on your level of comfort
- Confidentiality - don’t share information you may have learned about others
- Have fun!

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Problem statement

- 1. Racial and ethnic disparities in health care
- 2. Many people who go to their doctor are not satisfied
- 3. Most medical visits are not for biologically based illnesses

Philosophy
As our country becomes more diverse, many notable pediatric and governmental organizations have called for greater focus on cultural competency and awareness in the pediatric training curriculum. Doctors in training need to be given the opportunity to develop an awareness of the role of culture in health care delivery. In addition, they need to learn and practice basic skills that can aid them in delivering culturally relevant care to diverse populations. A greater awareness of the role of culture in the clinical encounter will likely improve the health outcomes of the medical visit. It will definitely increase the personal satisfaction of provider.
The Name Game

- Tell the story of your name and its origins
  - ethnicity
  - family history
  - birthplace/where you are from

We will start with an ice-breaker
Definitions

- **Race**: Classification of individuals who possess distinctive physical characteristics that are transmitted genetically.

- **Ethnicity**: Races or groups of people who are classed according to common background, languages, traits, customs, or appearance.
Definitions

- Cultural Group: People with common origins, customs, and styles of living; sense of identity and a shared language. No cultural group is homogenous, but contains diversity.
Cultural Competency

Synonyms:
- Culturally effective health care
- Culturally sensitive health care
- Cross-cultural medicine
- Multiculturalism

I am using the term Cultural Competency because it seems most widely used in the literature and is already used in the Dyson Curriculum, but the drawback is that it may suggest that the learner is culturally incompetent in some way, whereas in reality this is a process and not an endpoint…

The AAP points out the subtle differences in the terms. Cultural competence and cultural sensitivity refer to attributes of the pediatrician, whereas culturally effective healthcare refers to the interaction between the provider and the patient.
“Culturally Effective Healthcare:”

- Appropriate physician knowledge, understanding, and appreciation of cultural distinctions
- Takes into account the beliefs, values, actions, customs, and unique health care needs of distinct population groups
- Strengthens the physician-patient relationship and maximizes the health status of patients

AAP Definition:

culturally effective healthcare” is “the delivery of care within the context of appropriate physician knowledge, understanding, and appreciation of cultural distinctions… tak[ing] into account the beliefs, values, actions, customs, and unique health care needs of distinct population groups…thereby strengthening the physician-patient relationship and maximizing the health status of patients.”

In other words, it is a way to come to terms with the country’s increasingly diverse population and an awareness that one-size-fits-all approach to health care is the not most effective way.
Increased Focus on Training

- AAP
- APA
- AMA
- STFM
- LCME
- State Legislatures
- Department of Health and Human Services

“A growing body of federal and state laws, regulations, and standards seeks to guarantee that health systems respond to these diverse linguistic and cultural needs by becoming “culturally competent.”

AAP  ** Go to next slide

1. The **Liaison Committee on Medical Education** which accredits medical schools has proposed standards on cultural diversity.

2. Bills have recently been introduced into the New Jersey and New York legislatures that would require cultural competency training as a condition of physician licensure.
AAP article: “Culturally Effective Pediatric Care: Education and Training Issues,” the committee on Pediatric Workforce discusses these issues.

Advocates training at all levels
  - Medical school
  - Residency
  - Continuing Medical Education

…..“to enhance the ability of pediatricians to provide care that is responsive to the individual needs of each patient.”

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**AAP Rationale**
1. Ethnic differences in healthcare
2. Numerous barriers to care for minority children
   such as poverty, geographic factors, lack of cultural sensitivity, racism, and other forms of prejudice.
3. Health services in many institutions reflect majority culture values
4. “Patients and families that have a different cultural orientation may experience difficulties in their interactions with health professionals, and these difficulties may have an adverse impact on the delivery of health care.”

***In addition, the program requirements for residency education in pediatrics developed by the Residency Review Committee call for this type of training.***
Research: “Can Cultural Competency Reduce Racial and Ethnic Disparities?”

- Racial and Ethnic disparity data
- Data documenting increased satisfaction with Interpreter use
- Data documenting increased trainee knowledge and skills

A. What research supports paying attention to cultural differences?
   A. Racial and Ethnic disparity data
      A. [Racial and ethnic] “disparities have been documented within health care systems that provide equal financial benefits to all covered individuals, such as Veterans’ system, Medicare,” etc.

Trainee Knowledge and Skills Data

Goals:
To enhance self-awareness of attitudes toward minority groups
To increase knowledge about minority populations
To improve specific skills such as communication.

Outcomes
Resident self and faculty ratings documented increases in:
   Knowledge
   Cross-cultural communication skills
   Cultural Competency
Residents reported the skills learned useful in practice
Physician Culture

To know others, we must first know ourselves

--- Adage

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Workshop Exercise

- This exercise is designed to help you assess your own cultural heritage, including experiences that may influence your ability to work with patients from diverse backgrounds.
- There are no right or wrong answers.
Workshop Exercise

- What ethnic group, socioeconomic class, religion, age group and community do you belong to?
- What is the first experience you had with people from an ethnic group, religion, age group or community not your own? What was that experience like? How did you feel about it?
Workshop Exercise

■ What socio-cultural factors in your background might contribute to your being rejected by others? Have you experienced prejudice from others?

■ What personal qualities do you have that will help you establish interpersonal relationships from other cultural groups? What personal qualities may be detrimental?
Exercise Summary

- What were the assumptions you made about your partners before they talked? Did you predict what they were going to say?
- Was anything difficult to discuss? Did anything make you uncomfortable?
- What did you learn?
Awareness

■ Individual Cultural Heritage
  Includes provider’s own cultural family beliefs and upbringing re: health etiology, treatments and illness behaviors.

■ How does provider culture impact the health encounter?

2. Our individual cultural heritage

  I don’t have time to elicit family health beliefs from this group, which is a nice exercise to demonstrate the varied ways that we were brought up to think about illness etiology (comes from not wearing a hat, not enough vitamins, etc) to treatment (chicken soup, vitamin C), to how to act (stay in bed, ignore it...).
B. How does the provider’s culture impact the clinical encounter?

Arthur Kleinman, is an internist and anthropologist who argues that that traditional medicine model focuses on disease as a malfunctioning of biological processes in an individual patient. In contrast, the patient experiences illness which represents their personal reaction to the disease or discomfort. Illness is shaped by subjective perceptions, symbolic meaning and value judgments that arises from an individual’s culture. These 2 concepts of illness have not been given equal play in medical education – with the biological considerations being considered more “real” and often more interesting than psychological or sociocultural issues – in part because they are more readily treatable.

Physicians and patients often develop discordant explanatory models for the same illness or disease process. These discordances effect the clinical encounter.
Individual Health Beliefs
Exercise

- What were some of the values in your family around health?
- What were some of the beliefs and healing methods used?

Ignore it and it will go away
Avoid the doctor
Mom+ doctor

Easier to abandon the methods than the values.
Awareness

- Biomedical Culture
  Not Value-Neutral
  Every Patient Encounter is a “Cross-Cultural Experience”

1. Biomedical culture – is not value-neutral

  My own philosophy: Every patient encounter is a “cross-cultural” experience – the degree varies. We get into trouble when we presume that the patient is on the same wavelength.
The Anger Issue

- What are patients expectations of doctors?
- What are our expectations of patients?
- How do institutional policies increase this conflict?
Medical Culture

- What are the positive values of medical culture?
- What are the values of medical culture you would like to change?
- How are these values passed on?
- Have you ever been in an uncomfortable cultural situation among colleagues?

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The Hidden Curriculum

- What was being taught that was consistent with biomedical curricula?
- What was being taught that was outside the biomedical curriculum?
Curriculum

- YR1: Introduction to Cultural Competency & Language Skills
- YR2: Issues of Provider and Patient Culture
- YR3: Communication Skills and Cultural Exchange

Year 1.
Orientation walking tour to familiarize residents with the community
Introduction to interpreter usage
Spanish language skills enhancement
YR2: Issues of Provider and Patient Culture
1/2 day workshop on provider culture, culture of medicine and hidden curriculum
Ethnography of intake rounds
1/2 day workshop on patient culture
Literary case study of provider vs. patient culture - reading and discussion of “The Sprit Catches You and You Fall Down” with community members

YR3: Communication Skills and Cultural Exchange
Communication skills noon lectures
Role plays and practical communication strategies
Video taped clinical encounters in the ER - residents to tape and present clinical encounters for feedback and discussion
Components of Teaching

- Awareness
- Knowledge
- Skills
Intake Ethnography

■ An exercise designed to give a hands-on example of the hidden curriculum
■ Intake rounds will be both audio taped and you will take notes regarding the nature of the interaction.
■ Your observations will be discussed in a meeting subsequent to the experience.
Wrap up

- Name game
- Definitions of Race, Ethnicity, Culture and cultural competence
- Mandates and rational for learning about these issues
- Individual health beliefs
- Medical culture: Illness Vs Disease
- Anger
- Hidden Curriculum

A. Name game: to increase awareness of culture

B. Definitions