CULTURAL COMPETENCY

STUDENT MANUAL

Cultural Objectives for Block III
Core Competency Sessions

The purpose/goal of the Cultural Competency sessions that comprise part of the Cultural Diversity section of the Core Competency Course is to assist the students in applying concepts of cultural awareness and sensitivity to enhance performance in the clinical setting.

- Elicit a patient's "explanatory model" for his/her disease or illness, including how the problem started, and what makes it better/worse.
- Discuss the issue of health disparities in health and health care and the reasons underlying these disparities, including; access to care, health care economics, and mortality.
- Describe the influence of culture on the way patients and families interpret medical information.
- Relate the role of stereotyping based on culture as it influences clinical interactions.
- Defend a viewpoint about the reasons that medical information might be withheld by a physician from the patient or family.
- Appreciate the many ways that medical decisions are made for family members in different cultures.
- Describe the Civil Rights Act and its use in requiring the professional interpreters in cases where the patient or family does not have English familiarity.
- Discuss the issues in using family members as interpreters, when professional interpreters are not available.
- Relate the areas that the "culture of medicine" may clash with the values of another culture and impact the delivery of patient care.

Learning activities:

1) Session 1 the students receive objectives for the two sessions. They discuss selected readings and relate them to specific clinical situations they have encountered.
2) Session 1 the students watch the "Worlds Apart" video of the man who is Afghani and discuss salient points on the tape.
3) Session 2, the students complete a short answer/essay exam on the video and general cultural competency content discussed in Session 1.

Evaluation:

Students will complete the written short answer/essay examination and receive a P/F.
The exam will be graded by designated faculty and returned to the students with comments. If the student receives an "F" on the exam, he/she will be asked to review the content and tape and retake the written exam until receiving a grade of "P". Students will have the opportunity to evaluate the sessions and submit the anonymous evaluations to Community Administrators.

Cultural Competency Sessions in
Core Competencies
2005

In 1999, award winning physician/filmmaker Maren Grainger-Monsen made a series of teaching vignettes to explore culturally diverse patients' and families' experiences with the American health care system.

The project, called *"Worlds Apart"* captures many of the conflicts that arise when patients and health care professionals come together with different perspectives on health, illness and medicine.

"Worlds Apart" tells the story of Mohammad Kochi who is a 63 year old man from Afghanistan who is diagnosed with stomach cancer. He agrees to have surgery, but later refuses his oncologist's recommendations for chemotherapy due to his religious beliefs, language barriers and family conflict.

You will be viewing the video of Mr. Kochi and will then be discussing a series of questions about the tape. The objectives for this session are included.

During session 2, you will be doing an in-class examination about this video and discussion sessions.

Cultural Competency Civil Rights Act (Title VI)

Title VI of the Civil Rights Act prohibits discrimination against any person on the basis of race, color, or national origin in any program receiving federal assistance. Accordingly, the U.S. Department of Health and Human Services Office for Civil Rights, in a clarification of title VI in 2000, views inadequate interpretation in the health care setting as a form of discrimination.

This has set a precedent for the use of interpreter services in hospitals and other human service institutions. However, the reality of having professional interpreters available in the outpatient setting is logistically very challenging and expensive. In practice, both in hospitals and in clinics, family members and untrained staff commonly serve as "ad hoc" interpreters and often no interpreter is available.

Several lawsuits have been filed and won based on discrimination against people of limited English proficiency (LEP), especially in cases where it was shown to have led to a poor medical outcome. There were also several studies linking ineffective interpretation to worse medical outcomes.

Family members are generally not trained as interpreters even if they have served in this role many times. So the same pitfalls of using untrained staff or other patients as interpreters arise. Words are missed, subtle meaning is changes, and miscommunication is common. Accordingly, family members have their own biases that can lead to distortion of the patient's words. If they feel they already know what the problem is, they may avoid including important details of the patient's symptoms. They may try to protect their family member, make him appear more ill in order to make sure he is taken seriously, or less ill for other reasons.

They may have different opinions about how the patient should be treated and may influence clinical decisions. All of this may be more or less intentional or even totally subconscious. The patient himself may avoid saying certain things or change the way they are said because of the family member's presence. Finally, it can be a tremendous emotional burden on the family member and it is especially inappropriate for a child to assume this level of responsibility.

See: http://www.usdoj.gov/crt/cor/13166.htm

Focus on Explanatory Models

Roughly speaking, a patient’s explanatory model is her/his perspective and specific beliefs about her/his illness and its treatment. There are several general questions or areas of inquiry (as modified from Kleinman, et al.) that are useful in trying to understand a patient’s explanatory model. Health care providers should become comfortable with these types of questions and should develop their own which work well for them.

Explanatory Model Questions

- What do you think has caused your problem?
- What do you call it?
- Why do you think it started when it did?
- How does it affect your life?
- How severe is it? What worries you the most?
- What kind of treatment do you think would work?

If the patients seem reluctant to discuss their beliefs; it can be helpful to use normalizing statements to make them fell more comfortable. For example, “Many people feel that if a person doesn’t feel sick then there can’t be anything wrong with them. Do you feel that way?” Also, it is important for health care practitioners to realize that it might be someone else’s beliefs that are causing a patient or family member to act in a certain way (e.g., Bouphet refusing the operation due to her mother’s beliefs). Asking questions about that person’s perspective or involving him or her directly in the discussion can be very helpful.

REFERENCES

1. Carrillo JE, Green AR, Betancourt JR. Cross-Cultural Primary Care: A Patient-Based Approach. Annals of Internal Medicine 1999; 130: 829-834.

Abstract:

In today's multicultural society, assuring quality health care for all persons requires that physicians understand how each patient's sociocultural background affects his or her health beliefs and behaviors. Cross-cultural curricula have been developed to address these issues but are not widely used in medical education. Many curricula take a categorical and potentially stereotypic approach to "cultural competence" that weds patients of certain cultures to a set of specific, unifying characteristics. In addition, curricula frequently overlook the importance of social factors on the cross-cultural encounter. This paper discusses a patient-based cross-cultural curriculum for residents and medical students that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors. The curriculum consists of five thematic units taught in four 2-hour sessions. The goal is to help physicians avoid cultural generalizations while improving their ability to understand, communicate with, and care for patients from diverse backgrounds.

2. Post SG, Puchalski CM, Larson DB. Physicians and patient spirituality: Professional boundaries, competency, and ethics. Annals of Internal Medicine 2000; 132:578-583.

Abstract:

Clinical studies are beginning to clarify how spirituality and religion can contribute to the coping strategies of many patients with severe, chronic, and terminal conditions. The ethical aspects of physician attention to the spiritual and religious dimensions of patients' experiences of illness require review and discussion. Should the physician discuss spiritual issues with his or her patients? What are the boundaries between the physician and patient regarding these issues? What are the professional boundaries between the physician and the chaplain? This article examines the physician-patient relationship and medical ethics at a time when researchers are beginning to appreciate the spiritual aspects of coping with illness.

3. Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life: "you got to go where he lives" JAMA 2001; 286:2993-3001.

Abstract:

Culture fundamentally shapes how individuals make meaning out of illness, suffering, and dying. With increasing diversity in the United States, encounters between patients and physicians of different backgrounds are becoming more common. Thus the risk for cross-cultural misunderstandings surrounding care at the end of life is also increasing. Studies have shown cultural differences in attitudes toward truth telling, life-prolonging technology, and decision-making styles at the end of life. Using 2 case studies of patients, one of an African American couple in the southern United States and the other of a Chinese-American family in Hawaii, we outline some of the major issues involved in cross-cultural care and indicate how the patient, family, and clinician can navigate among differing cultural beliefs, values, and practices. Skilled use of cross-cultural understanding and communication techniques increases the likelihood that both the process and outcomes of care are satisfactory for all involved.

4. Crawley LM, Marshall PA, Lo B, Koening BA. Strategies for culturally effective end-of-life care. Annals of Internal Medicine 2002;136:673-679.

Abstract:

As a result of profound worldwide demographic change, physicians will increasingly care for patients from cultural backgrounds other than their own. Differences in beliefs, values, and traditional health care practices are of particular relevance at the end of life. Health care providers and patients and families may not have shared understandings of the meaning of illness or death and may not agree on the best strategies to plan for the end of life or to alleviate pain and suffering. Good end-of-life care may be complicated by disagreements between physicians and patients, difficult interactions, or decisions the physician does not understand. Challenges may result from cultural differences between the patient's background and traditional medical practice. Values so ingrained in physicians as to be unquestioned may be alien to patients from different backgrounds. Physicians need to be sensitive to cultural differences and to develop the skills necessary to work with patients from diverse backgrounds.

Community and cultural ties provide a source of great comfort as patients and families prepare for death. This paper describes two cases that raise issues about cross-cultural end-of-life practice and suggests strategies for negotiating common problems. Physicians should assess the cultural background of each patient and inquire about values that may affect care at the end of life. They should become aware of the specific beliefs and practices of the populations they serve, always remembering to inquire whether an individual patient adheres to these cultural beliefs. Attention to cultural difference enables the physician to provide comprehensive and compassionate palliative care at the end of life.