

## **Chapter 2**

# **Cultural Competence in Healthcare Specialties**

Successful healthcare depends on the teamwork of various professional disciplines, including physicians, nursing, medical technology, physical therapy, social work, nutrition, clinical psychology, and so on. In this chapter, culturally relevant healthcare within several specialties will be discussed.

### **Care by Physicians**

Physicians of all medical specialties need to recognize the importance of cultural issues. To be truly clinically competent, they need to be culturally competent. All patients are influenced by culture, no matter what the ethnic background—be they minorities or majorities. However, particular concern should be directed toward minorities and migrants.

Minorities have been shown to receive inferior healthcare in such areas as referral for cardiac diagnostics and therapeutic procedures, referral for kidney transplants, pain treatment for cancer and fractures, care for pneumonia and heart failure, accessing standard immunizations, and referral for breast cancer and cervical cancer screening. Minorities usually have less health insurance coverage, less healthcare access, more acute and chronic illnesses, and lower life expectancies (Rosa 2006).

The Institute of Medicine—a prestigious advisory organization that is part of the National Academy of Sciences of the United States—has reported on the widespread disparities in healthcare among various minority and cultural groups (Institute of Medicine 2002). It has concluded that these disparities lead to worsened health outcomes, and are unacceptable. It has encouraged the acquisition of cross-cultural skills as one remedy for this problem. This topic has been included in recent texts in family medicine (Taylor 2003) and pediatrics (Behrman, Kliegman & Jenson 2004). Thus, the growing awareness of the need for cultural competence in healthcare has been increasingly recognized, and is being strongly promoted.

Primary care physicians have been found to have less effective communication with ethnic minorities. This causes misunderstandings that are, in turn, associated

with noncompliance (Harmsen, Meeuwesen, van Wieringen, Bernsen & Bruijnzeels 2003). Family medicine and internal medicine residents report that they consider cultural competence to be relevant to their clinical work, and that they generally see themselves as fairly sophisticated in cross-cultural communication. If cultural issues cause a problem in communication, however, they tend to blame the problem on patient shortcomings (Shapiro, Hollingshead & Morrison 2003).

Cultural competence training has been recommended for ophthalmologists. Vision impairment disproportionately affects blacks and Hispanics in comparison to whites. Opportunities exist to improve care for diabetic retinopathy, glaucoma, and cataracts in minorities. Culturally appropriate education for physicians and patients offers the best solution to finding strategies to address the care of eye disease in minorities (Wilson & Eezzuduemhoi 2005).

The American Academy of Pediatrics has endorsed the concept of cultural competence as an important part of pediatric practice and a vital social value. It has called for increased diversity in the workforce and cultural education and training from medical school through ongoing CME activities (American Academy of Pediatrics Committee on Pediatric Workforce 2004).

A recent prospective study evaluated the treatment of asthma in children in managed Medicaid practice sites in three states. It found that policies designed to promote cultural competence were a main factor in predicting higher quality asthma care (Lieu, Finkelstein, Lozano, Capra, Chi, Jensvold, Quesenberry & Farber 2004). In a study of informed consent, it was shown that the content and quality of physician communication differed depending on parents' ethnicity, perhaps reflecting physician attitudes toward the ethnicity (Simon & Kodish 2005).

Surbone (2006) has called for culturally competent cancer care, which is important not only at the level of the healthcare provider, but also at the systems and organizational levels. He defines culturally competent cancer care as being "based on knowledge of the notion of culture; on awareness of possible biases and prejudices related to stereotyping, racism, classism, sexism; on nurturing appreciation for differences in healthcare values; and on fostering the attitudes of humility, empathy, curiosity, respect, sensitivity and awareness" (Surbone 2006).

Obstetrics and gynecology (OB-GYN) is a special field of medicine that only concerns health issues specific to women—usually related to the reproductive organs. In many countries, OB-GYN doctors are predominately male. This was originally also true in the United States (Haar, Halitsky & Stricker 1975). Now, however, the majority of OB-GYN residents in training are women, in conjunction with a cultural shift in the attitudes of women patients. Between 1999 and 2003, the number of male graduates of OB-GYN training programs decreased 31.3 percent, while female graduates increased 18.2 percent. In a typical study, 53 percent of women stated they would prefer a female gynecologist, 10 percent would prefer a male, and 37 percent had no preference. Most women, however, found that other factors were more important than the gender of their physician, including competence, bedside manner, and experience (Plunkett, Kohlip & Milad 2002). As women doctors increasingly take care of women patients, there is concern that the productivity of these physicians will be less due to socioeconomic reasons, such as their

own need to give birth and raise children. It is estimated that the productivity of female OB-GYN doctors will be 85 percent that of males, and that this will lead to, or exacerbate, future physician shortages (Pearse 2001). There is also concern about a decline in the number of medical students choosing OB-GYN as a specialty, partly because of the hard work, the need of availability for night deliveries, and the high cost for medical malpractice insurance for this specialty. Some OB-GYN doctors have been sued two decades after the delivery of a baby. Thus, the looming shortage reflects not only medical issues, but also social and cultural matters.

Residency training programs in all specialties are increasingly including cultural competence in their curricula. In 2003, 50.7 percent of programs provided opportunities for developing cultural competence—a rapid and substantial increase from 2000 when the percentage was 35.7 percent (Brotherton, Rockey & Etzel 2004). In pediatrics, cultural competence and antiracism training appears to be not only well-received, but effective in facilitating quality care (Webb & Sergison 2004). A survey of residents receiving training in cultural competence, however, found that although the issue was presented to them as being important, little time was actually allotted to cross-cultural issues, nor was there much in the way of training, formal evaluation, or role modeling (Weissman, Betancourt, Campbell, Park, Kim, Clarridge, Blumenthal, Lee & Maina 2005).

Among medical school faculty however, minorities are underrepresented. In 2003, 75 percent of fulltime faculty members were white, 5.8 percent were African-American, and only 3 percent were Hispanic. The proportion of underrepresented minority faculty has not increased from 1998 to 2003 (Barzansky 2003). This is a significant issue because access to and interaction with faculty and peers from different cultural groups will usually enhance cultural sensitivity.

Among medical schools with cross-cultural education curricula, considerable variation has been found. Themes included the doctor-patient relationship, racism, socioeconomic status, and specific information about the ethnic communities being served (Peña Dolhun, Muñoz & Grumbach 2003). Some programs recommend or utilize immersion programs and even language training to provide cross-cultural skills.

Many medical schools have adopted the LEARN model (Berlin & Fowkes Jr. 1983). This consists of the following objectives:

- L - Listen to your patient from his or her cultural perspective
- E - Explain your reasons for asking for personal information
- A - Acknowledge your patient's concerns
- R - Recommend a course of action
- N - Negotiate a plan that takes into consideration your patient's cultural norms and personal lifestyles

A more recently developed mnemonic to provide training is the CRASH course in cultural competency. CRASH designates certain components considered essential to culturally competent healthcare: consider **C**ulture, show **R**espect, **A**ssess/Affirm differences, show **S**ensitivity and Self-awareness, and do it all with **H**umility (Rust, Kondwani, Martinez, Dansie, Wong, Fry-Johnson, Woody, Daniels, Herbert-Carter, Aponte & Strothers 2006).

After an extensive review of research relevant to cultural competence, Rosa (2006) concluded that while there was little in the way of outcome studies on the effect of cultural competence on patient health, there was good evidence that cultural competence improved patient-physician communication and interaction, and is necessary for high-quality patient care.

## Care by Nurses

Cultural competence is recognized as a key component of nursing care. Cultural competence in nursing has been comprehensively defined as “an ongoing process with the goal of achieving the ability to work effectively with culturally diverse groups and communities with a detailed awareness, specific knowledge, refined skills and personal and professional respect for cultural attributes, both differences and similarities” (Suh 2004). The concept of *transcultural nursing* has been advocated by nurses for many decades (Leininger & McFarland 2002, p. 3–37; Giger & Davidhizar 1999, pp.3–19). This involves caring for patients who have different ethnic/cultural backgrounds from their nurses, and is derived from the clinical experiences with patients of various ethnic/cultural groups in multiethnic societies (Callister 2005; Cioffi 2005). Cultural competence in nursing care is particularly emphasized by community and public health nurses through their encounters with clients from distinctly different sociocultural settings (Degazon 2004). Learning to inquire into an individual’s personal interpretations of life’s world experiences rather than relying on catalogs of cultural attributes and stereotypes has been shown to increase nurses’ confidence in providing a more culturally competent, higher quality of patient care (Kleiman 2006). Recruitment and training of culturally diverse nursing practitioners is considered an important objective in achieving the goal of culturally competent nursing care (Pacquiao 2007).

## General Issues

### The Role and Status of Nurses

The role, status, and function of nurses vary in different societies. They are basically shaped by the social culture and medical culture operating in a given society at a particular time. For example, in many Asian societies, physicians have relatively complete authority in administering inpatient services, and nurses have only subordinate status and supplementary roles in providing nursing care. In many European-American societies, on the other hand, nurses play major roles in administering services in the inpatient unit, while physicians only provide medical treatment.

The different role and status of nurses in different cultures is exemplified by the situation in Thailand. There, nurses are discouraged from thinking and acting independently. Thus, nurses trained in Thailand are not suited to work in Western settings (Ekintumas 1999).

**Relations with Physicians**

In many countries, most physicians are male and most nurses are female. As a result, physician-nurse relationships are subject to the male-female gender relationships defined in society. In Japan, for example, where men still generally have a higher status than women, nurses are expected to bow to physicians when they meet them. Nurses are expected to play only supplementary and subordinate roles under physicians (Long 1984). In the United States, however, this hierarchy is less obvious, and nurses and physicians relate to each other more or less in a spirit of equality and democracy, while retaining their own areas of expertise.

**Relations with Patients**

In general, nurses have a great deal of direct contact with patients, providing care and maintaining a close relationship. This is particularly true in a society where physicians play rather authoritative roles in their relations with patients. Physicians' interactions with patients are relatively minimal and professional distance is maintained. In this situation, patients feel that nurses are the staff with whom they can communicate and to whom they can relate. Questions or concerns are addressed to the nurses, rather than the physicians. Nurses play the role of intermediary between physicians and patients and their families (see Chapter 1).

***Special Issues Relating to Nursing Care*****Assessment and Judgment of the Patient's Behavior**

In addition to general medical professional competency, nurses need to develop cultural competency in their care of medical patients in the same way as physicians. Competent nursing practice must include being able to negotiate care in an encounter where at least some of the beliefs, values, attitudes and experiences of the nurse and patient differ. It is appropriate for nurses to acquire specific knowledge about what possible aspects of a client's ethnic identity and cultural background may have a bearing on healthcare (Culley 2001). Cultural competence also includes learning how to observe and understand the patients', as well as their families', behavior from a cultural standpoint, so that proper assessment can be made and relevant care can be provided.

**Matters Related to Nurturing and Independence**

Even though nurturance for ill or disabled patients is a basic part of nursing care, careful consideration needs to be given to what nurturing care means for a given



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