Approaches to Cultural Competence

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Counties are shown according to which races have a population greater than the national average in that county. Counties in which more than one race has a population greater than the national average are shown as multiethnic.

- **Asian (non-Hispanic)**
- **Black (non-Hispanic)**
- **Hispanic**
- **Native American (non-Hispanic)**
- **Pacific Islander (non-Hispanic)**
- **White (non-Hispanic)**
- **Multiethnic**
Increasing cultural diversity in US, health care providers seeing a wide range of ethnic groups

The quality of the patient encounter depends on provider’s skills and cultural sensitivity

Intention is not to stereotype, but rather to reflect on cultural factors that may affect care
Cultural Competence Training

What are some facets of patient care influenced by culture?
- Treatment goals and priorities
- Compliance
- End of life decisions

Health care providers also bring their cultural ideas and background to patient encounters.
Cultural Competence Training

• AGS (EthnoGeriatrics Committee):
  • **Core Competencies** for attitudes, knowledge and skills

• **Attitudes**
  • describe their cultural values, perspectives, preconceptions, and health beliefs
  • – consider their own personal views and beliefs (perhaps unconscious) about other groups of people
  • – explain how the above may affect their care of patients
  • avoid stereotyping and overgeneralization
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- **Knowledge**
- describe the following for major ethnic minority groups:
  - differences in:
  - the epidemiology of common diseases
  - health disparities
  - differences in response to medications
  - validated measures for assessment (e.g., cognitive status, depression, osteoporosis, spirometry)
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Skills

- work with trained interpreters and describe the advantages and disadvantages of using different types of interpreters in a clinical encounter

- take a social history from patients with special reference to their cohort experiences

- critique current health policy decisions in terms of their effects on healthcare access and care practices
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• “Doorway Thoughts” (AGS)

15 groups of ethnoreligious backgrounds

  • Preferred cultural terms, formality of address
  • Respectful non-verbal communication
  • Tradition and health beliefs
  • Culture-specific health risks
  • Approaches to decision-making
  • Gender issues
  • End of life care issues
“Mary”

- 52 year old Arab American female
- Muslim religious background
- History of muscular dystrophy
- Ventilator-dependent, tracheostomy
- Parenteral feeding tube
- Refusing physical exam from all providers

Doorway Thoughts?
“Mary” – Cross-cultural reflections

- Female clinicians usually preferred
- Handshake and eye contact often avoided
- Concept of preventative medicine often looked at with suspicion
- Males frequently have authority for decisions
- Bad news often withheld from patient and communicated to male relative
- Medical treatment balanced with God’s will
Transcending Cultural Differences

- Some things are universal:
  - Needing to be heard
  - Needing to be listened to
  - Needing the support of friends
  - Needing to love and be loved
  - Needing to be remembered
• http://joshspector.com/2011/02/13/now-this-is-a-great-commercial/
References

- “Doorway Thoughts 2/e”. American Geriatrics Society.