Culture, cultural competence and the cross-cultural consultation: Culture and cultural competence

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VIEWPOINT

Culture, cultural competence and the cross-cultural consultation

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We are living in increasingly ethnically diverse communities with economic migration on top of significant movement of refugees. Adding to this diversity is variation in gender identity, sexuality, levels of disability, levels of education and socio-economic status. It has become apparent that our health-care systems are well designed to care for the dominant cultural groups but there are sometimes large health outcome disparities for those on the margins. In this viewpoint article, I will provide some tools to understand this diversity and how to try to provide equitable health care for all.

Cultural Competence

The regulatory response to this increase in diversity has been to mandate 'cultural competence'. In New Zealand, the health practitioner registration authorities are charged with setting standards 'of clinical competence, cultural competence, and ethical conduct'.[1] In Australia, the National Health and Medical Research Council produced a detailed document Cultural Competency in health: A guide for policy, partnerships and participation.[2] It is difficult to understand the concept of cultural competence without first addressing what culture is.

What is Culture?

Culture as a concept is used in several ways.[3] For our purposes, we are not talking about '[t]he cultivation of bacteria, tissue cells, etc. in an artificial medium containing nutrients'. Nor are we talking about '[t]he arts and other manifestations of human intellectual achievement regarded collectively.' Closer is '[t]he ideas, customs, and social behaviour of a particular people or society, [or] [t]he attitudes and behaviour characteristic of a particular social group'. Ramsden[4] who has written widely on this topic uses the definition:

> Being a member of a culture surrounds a person with a set of activities, values and experiences which are considered to be real and normal. People evaluate and define members of other cultural groups according to their own norms. (Ramsden 1992: 21)

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This definition highlights the sense that 'our' culture is normal and other groups are compared with our norms.

My favoured definition is Matsumoto:[5]

> a dynamic system of rules—explicit and implicit—established by groups to ensure survival, involving attitudes, values, beliefs, norms, behaviours, shared by a group, but harboured differently by each [individual] within the group communicated across generations, relatively stable but with the potential to change across time (Matsumoto 2000: 24)

This definition highlights that the concept is dynamic and harboured differently by individuals with the potential to change. The corollary of this is that any attempt to describe a 'culture' and be able to presume any member of that culture fits that description will at best provide only a partial description of the values and beliefs of that person and at worse lead to serious misunderstandings.

Despite this, every day we make assumptions on who people are, based on their gender, ethnicity, language or age. The movie *Cool Runnings*[6] is funny because we all know that Germans are precise and ordered and Jamaicans are happy go lucky. Hofstede has carried out extensive work on this phenomenon since his original paper in 1983[7] using extensive surveys all around the world. He argues that all cultures vary according to six main variables: power difference, uncertainty avoidance, individualism versus collectivism, gender difference, long term orientation and indulgence versus restraint.[8] The *Cool Runnings* example is confirmed by comparing uncertainty avoidance between the two countries: Jamaica is 75th (least avoidant of uncertainty), Germany 43rd (more avoidant of uncertainty) out of 76 countries.[8] Hofstede's measurement gives rise to the idea of cultural distance; the extent to which two cultures are similar or different. Like Matsumoto, Hofstede emphasises that there is as much variation within a country on each of these variables as there is between countries.

Culture is often confused with race or ethnicity but given the definitions above it is not limited to that. Other groups that would share a culture might include those who speak the same language, those of the same gender, followers of particular religious faiths and those with a shared disability such as deaf people. It is therefore likely that any individual is likely to belong to several 'cultures'. In short, everyone is different from me to a greater or lesser degree. I share some values and beliefs with other men, New Zealanders, people born in England, singers, married people, fathers, but my particular values and beliefs will only bear a partial relationship to any generalisation based on any of these groups.

Finally, I am a doctor. Ramsden's definition above is apposite to doctors as in medicine we think of medical culture as being real and normal. We would like our patients to be 'health literate' by which we mean that they understand their health in the way that we understand health. The views of patients who have a different understanding of health are described as 'cultural'; for example, a Chinese belief that ill health might be due to a 'wind' disorder from over indulgence in sex with prostitutes rather than depression.[9] Taylor[10] describes this well:

> Medical knowledge is understood to be not merely "cultural" knowledge but real knowledge. To change this situation will require challenging the tendency to assume that "real" and "cultural" must be mutually exclusive terms. Physicians' medical knowledge is no less cultural for being real, just as patients' lived experiences and perspectives are no less real for being cultural. (Taylor 2003: 559)

I think the most useful way to approach culture is to think of every consultation as a cross-cultural consultation (everyone is a different culture from me) and to apply our knowledge of how to conduct these consultations with every patient not just those that are obviously different.

Ethics

Given that culture is about values and beliefs it follows that what is 'right' is culture bound. Traditional bioethics argue that there is a common morality that:

> … Is the set of norms shared by all persons committed to morality. The common morality is applicable to all persons in all places and we rightly judge all human conduct by its standard (Beauchamp and Childress 2009: 417)[11]

There is a fundamental philosophical problem in this assertion. If two people disagree about what is moral, how can we judge who is right? Parekh[12] addresses this succinctly and argues that the only reasonable way to approach such a disagreement is through dialogue to decide how to proceed together (either within a diverse society or between a clinician and a patient) which could lead to reaching agreement about the dilemma but may lead to an arrangement where both parties can agree to differ. In a pluralistic society, this does not mean that there is no agreement on how to behave, as many ethical values are shared across different cultures. For those who think that ethical relativism is unacceptable based on a presumption that there are at least some universally held ethical principles, Parekh provides clear argument as to why this position is untenable. A central feature of most cultural competence policies is a respect for your patients and an understanding of their cultural beliefs, values and practices and not imposing your values on your patients.[13] The important distinction here is not that as a doctor you have to agree with what your patient thinks is right, but that you have to respect their right to hold their own views and where there is disagreement enter a dialogue to work out how to move forward. The intercultural development inventory[14] assesses the capability of people to operate interculturally. They describe a continuum from denial of cultural difference through to full adaptation. Traditional bioethics as exemplified by Beauchamp and Childress[11] clearly fits in the middle of this continuum of Minimisation where the own cultural view is viewed as universal. Deep cultural differences are obscured. Minimisation masks the recognition of own culture and the institutional privilege it affords its members. Other cultures are trivialised or romanticised. It asserts that deep down we are all the same.[14]

Understanding Self

An important consequence of being a member of a culture is that the world is divided into 'us' and 'them'. This may lead to an explicit bias for example many fundamentalist religious groups view homosexual people as being abnormal. These are acknowledged differences in values and belief that because they are explicit are open to discussion and debate. It is important to have good insight into your own explicit biases (e.g. opposition to abortion) so that you can plan in advance how to respond when these issues come up.

In addition, we all have implicit biases. These are biases that we are brought up to understand as 'normal' that we may not be aware that we have. An example of an explicit bias widely held by doctors is a bias against fat people. They are frequently labelled as being responsible for their own health problems and thus less deserving of other treatment, despite the evidence that very few fat people will ever significantly change their weight permanently without bariatric surgery[15,16]

Project Implicit at Harvard University have done a lot of work in this area and have developed an implicit association test.[17] There are tests looking at many variables but the most widely publicised measures implicit bias against black people. A meta-analysis of studies looking at implicit bias in health-care providers (mostly from the USA) showed that 26 of 31 studies found that most HCPs have some level of pro-White/anti-Black bias ranging from slight to strong.[18] My view is that this is measuring the way in which people are acculturated and does not necessarily (and in fact often does not) reflect explicit bias. It does not mean, for example, that a person with a strong implicit bias against black people is racist, it may just reflect the fact that they grew up in a southern state of the United States where such views were 'normal'. The usefulness of this work is that if you as an individual are not aware of your own implicit bias then you cannot do anything to compensate for it. A study of American cardiologists using vignettes of acute coronary syndrome showed that there was a correlation between implicit bias and the decreased likelihood of referral of black people for thrombolysis despite the cardiologists reporting no explicit bias.[19]

An area of particular concern is the care of people with limited English proficiency. Despite a comprehensive translating and interpreting service in Australia[20] the few studies in Australia on interpreter use show low uptake.[21,22] It seems that an implicit bias against 'foreigners' has to be part of the explanation of why doctors continue to see patients without being able to communicate with them properly.

Conducting a Cross-Cultural Consultation

At my medical school, we use the Calgary Cambridge guide to the consultation[23]as the basis for our undergraduate consultation

skills teaching. This is an evidence-based model of the consultation that is largely based on cross-cultural consultations as these are the most challenging. However, a widely promoted[24] simpler framework is the LEARN model.[25]

First you must 'Listen' with sympathy and understanding to the patient's perception of the problem. It is important that this is done in some detail before the physician discusses their perception of the problem. For example, a parent who does not believe in vaccination is much less likely to talk about that in detail if the physician has already put a forthright view in favour of vaccination. Next, the physician needs to 'Explain' their perception of the problem. Again, it is important how this is couched, for example, 'my view is that vaccination against tetanus is an effective intervention because …' rather than telling the parent that vaccination is best. Next is to 'Acknowledge' and discuss differences and similarities. This needs to be done in as neutral and exact a manner as possible; 'We are both interested in the best health of your son. I believe this would be improved by vaccination whereas you are not sure that it will be safe and whether the risk of tetanus warrants the risk of the immunisation'. You then need to 'Recommend' treatment and then 'Negotiate' an agreement.[26]

Conclusion

It is useful to consider all consultations as cross-cultural consultations with varying degrees of cultural distance. Navigating a cross-cultural consultation effectively entails having a good understanding of the concept of culture. It also requires an understanding of your own culture and in particular your explicit and implicit biases. To be successful in our diverse world, we need to develop intercultural competence. This is particularly important in Paediatric practice because of cultural variation in what is normal child rearing practice, and the difficulty of balancing these practices against the paediatrician's perception (from their particular cultural background) of the child's best interest.

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