Culturally Competent Care

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Why is it important?

- 2009: 27 million refugees and immigrants - 10%
- 2008 US Census: Minorities now 33% of US pop - majority by 2042
- Increasing ethno-cultural diversity in US
- Health care policy and practices
- Principles of CCC apply to all patients
- Focus on Refugees and Immigrants
Ethno-cultural diversity
Challenges facing refugees/immigrants in the clinical encounter

- Language barriers
- Differences in held values and cultural practices
- Deficits in cultural competence of providers
Definition of CCC

• High quality care delivered in a culturally sensitive manner
Objectives

• Levels at which culturally sensitive care occurs.

• Frameworks for clinical use.
Levels

- Individual level
- Group Practice level
- Institutional level
Individual level- what counts?

- Good communication
- Trust
- Relationship
The Community House Calls Program of Harborview’s Interpreter Services

• Works to “contribute to the health and well being of refugee and immigrant patients, families and communities through a partnership that promotes culturally competent care.”

• Community House Calls’s case worker/cultural mediators are bilingual and bicultural and deliver services to providers and patients in English and Amharic, Cambodian, Tigrigna, Spanish, Somali and Vietnamese.
From Community House Calls’ Caseworker/Cultural Mediators

- Show patience
- Allow patient to tell their story
- Don’t be paternalistic
- Apologize if you are late
- Give ideas of how to move on
More from the Caseworker/Cultural Mediators

• Open discussion first
• Emphasize working together (eg. TB)
• Knowledge of patient’s background
• Don’t give too much choice
Good communication

• Verbal – competent interpreter who the patient trusts
• Non-verbal- patience
  - kindness
  - respect
  - demonstrate an interest in understanding culture of pt
  - etiquette/ greeting
Trust

• No racism, prejudice or bias
• Pt must feel valued and understood
• Authority figure- be careful what you ask
Relationship

• Through good communication and trust relationships are built with patients
Example of an approach
Brief History from 1970

• 1970- General Nol

• 1970-1975- Growth of Khmer Rouge

• 1975- Khmer Rouge under Pol Pot
• 1975-1979 - Reign of terror

• “Super Great Leap Forward”

• Approximately 2 million eliminated (25% of the population)
• Many Cambodians fled to refugee camps
• 1979- Vietnamese ousted Khmer Rouge
• United States accepted over 180 000 Cambodians
• 3 groups- 1975, 1979, since 1980.
Case presentation: Mrs. N.

• 57y.o. female with Depression. Never complained of PTSD symptoms.

• “New” symptoms:
  – Nightmares
  – Anxiety
  – Startles easily
Mrs. N.

• PTSD triggered by MVA

• Discovered she had “ghost sickness”

• Treatment- added Prazosin
Case illustrates

- Knowledge of cultural background important in understanding context of PTSD symptoms
- Importance of trusting relationship which enabled her to feel comfortable enough to share her symptoms
- Culture specific syndromes- not expected to know this detail, but bonus when you do!
- CCC at an individual level
Connection

• Not always possible to gain knowledge/background ahead of time in order to increase the chance of connection with a patient

• It is important to be open to unexpected chances of connection
Group practice level-what counts?

- Access to services
- Reminder calls- language; calender
- Continuity of care
- Respect- from the front desk to the exam room
Institutional level- what counts?

- Support of programs like Housecalls
- Interpreter services
- Hiring practices- diversity in the workforce
- Cultural Competence training programs
- Policies that ensure a fair environment for all personnel and patients
Frameworks for increasing cultural sensitivity and awareness

- DSM IV Cultural Formulation
- Kleinman’s Eight Questions
- The ADDRESSING framework
Cultural Formulation

- Cultural Identity
  - country of origin
  - migration history
  - ethnic or cultural reference groups
  - degree of involvement with culture of origin/ host culture
  - language abilities
Cultural Formulation

- Cultural Explanations of Illness
  - idioms of distress through which symptoms are communicated
  - meaning of symptoms to pt
  - perceived severity
  - explanatory model pt/ family using to explain illness
Cultural Formulation

• Cultural Factors related to Psychosocial Environment and Level of Functioning

  - available social supports
  - level of functioning/ disability
  - role of religion/ kin networks
Cultural Formulation

- Cultural elements of individual/clinician relationship
  - difference in cultural and social status
  - problems these differences might cause in diagnosis and treatment
Cultural Formulation

• Overall cultural assessment for diagnosis and care
  - how cultural considerations influence comprehensive diagnosis and care
Arthur Kleinman’s Eight questions:

1. What do you think caused your problem?
2. Why do you think it started when it did?
3. What does your sickness do to you? How does it work?
4. How severe is your sickness? How long do you expect it to last?
5. What problems has your sickness caused you?
6. What do you fear about your sickness?
7. What kind of treatment do you think you should receive?
8. What are the most important results you hope to receive from this treatment?
ADDRESSING FRAMEWORK

• Age and generational influences
• Developmental and acquired Disabilities
• Religion and Spiritual Orientation
• Ethnicity
• Socioeconomic status
• Sexual orientation
• Indigenous heritage
• National origin
• Gender
Conclusion

• Providing culturally competent care leads to improved patient-provider relationships and communication
• This in turn leads to enhanced health care outcomes and reduced disparities
How do we make a difference?

“We convince by our presence”

Walt Whitman