Chapter 1.3.1

INTERCULTURAL COMPETENCE IN RURAL MEDICAL PRACTICE

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Cultural competence: conceptualisation and institutional

Cultural competence in health care can be simply and practically conceptualised as the ability of systems and people within them to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural, and linguistic needs (1). Other terms for cultural competence which have slightly different meanings include 'cultural responsiveness', 'cultural awareness' and 'cultural sensitivity'. The term 'intercultural' is also frequently used to indicate that science is also a cultural model and health professionals are also entwined in cultural nets.

Life and death, illness processes and the search for relief are all complex and are always culturally lived. Failure to provide culturally appropriate care can lead to patient dissatisfaction, poor adherence and adverse health outcomes (2); it can also be related to dissatisfaction of health professionals. Cultural competence skills must therefore be included in the curricula of all health professionals.

Health systems and cultural competence

Cultural competence is considered a characteristic of good medical practice and of an adequate health service and/or system (3). The more a health system is oriented to primary care, the closer it will come to achieving cultural competence, given primary care's characteristics of continuity, comprehensiveness, co-ordination, and decentralized access. This is further supported by ensuring that cultural competence is embedded in the philosophies, mission statements and policies of health educational institutions (4), and health services.

Some features of a health system that help to attain better cultural adequacy include using territorial definitions of the populations served; ensuring there are adequate population:health resources[1]; decentralized policies; the use of local and regional diagnosis as the start point of planning actions; and ensuring some continuity of professionals[2]. (This is especially important in rural and remote areas, considering the shortage of health professionals in these areas (5).)

Local information

There tend to be clear cultural differences between rural communities and those living in urban centres; and there is a strong feeling in rural communities that they are different from, and have special qualities not found in the cities (6). In addition there are often significant cultural differences between communities in rural areas – so assumptions cannot be made about the homogeneity of rural people.

Stereotyping prejudices and the perceptions of heterogeneities inside groups often leads to preconceptions and discrimination. This does not mean that common characteristics cannot be useful when used carefully, however. Local demographic and epidemiologic patterns, as well as anthropological information, can be helpful and should be made accessible to health professionals and students wherever possible.

While geographical access to health services is important, for a health service to be fully accessible it also needs to address other factors – like language, gender sensitivities, hours of opening – which would contribute to guaranteeing cultural competence and greater accessibility (7).

1 The ratio of people / health teams matters in the sense that 'cultural competence' (medical quality, access, continuity etc) are very hard to achieve when there are not enough health professionals to properly serve the people.

2 When health professionals move often it can take them time to learn the 'cultural issues' in an area.

Educational, training and health care processes

Cultural awareness among health professionals

The Wonca Working Party on Rural Practice's *Policy on Rural Practice and Rural Health* (8) and for indigenous health (9) recommended that health professionals receive education and training in cultural awareness – and it is indeed important that all those involved in educating health professionals are trained in diversity and cultural questions.

Wherever possible, diversity among educational staff (at all institutional levels) should be correlated to local and regional patterns (4). Some professional recruitment and retention strategies for rural areas can help to democratise access to health schools, through decentralising institutions and facilitating training positions which enhance the representativeness of minorities (10).

In addition, the importance of language in health care and cultural competence should never be underestimated. For example, physicians' self-rated language ability were independently associated with patients' reports of interpersonal processes of care in patient-centered domains (11).

Rurally-oriented medical education

Experiences of different kinds of rurally-oriented medical education (12) has shown it to be as good as, or even better than (13), their urban counterparts. One of its strong points has been the added value of culturally lived health experiences. Students based in tertiary hospitals did not mention continuity or the importance of understanding a patient's cultural background, as rural students did (14).

Culture in the curriculum

The Wonca Working Party on Rural Practice's *Policy on Rural Practice and Rural Health* (8) recommends that people of different cultures be engaged in the design, execution and evaluation of education, including vocational training schemes.

Cultural issues need to be included at every stage of the educational curriculum, starting at the beginning (15). They can be included at the pre-clinical and clinical undergraduate stages; as part of the humanities topics covered in the medical curriculum (16); as part of internet-based (17) and postgraduate activities, as well as immersion experiences (18). It is important that cultural issues be seen as a transversal and progressive subject (19) – and it is better to focus initially on real people and their contexts and then to progressively develop the theory and techniques from these case discussions (2).

The health education curriculum must make efforts to change its approach to treating the question of cultural competence as a moral virtue of professionals, something almost altruistic, to rather thinking of it as a standard attribute of good practice and an indispensable skill of all health staff, since cultural sensitivity is embedded in every health care contact (20).

Promoting intercultural competence

Four steps are suggested to improve cultural competence:

1. Sensibility
2. Information
3. Techniques
4. Practical experiencing

Sensibility

The idea of 'culture'

Sensibility includes the perception of one's own culture and of medical science as cultural, despite its tendency to see itself as a 'culture of no culture' (21). It is important to discuss the false idea of culture as something that exclusively competes with or disturbs the ongoing preconception of a non-cultural science. The consequent posture of these preconceptions is that the scientific project must 'purify' all cultural and social interferences through biological processes, to better treat people.

The idea of culture as something static or crystallised must also be questioned as when cultural identities are judged by past behaviours or material elements what often results is a reduction of the notion of 'culture' to the exotic, reinforcing the idea of the otherness of culture. (For a review of the spectrum of cultural concepts, see Stocking Jr (22), Kuper (23) and Eriksen and Nielsen (24).)

Culturally appropriate care

It is important to start from an understanding that the processes of life-illness-searching for help-death is complex and a culturally lived experience. As seen earlier, a failure to provide culturally appropriate care can lead to dissatisfaction of all involved, as well as poor adherence and adverse health outcomes. The triad of empathy, curiosity and respect must be encouraged (2).

Information

The information step should initially focus on the characteristics of each context and on specific minorities and how these aspects relate to epidemiologic and demographic data, as well as cultural information.

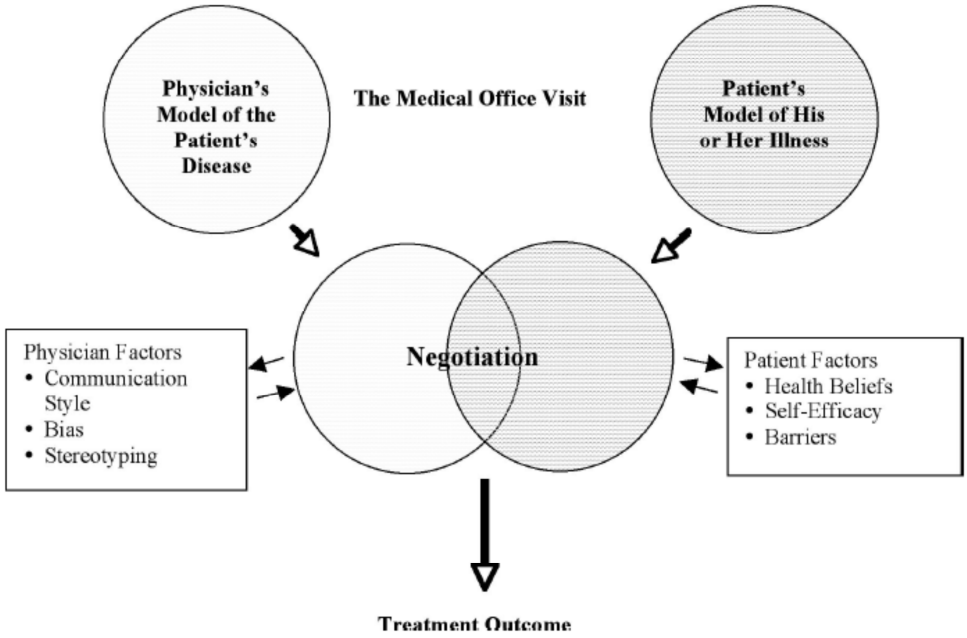
Rather than attempting to learn an encyclopedia of culture-specific issues, however, a more practical approach is to explore the various types of problems that are likely to occur in cross-cultural medical encounters and to learn to identify and deal with these as they arise (2). This kind of 'cultural information' must be continuously updated, as should epidemiologic and demographic data. The different cultural concepts that impact health care (25) can probably be better learned during clinical years where there is already practical experience of individual care and clearer results of its applicability.

Techniques

While many techniques have been developed to help health professionals improve their levels of intercultural abilities, these cannot be successfully applied alone nor without undertaking the previous steps of sensibility and information. These questions and attitudes must not be simply added in an anamnesis routine, however, without deep and individualised reflection.

One common starting point is the Explanatory Models of Illness and Disease (26) – in Figure 1 below. In this theory, the process of illness is seen by health professionals and patients in two different ways. The term 'disease' is used to define the physician or biomedical model of explaining symptoms, etiology, prognosis and better actions to take - while 'illness' is about the way in which the patient, his/her family and cultural group 'see things'. In this way, the role of intercultural competence remains in a middle space of exchange and negotiation - all with a view to establishing a good therapeutic outcome.

Figure 1:
Explanatory models of illness and disease



For this negotiation the LEARN rule can provide a useful guide (27). This mnemonic consists of:

- **L**isten: Listen with empathy and try to understand the other's perception.
- **E**xplain: Explain in accessible words the medical view of the problem and diagnostic or therapeutic options.
- **A**cknowledge: Acknowledge and discuss the differences and similarities.
- **R**ecommend: Recommend actions and/or treatment.
- **N**egotiate: Negotiate agreement.

There are other mnemonic rules and explanatory models and frameworks which are also useful (28, 29) - including the introduction of mapping therapeutic itineraries, making visible the relation between health systems (official or not).

The point that these new discussions can offer is that the negotiations between parts should not be restricted to values and ideas but also to which actors and concrete things in the worlds involved in health process must be mobilized to reach the agreed objectives. So the issue for cultural competence extends to all the abilities and knowledge used by primary health care teams in the care of patients, families and communities. It cannot be reduced to an exoteric discussion about beliefs, which many physicians may find difficult, and makes the work much harder. So, for example, constructing a narrative of an illness can be done by asking the following questions (30):

1. How do you describe this problem?
2. What do you believe is the cause of this problem?
3. What course do you expect it to take? How serious is it?
4. What do you think this problem does inside your body?
5. How does it affect your body and your mind?
6. What do you most fear about this condition?
7. What do you most fear about the treatment?

One way of taking forward this intercultural perception and communication is through something like a 'mini-ethnography' (alluding to the core methodology of anthropology) (22). This could entail the professional and health team doing the following six things:

1. Identify ethnic identities, without stereotyping. Sometimes, the best way to start it to simply ask the patient about ethnicity and its salience.
2. Define what is at stake in this specific episode of illness, in an individual and broader perspective.
3. Reconstruct the illness narrative (see questions 1-7 above);
4. Consider psycho-social stresses that may be associated – and construct a list of possible interventions together.
5. Perceive the influence of culture on clinical relationships. Critical self-reflection can produce the unsettling but enlightening experience of being between social worlds (for example, the world of the researcher/doctor and the world of the patient/participant of ethnographic research).
6. Take into account the question of efficacy and the problems of a cultural competency approach. Be aware of the potential side-effects of this (see Table 1 below).

Table 1:
Potential mistakes in, and side-effects of,
the cultural competence approaches

Intrusion	Sometimes people, families or communities have a cultural interest in a therapeutic process, seeing it as inadequate or intrusive. This can happen especially when cultural problems are hyper-valued or when a difficult symmetrical dialogue takes place between science and other knowledge systems.
Evolutionism	Transforming distances in time (31), where science and occidental lifestyle are the parameters of judgement of all other forms of lived and known reality. Medicine becomes the moderniser or saviour of others and of their delay.
Homogenising identities	Stereotyping produces a tendency to overlook internal differences that can be important – and has the potential to impoverish practice and negatively discriminate. It is useful to be careful in some situations.
Reduction of culture to exotic aspects	Forget that our own culture and science, as health professionals, are parts of a cultural system – producing a tendency to be ethnocentric.
Crystallization of culture	Condemn people to immobility, barring them from living as they want to. Discrimination because of 'culture lost' can occur.
Hyper-valorisation of culture and culture competence	The illusion that when cultural aspects are identified the problems will automatically be resolved. It can also delay the discovery of other relevant aspects.
Neglect cultural aspects as 'social interference'	Seeing cultural aspects as 'social interference' sacrifices the possibility of understanding and help. This narrowing of the net involved in such health processes diminishes the potential of therapeutic encounters.

Practical experiencing

All practical training and practice must be directed at establishing an empathic climate which includes various worlds and points of view. This is important not only in individual consultations but in all contacts between the health professional and their community - especially in rural and remote areas and small cities where relationships are often closer.

Cultural aspects can be more effectively addressed when they are included in all students' and residents' activities – such that non-contextualised discussions are avoided wherever possible. There needs to be a deep understanding of the possible problems inherent in the cultural competence approaches (see Table 1 above) and be included in learning activities.

Community health workers can provide an important intercultural bridge. They can help with many tasks of the health team such as picking up various heterogeneities in a community, identifying sub-groups at special risk, learning local expressions and local values, and identifying regional non-official resources in health that are references for population like traditional healers, prayers, midwives, people who knows herbs and natural medicines. Respectful relations must be established with these other systems and co-operation must be attempted whenever possible.

Anthropology's contribution

This approach to cultural competence can sometimes erroneously be seen as too 'mental' or semiotic, since it is derived from an interpretative approach in social anthropology, led by Clifford Geertz (32). The idea that intercultural health encounters provide the challenge to create bridges exclusively between points of view of an external reality, presents health professionals with serious difficulties. In some situations there is a feeling that it is not enough - or conversely that the situation is brimming with ethical questions in which physicians feel caught between yielding too much to non-scientific theories/ being seen as negligent and being too yielding / being ethnocentric.

Recent advances in anthropological theories (33, 34, 35, 36) can help to further develop this co-operation between social and health sciences to provide better health care in relation to the needs of various people (20). Perhaps the main question is about the possibility of a really symmetric dialogue between points of view which are as differently empowered as medical science (disease) and others

(illness) – given that one of these poles always thinks that it has privileged access to something that the other does not, namely 'reality'. It is not a matter of whether or not scientific method is valued as better than other ways/methodologies of dealing with natural challenges that humanity faces. It is also not a matter of knowing if the results obtained in many areas through science are real or not, but rather what the exact reasons are for this; and, especially, what everyone can learn from each other, with these diverse of forms of knowledge.

Ten key questions for organisations striving for cultural competence (4)

1. Is cultural competence embedded in the philosophy, mission statement, policies and key objectives of the organisation?
2. Are culturally and linguistically diverse staff employed throughout the hierarchy of your organisation?
3. Have you ensured that all staff receive comprehensive training for cultural competence on commencing employment?
4. Are resources on cultural competence and ethno-specific information readily available to employees in the workplace?
5. Has a cultural self-assessment of your organisation been conducted, and if so, have strategies been implemented in the areas identified as needing further improvement?
6. Do you have a strong understanding of the cultural profile of your local community?
7. Are employees encouraged to be flexible in their approach and seek information on specific cultural behaviors or understandings so that interactions with staff, clients and partner organisations are sensitive to cultural differences?
8. Does higher management actively promote the benefits of cultural competence?
9. If you are delivering essential services do you have an adequate translating and interpreting policy?
10. Is there a system of incentives or rewards for initiatives in the workplace which are culturally competent?

Looking forward

It is not possible to reproduce here all the possibilities for future research on cultural competence but it is important that a reflection on the limitations of current theories and techniques be made and complements or alternatives looked for. It is especially important when researchers (37) conclude that some academic family medicine practices are frustrated and are challenged to integrate cultural and linguistic competence into patient care.

Finally, periodic evaluations of intercultural abilities and users' perceptions of cultural adequacy need to be undertaken, as well as feedback remodeling actions. These evaluations must address all levels of learning and practice - like sensibility, information, techniques and lived experiences as well as all organisational, educational and practical levels. The involvement of community members and the stimulation of collegiate councils are strongly recommended.

Practice pearls

What to do

Health policies, educational institutions and training positions

- Reinforce primary care characteristics such as continuity, comprehensiveness, coordination, decentralised access.
- Embed cultural competence in the philosophy, mission statement and policies of health educational institutions and all health policies.
- Ensure cultural diversity (including racial, gender, minority identities) in all involved in educational process according to local context.
- Democratise access to health undergraduate and postgraduate education and decentralise institutions and their training positions.
- Train all professionals involved in educational process in cultural competence.
- Facilitate access to demographic data, epidemiologic patterns and anthropologic researches.
- Facilitate access to adequate information for users and cultural accessibility.
- Have professionals skilled in translation and intercultural intermediation available when health professionals are not proficient.

- Periodically evaluate health professionals' intercultural abilities. This must address sensibility levels, information, abilities (techniques) knowledge and practical experiences/ performance.
- Evaluate users' perceptions of the cultural adequacy of health services.
- Implement incentive, dissemination and rewards systems.
- Involve community members, stimulate collegiate councils.
- Secure faculty time, teaching time, and funding for cultural competence curriculum.

Teaching process and care practice:

- Include cultural competence as a continual process throughout all training - passing through stages of sensibility, information, techniques and practical experience - rather than treating it as an ability to be acquired in a single moment.
- Integrate components of cultural competence into different aspects of the educational curriculum so it is not viewed as an added burden.
- Integrate the issue into scheduled activities by discussing cultural aspects in all activities with students and residents, especially in clinical years - in clinical cases, seminars, rounds, etc. - to ensure it is not addressed only in theoretical non-contextualised discussions.
- The educative process must achieve:
  - ❖ recognition that life and death and the process of becoming ill are complex and culturally lived;
  - ❖ acknowledgement of cultural competence as a Primary Care and general good medical practice;
  - ❖ recognition that a failure to provide culturally appropriate care can lead to patient dissatisfaction, poor adherence, and adverse health outcomes;
  - ❖ recognition that all health professionals belongs to a culture; that there is no totally neutral science and that culture is not only a feature of someone else;
  - ❖ understanding that the same disease can be perceived and lived in different ways by each person, family, community (and health professional) – that there are different notions of 'disease' and 'illness';
  - ❖ understanding and use of the explanatory models, the LEARN rule, the mini-ethnography, mapping of therapeutic itineraries;
  - ❖ the importance of accessing information about more common local beliefs, behaviours, values;

- ❖ capacity of work with interpreters and health community health workers;
- ❖ ability to establish a respectful and, when it is possible, co-operative, relationship with traditional healers.

What not to do

- Do not insert punctually but transversally the training of cultural abilities and experiences in curriculum;
- Avoid working with notions of:
  - ❖ culture as something that competes with or disturbs the ongoing concept of a 'non-cultural' science;
  - ❖ culture as something static, crystallised;
  - ❖ reducing culture to exotic aspects;
  - ❖ identities as homogeneous blocks; and cultural competence as encyclopedic data about each culture which can simply be memorised.
  - ❖ stereotyping groups, while acknowledging the presence of common attributes;
  - ❖ cultural competence as a way of knowing the other, convincing them to 'do what is right';
  - ❖ cultural difference as temporal; do not use medicine to 'modernise the primitive';
  - ❖ cultural competence as a moral attribute rather than a medical skill.
- Do not hyper-estimate the value of cultural aspects in all cases.
- Avoid incorporating the techniques and questions about culture in an automatic way in an anamnesis routine.

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