Module I
INTRODUCTION TO CULTURAL COMPETENCY

Readings:

To be completed prior to the first session of this module. These articles are easy reads- short and to the point. Consider after reading each article how you think the situation could have been handled differently to produce a more positive outcome.

Reading I.A: Needham Phil, Wolff Derek. "Amputee to get $1.3 million in lawsuit over misdiagnosis." Vancouver Sun. Tuesday, March 27, 1990: Section B.

Reading I.B: Walton, Paul. "Medical system failed woman." Nanaimo Daily Free Press. Saturday, June 1, 1996.

Module Objectives:

Students will be able to:

1. define and differentiate between culture, race, ethnicity and cultural competency
   Relevant section: I.1
2. give four reasons for why the study of cultural competency is important for health care professionals
   Relevant section: I.2
3. define and provide several examples of health care disparities
   Relevant sections: I.2, I.3
4. list three sources from where they obtain their cultural information and provide an example of a belief or value they have learned from each of these sources
   Relevant section: I.4a
5. describe five characteristics of their personal communication style
   Relevant section: I.4b
6. list three behaviors displayed by others that trigger a negative reaction in themselves and a reason as to why each behavior may not be viewed as offensive by the person displaying it
   Relevant section: I.4c

HOUR 1: LECTURE / DISCUSSION

TIME: 10-15 minutes

MATERIALS:
Overhead I.1A:Terms

I.1 Establishing a Common Language

The terminology of cultural competency is widely misused and misunderstood. This section clarifies terms and provides the foundation of understanding upon which you will develop new insights and communication skills.

How would you define the following: culture, race, ethnicity, cultural competency. Consider the differences between each term, then view *Overhead I.1A:Terms* and discuss the following based on the definitions given:

- What is culture?
- What is race?
- What is ethnicity?
- What is cultural competency?

TIME: 45 minutes

MATERIALS:

Overheads

I.2A:Demograph.Can

I.2B:Demograph.BC

I.2C:Demograph.All

I.2D:Disparities.Def.

I.2E-1 & I.2E-2: Disparities.Can

I.2F:Acts

I.2 Rationale: Why Should You Learn to Become a Culturally Competent Clinician?

1. Demographics

The ethnic makeup of Canada is changing, and part of being an effective health practitioner is to know your patients/clients.

Observe the trends in *Overheads I.2A:Demograph.Can, I.2B:Demograph.BC and I.2C:Demograph.All*. British Columbia has the most diverse population in the country; in 2001, 21.6% of the province's residents belonged to a minority group, which is up from 17.9% just five years earlier in 1996. Vancouver is the most diverse city in Canada, with 36.9% of its residents belonging to a minority group in 2001. Consider the implications of this for your future practice.

2. Health Disparities

What do you think is meant by 'health disparities'? View the definition given on *Overhead I.2D:Disparities.Def*.

View *Overheads I.2E-1 and I.2E-2:Disparities.Can* and discuss the findings in terms of their possible causes or explanations. For example:

What are some possible explanations for why immigrants and non-white ethnics use fewer services than the general population? (e.g. are they perhaps healthier due to cultural practices in maintaining health? Could it be because they do not seek out such services as often as their Canada-born counterparts due to language barriers, distrust, or other hindrances? etc.)

What cultural explanations might there be for why fewer pap smears are being done for First Nations women than women of other ethnic backgrounds?

What role could clinicians play in the development of these health disparities? (e.g. their own cultural biases/stereotypes, misunderstanding or misinterpretation of the patient's/client's description of the problem, etc.)

Can you think of any other examples of health disparities?

3. Costs

Identify ways in which improper communication between a clinician and their patient/client might result in excessive costs- both monetary and otherwise. Some examples:

- The health professional might engage in "defensive testing," where as a result of lack of understanding of the patient's/client's concerns the clinician performs many more tests than are necessary
- Incorrect diagnoses may occur, causing more resources to be used up as clinicians try to determine the real problem
- Patients/clients access emergency services more often
- The patient's/client's life may be put in danger as a result of a misdiagnosis or being given the incorrect medication

4. Law and Liability Issues

View *Overhead I.2F:Acts* and consider how this pertains to the provision of culturally competent care.

In 2005, the Canadian Council for Health Services Accreditation (CCHSA) will be releasing cultural competency standards/requirements that will be legally enforceable. The preliminary draft of the standards is expected to be released for review in early 2004.

While lawsuits regarding malpractice are nowhere near as common in Canada as they are in the U.S., legal action is still a very possible consequence of negligence. Some examples of cases where patients/clients suffered as a result of lack of communication and understanding are provided in your readings.

The bottom line is that if as a health practitioner you don't offer culturally competent care you may be putting yourself or your organization at risk.

HOUR 2: LECTURE / DISCUSSION / ACTIVITY

I.3 What Does Cultural Competency Look Like?

TIME: 20 minutes

MATERIALS:

Overheads

I.3A:Model

I.3B:Model

I.3C:Model

Culture is a framework that shapes and directs the way we behave and the way we interpret other people's behaviors. It gives us a set of rules for how to interact with others, how to express ourselves and how to deal with conflict. Culture influences the way we experience illness, and how we express illness, pain and our health care decisions.

Culture is not always visible- it is not the color of someone's skin or the clothes they wear. We are usually unaware of how culture influences our behavior and assume that our cultural rules are the norm. Cultural competence does not come naturally; it is human nature to think that our culture is the "best" and to use our cultural rules as a basis of comparison or judgment for people who are different from us. The first step to becoming culturally competent, therefore, is to examine our own cultural norms and values.

View *Overheads I.3A:Model and I.3B:Model*. These models can serve as a framework to describe the cultural competency continuum, and can be useful at a personal, workplace or institutional level. It should be noted that while visualizing cultural competency in terms of a continuum can be helpful, cultural competency is not simply about progression from one stage to another. One may have "advanced competence" in some respects but may be "culturally destructive" in others, and it is possible to regress from one "stage" to another. Cultural competency is a skill that is always changing and always evolving. Consider the following:

Think about where you would currently place yourself along the continuum, and where you would like to be upon completion of the training.

What problems might be encountered at each stage of the continuum? e.g. someone who is culturally blind might overlook an important cultural influence in assessment of a new patient/client, someone who is culturally destructive might never earn the trust of his/her patient/client, thereby seriously hindering his/her ability to provide care.

View *Overhead I.3C:Mode*l to understand the long-range goal of the training. Cultural self-awareness, knowledge and skills are all critical elements in the delivery of culturally competent health care. Their relationship to one another can be likened to the three legs of a stool: all three must be present to maintain cultural competence, and the absence of one undermines the effectiveness of the others.

I.4 Learning Activities:

The first step to achieving cultural competency is to look within ourselves at the things which drive us to do the things we do, think the way we think, and act the way we act. The following activities are designed to make you aware of your own cultural norms and values.

a. Origin of Values and Beliefs

TIME: 30-45 minutes

MATERIALS:

Pen and Paper for Students

Flipchart / Overhead Markers

Type of Activity*:* Discussion – small or large group

Purpose: To help students become more aware of their own cultural norms and to identify the origins of these norms

If you wish, break into small groups.

Think about how you acquired your cultural beliefs and attitudes. What were the sources of your information?

> Give examples only if they are struggling e.g. parents/family, religion, where they grew up, health professions education/training, friends, travel, etc.

As a group, write down each source of cultural learning on an overhead/flipchart, leaving space between each source.

In the space you have left after each listed source, write down examples of values, beliefs and rules you have learned from that source (you may want to focus on only a few sources from your list). Write down how these values and beliefs affect your work as a clinician.

Use some or all of the following questions for discussion:

- What were the most important influences that shaped your values and beliefs?
- How have your values and beliefs changed over time?
- What caused these changes?
- How might values and beliefs from one source conflict with those from another?

- How do you reconcile these differences?
- How do your beliefs and values influence your work?
- How does your work influence your values and beliefs?
- How does working in a diverse environment challenge your beliefs and values?
- How can your understanding of the sources of your cultural learning help you in your job?

HOUR 3: ACTIVITIES

TIME: 30 minutes

MATERIALS:

Overhead Projector,

Overhead I.4A: Communication

b. Communication Styles

Type of Activity: Lecture / discussion

Purpose: To help students identify their own personal communication styles and consider how different communication styles affect clinical interactions.

While we may assume that the most important aspect of communication is verbal, in fact we communicate much of our meaning nonverbally. Interpretation of this non-verbal communication can be especially difficult when the interaction is between two people from different cultures. Assuming that everyone shares our communication behaviors and preferences can lead to misunderstandings.

In the clinician-client/patient encounter, there are a number of communication cues to be aware of in order to conduct an effective interview. View Overhead I.4A:Communication, and go over each of the elements of communication. The following is a list of discussion questions for each point:

- *Language:* What language do you prefer to practice in? Does your patient/client share this language, or is there a language barrier? How can you tell? There is a common misperception that people with an accent do not speak English fluently. Remember that language barriers can also exist even when both you and your patient/client speak the same language (e.g. technical terms, medical jargon, idioms, etc).

- *Degree of directness*: What degree of directness do you prefer? Do you appreciate direct, concise answers or do you have an affinity for lots of background information from which answers can be gleaned? What degree of directness do you think is valued in Canadian culture? Most Canadians born in Canada fall on the direct end of the direct-indirect spectrum of communication, although women are generally more indirect that men in our culture. What happens if a clinician who values direct communication is working with a patient/client who doesn't answer questions directly? How can this difference be reconciled?

- *Facial expressions/gestures/eye contact*: When you communicate with others, what does your expression look like for various emotions? When you are happy? Sad? Angry? Do you like to make a lot of hand gestures or do you prefer to communicate primarily with words? How much eye contact are you comfortable with? What do these variables/preferences look like in general in our culture? Do you think your preferences for these variables are in alignment

with Canadian culture? These vary widely by culture. For example, smiling can be a sign of embarrassment or confusion in some Asian cultures, Aboriginal individuals may view a lot of direct eye contact as being disrespectful and the use and meaning of hand gestures varies greatly.

- *Touch*: What is your comfort level in terms of personal space and touching? What do you think is the cultural norm for this variable in Canadian culture? Remember that different cultures have different rules about who can be touched and where.

- *Speaking Style*: What is your speaking style like – do you speak quietly, loudly, quickly, slowly? How would you describe your pitch? Are you an animated speaker or are you more reserved? What kind of reactions have you found your speaking style elicits from others? In general, how would you describe the speaking style of Canadians? Remember that what is considered a normal tone of voice in one culture may be considered aggressive and angry or passive and childlike in another culture. In addition, people may speak more loudly when they are interacting with someone of limited English ability. How do you think that makes an individual feel? What are more effective ways of bridging language barriers? (e.g. speak more slowly, use simpler sentences, avoid idioms and technical terms.)

- *Silence*: How comfortable are you with silence? How long can you stand silence before you feel the need to fill it, or are you content to let it go on as long as necessary? Silence makes many Canada-born Canadians uncomfortable. What are some explanations for silence? (time to think, lack of understanding, discomfort) What is the meaning of silence for you?

- *Appropriate subjects for conversation*: How open are you? Are you willing to talk about anything or are there certain subjects that make you feel uncomfortable? If you were forced to talk about such a subject, how would you react and how would you feel? This variable is very different between cultures- in some, thoughts, feelings and problems in general are kept to oneself, in others, many topics are open to discussion but there may be a few that are 'off-limits' (e.g. sex, birth control.) How might this affect the patient/client-clinician interaction? If you were a patient/client being asked by your clinician about something that made you uncomfortable, how would you want your clinician to handle the situation? How would you react? How would you feel?

- *Status / power*: What are your thoughts on family hierarchy? To what extent do you feel that certain members of the family (e.g. parents or spouses) should

have a say in a patient's/client's health care? How does it work in your family? What situations have you witnessed or been a part of where status or power struggles played a central role? How do you think someone who viewed clinicians as authority figures would behave differently from someone who saw the relationship as a partnership?

Identify other elements of communication that may have been omitted and apply them to yourself, thinking about how the elements could affect health care experiences.

c. Recognizing Your Own Behavioral Triggers

TIME: 30 minutes

MATERIALS:

Handout I.4A: Worksheet

Pens for Students

Type of Activity*:* Discussion / small groups

Purpose: To explore emotional reactions to specific behaviors and to begin to understand the cultural sources of these behaviors.

Different communication styles can trigger emotional reactions. How do you feel when someone does not make eye contact with you or when he/she shows no facial expression when you speak to him/her? We may experience frustration, irritation or confusion when someone behaves in a way that does not correspond to our preferences. This is more likely to happen in interactions in which people do not share cultural backgrounds.

This exercise is to help make you more aware of your own behavioral preferences and reactions to behaviors that challenge those preferences. The more self-awareness we possess, the greater our understanding of the role of culture in communication, and the less likely we are to feel annoyed or frustrated when we encounter differences.

Obtain a copy of *Handout I.4A:Worksheet* and put a check next to the behaviors you find to be the most difficult or frustrating. Write down your typical reactions to the behaviors you checked as well as reasons you find the behaviors irritating. Take about 10 minutes to do this.

When you are finished, break into groups of 3-5 and share your responses with other group members, working together to try to identify possible cultural explanations for the behaviors. In doing so, consider the following questions:

- Do any of the group members have opposing views on any of the behaviors? What explanation does each person offer?

- Are there any behaviors commonly checked by the group to be irritating? Why do you think that might be?
- What might be the explanation of someone who engages in such a behavior?

Come back together as a class after about 10 minutes.

Instructor should lead a short discussion on the participants' new insights and perspectives. Finish by encouraging students to explore possible cultural explanations for a behavior when faced with challenging interactions.

I.5 Evaluation:

Sample exam question:

Describe three reasons why cross-cultural communication training is important for today's health care practitioners.

Possible Answers:

- *demographics plus something about how Canada/B.C./Vancouver is becoming more ethnically diverse*
- *health disparities plus something to indicate student understands what is meant by the term e.g. population-specific differences related to: utilization of services, health outcomes, access to care, poorer overall health, social, economic, cultural and other barriers to optimal health*
- *costs plus something about the types of costs e.g. that there are both monetary and personal costs involved or an example of such a cost*
- *law and/or liability plus something about either the Canadian Health and Human Rights Acts, the new standards coming out in 2005, reference to the two readings given or that by not offering culturally competent care you put yourself and your organization at risk*

Sample assignments:

Note: The instructor is free to determine his/her own marking scheme, but due to time constraints with marking may want to consider grading the following suggested assignments on a complete/incomplete basis.

1. Describe in several paragraphs your most influential sources of cultural learning (that which helped shape your own values and beliefs and what gave you ideas about other cultures, e.g. parents, religion, community, etc.) Be sure to address the following in your answer:
    - Why have these sources been important to you?

- Have multiple sources had conflicting views on the same topic?

  If yes, how did you resolve this conflict and come to form your own opinion? If no, describe a situation that challenged your beliefs about a specific topic.

2. Provide examples of the beliefs/values you have acquired that can be credited at least in part to the influential sources you choose to describe.

   a. Describe one cultural belief/value you hold (e.g. your opinion on family hierarchy/family roles, level of autonomy, use of alternative medicine, etc.)

   b. Ask someone of a culture different from your own (e.g. a friend, classmate) his/her thoughts on your chosen belief/value.

   c. Compare and contrast the two opinions in several paragraphs. Be sure to address the following in your answer:

      - Does your partner's opinion differ from your own?
      - On what are the opinions of you and your partner based?
      - Do you have common influences?

I.6 References: Introduction to Cultural Competency

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