

Promoting skill-building in cultural competence: A must for paediatricians who care for socially vulnerable populations

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The demographics of Canadian society have evolved significantly over the past 40 years. The switch in immigration policy from a geopolitical quota-based system to a points-based system of immigration in the mid-1960s has contributed to an unprecedented cultural and ethnic diversity in this country. There is increasing recognition among health science educators that there is a specific skill set that tomorrow's (and today's) health care professionals will require to practice effectively in this exciting new reality. Canada's largest city, Toronto, Ontario, is second in the world after Miami (USA) in having the largest number of foreign-born residents on earth (43.7% at the 2001 census; the geographical origins of Toronto's foreign-born are much more diverse than in Miami) (1). Immigration has contributed to the significant cultural diversity that exists in all major urban centres in Canada, and newly arrived Canadians are often faced with downward mobility that increases the risk of marginalization through poverty (30% of immigrants versus 21.6% of all Canadians were living below the poverty line in 1995) (2).

Canada's First Nations peoples represent another important, culturally diverse and severely marginalized population. Significant and discouraging health status disparities are well-documented among these diverse cultural groups (reviewed and referenced below). These populations are not only affected by geographical isolation, but also by chronic poverty, under- or unemployment, substance use and abuse, and limited opportunities for education and social advancement (to give but a few examples of observed social determinants of health among Aboriginal populations in Canada) (3).

It is, thus, important to recognize that the efficacious medical practitioner who cares for populations that are socially vulnerable and marginalized by poverty needs competence in caring for patients from a diverse set of backgrounds, including cultural and socioeconomic diversity. As paediatricians, we have long recognized that children fundamentally exist within the context of a family and a community, and that practicing effectively in the care of children means incorporating these realities into

therapeutic decision-making. If we are to train tomorrow's paediatricians to care and advocate for Canada's most vulnerable children and to view working toward eliminating health care delivery biases as a part of the social accountability of the profession, we will need to promote the development of skills in negotiating culture in the clinical encounter, as well as an understanding of broader issues, such as discrimination and bias, in the way health care is experienced by marginalized populations such as our oldest (First Nations) and newest (recently arrived Canadians) cultural groups.

CHILD POVERTY AND CULTURAL COMPETENCE SKILLS – WHAT IS THE LINK?

Patients and populations exist within defined historical, geopolitical and social contexts. The health care disparities of Canada's First Nations peoples, whose marginalization and exclusion are the products of a history of aggressive colonization, need to be understood by practitioners as having root causes in these contexts, such that these may be properly addressed. Increased rates of diseases such as type 2 diabetes mellitus, suicide and accidental injury are well-documented among Canada's First Nations peoples (4). If this were the "Australian Journal of Infants and Children", the exact same list could be reported as pertinent to the health of Australia's Aboriginal populations (3). Canadian and Australian Aboriginal peoples share similar colonization histories, but could not be more distant, lineage-wise and climate-wise.

Less well-documented in Canada have been issues related to institutional discrimination and health care delivery biases. Yoshida et al (5), in a study of liver transplant rates among the British Columbia Aboriginal population, have demonstrated significant differences in the rates of offering liver transplant to Aboriginal patients in comparison with others, to give a particularly poignant example of such a bias.

Without implying that Aboriginal experience can (or should) be compared with the process of immigration (both quantitatively and qualitatively), there are commonalities

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<p>Knowledge</p> <ul style="list-style-type: none"> • Define culture and list various factors that influence it. • Describe cultural beliefs, values and behaviours of a cultural group different than one's own. • Discuss important cultural influences of particular patients. <p>Skills</p> <ul style="list-style-type: none"> • Inquire about beliefs, practices and values for patients and families as pertinent to medical problems. • Obtain a medical history, considering cultural information. • Consider cultural information in making diagnostic and therapeutic plans. • Work with interpreters in an effective manner. • Apply general cultural information as hypotheses and not as stereotypes. <p>Attitudes</p> <ul style="list-style-type: none"> • Respect patients' and families' behaviours and values. • Be aware of the influence of sociocultural factors on patients, providers, the clinical encounter and interpersonal relationships. • Appreciate the heterogeneity within cultural groups. • Insight into one's own cultural beliefs, values and practices that influence the self as a 'cultural' person.
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Figure 1) Key competencies in the developmental model for the cultural training of health care professionals. Adapted from reference 10

to the process of migration that can also promote marginalization and health care disparities for new Canadians. Downward mobility (eg, nonrecognition of credentials), language barriers, loss of social supports and cultural 'upheaval', and discrimination are well-documented factors that can diminish socioeconomic potential and can promote poverty among newly arrived immigrant groups (6); this demographic is of huge numerical significance in Canada.

Training curricula around culture for health care professionals should, thus, explicitly address these broader societal issues including institutional discrimination, power and hierarchy, and barriers to access experienced by marginalized populations.

'Evidence-based' cultural practice

When considering incorporating cultural training in any curriculum of training for paediatric residents, it is important to address the skeptic viewpoint. Inevitably the question, "Does this make a difference?" will be asked, and rightly so, because our training programs are bursting at the seams with multiple curricular priorities. Much scholarly work is available linking culturally sensitive practice to health outcomes. There is evidence that the culturally sensitive practitioner will have:

- A more satisfied patient;
- A patient more likely to adhere to therapies proposed; and
- A more complete history from a patient (7,8).

The Royal College of Physicians and Surgeons of Canada, which accredits specialty residency training in Canada, recognizes the importance of cultural sensitivity to effective practice. Sensitivity to diversity is seen as a core professional value, effective sharing of information with patients of diverse backgrounds is seen as a core communicator skill, and understanding culture as a factor in the doctor-patient interaction that contributes to health

outcomes is seen as core medical expertise for the specialty physician in Canada (9).

Frameworks for cultural training

Frameworks for 'cultural competence' in medical training generally involve a set of skills to foster awareness of different understandings of health, sickness and the body among different cultural groups and, crucially, the ability to view biomedicine as a 'cultural' entity that can be critically analyzed and examined. Explicitly, training about the impact of culture on patients' experience of disease and health is not about the development of 'trait-lists' of the dominant characteristics of the various cultural groups encountered in one's practice (eg, 'X patients are stoic in their pain behaviours', or 'Y patients have long pauses in conversation with the doctor'), because this 'cultural encyclopedia' approach can lead to unwitting stereotyping for individuals from a particular culture who do not share its dominant beliefs or behaviours with respect to a specific issue. To be sure, normative beliefs and behaviours of particular cultures encountered in practice are important to know, but the skill-building required to be effective would dictate that these 'traits' be applied as hypotheses only, and not hard and fast rules that apply to all members of a particular culture.

Culhane-Pera et al (10) have proposed a developmental model for the cultural training of health care professionals, which emphasizes skill acquisition across the continuum of medical training. They further elaborated the goals of cultural training for health care professionals into a useful framework of knowledge, skills and attitudes, as seen in Figure 1.

This framework can easily be adapted and contextualized to specific training milieus, such as a paediatric residency program. It would be important to ensure that this training occurs even in regions where there is much less multicultural presence. In such settings, program directors may need to be more creative in ensuring learning opportunities. Broadly, activities in cultural training for residents, students and health care professionals in general should focus on:

- Developing the learner's capacity for reflection as the basic skill building process required for effectiveness in practice;
- Fostering activities that allow the learner to see him or herself as a cultural entity in the clinical encounter in addition to his or her patient; and
- Exposure to broader issues of discrimination and marginalization experienced by cultural groups in encounters with the health care system.

Ideally, the training should be grounded in the clinical encounter (implied here is the importance of faculty development in any cultural training program), with didactic or interactive sessions reinforcing the clinical reality by building reflective practice capacity.

Complete the brief exercise below and be prepared to discuss your answers in your small groups:

Consider your own identity as belonging to various 'sociocultural groups'.

- Write down four or five 'sociocultural groups' to which you feel the most sense of belonging and shared identity.
- For each of your 'sociocultural group' identities, consider the ways in which you are stereotyped and viewed as 'different' by the majority culture. (Because you may also have identities that you feel are part of the 'majority' culture, this exercise may be less relevant to you vis à vis those identities.)

Figure 2) Sample reflective exercise – the complex nature of identity

Figure 2 shows an example of an exercise where participants are asked to focus on themselves as human beings with identities. In debriefing this exercise, participants are able to reflect on themselves as cultural beings, on the complex nature of identity itself, and on the multiple identities that their patients bring to clinical encounters.

There are many teaching modalities that can be used to enhance residents' and students' learning outside of the clinical encounter; these have been summarized by Pedersen (11) and are presented in adapted form in Figure 3.

CONCLUSION

Tomorrow's paediatricians will be increasingly called on to have skills for effective practice in a diverse demographical milieu. Training for this reality will prepare them well for practice in this environment if it emphasizes skill building through reflection, and an understanding that while

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1. Strategies for promoting awareness (rely primarily on experiential exercises that directly challenge one's own assumptions)
 - Reflective exercises
 - Case studies
 - Role plays and simulations
 - Field placements (direct immersion)
 - Critical incident debriefing
 - Small group discussions
2. Strategies for increasing knowledge (rely primarily on conventional instructional methods)
 - Lectures
 - Readings
 - Multicultural panel discussions
 - Guided self-study and online tutorials
 - Films and video clips
3. Strategies for strengthening skills (rely primarily on demonstrations of particular behaviours or activities)
 - Role modelling
 - Reflection on practice
 - Direct supervision
 - Structured observation with follow-up debriefing (live or videotaped)
 - Structured opportunities to practice specific skills/behaviours

Figure 3) Teaching strategies for promoting cultural competency. Adapted from reference 11

knowledge about cultural groups encountered in practice is important, unwitting stereotyping may occur if this knowledge is applied unsophisticatedly. Finally, we must inculcate the values of confronting health care inequities and discrimination for marginalized populations as a professional imperative integral to our social responsibility toward society.

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