Cultural competence: a proposal for physicians reaching out to Native Hawaiian patients

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Abstract

Many physicians of Native Hawaiian ancestry, as well as others, have noted a cultural gap between themselves and their Native Hawaiian patients[1]. This cultural gap could potentially lead to discordance in the physician-patient relationship, and in turn, result in less than adequate therapeutic outcomes. Native Hawaiian physicians and those who treat Native Hawaiian patients are seeking ways to improve therapeutic relationships. Developing cultural competency in Native Hawaiian physicians and those who treat Native Hawaiian patients may be expected to improve therapeutic relationships. Principles of cultural competency, including increasing awareness of self and others, enhancing one's cultural knowledge base, and developing skills to communicate effectively, could be applied to physician-patient encounters with Native Hawaiian patients. The principles and skills of cultural competency could be learned during the formal and continuing medical education process. Developing an educational system that promotes cultural competency in physicians is necessary to address the health needs of Native Hawaiians and other diverse populations in Hawai'i.

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Introduction

In August 2000, 22 Native Hawaiian physicians and approximately 40 others journeyed to the uninhabited island of Kaho'olawe. Their objective was to learn about and develop strategies to address the healthcare concerns of the Native Hawaiian people. This article is based, in part, on discussions held on that trip (see Kamaka, *et al.* in this issue for a detailed account of this journey).

Kānaka maoli, the indigenous people of Hawai'i (hereafter Native Hawaiians), have been acculturating and assimilating into the dominant American society for over 100 years. During the acculturation process, the identity and culture of one's ancestors are often lost. There have been several research efforts to measure the effect of acculturation on ethnic identity and the health status of Native Hawaiians[2-4].

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Native Hawaiian physicians have also been subject to continuing acculturation and assimilation processes. The training and practice of Western medicine demand a high degree of acculturation and assimilation to be successful. A telephone survey with anecdotal reports from Native Hawaiian physicians revealed that many felt a significant cultural gap, emotional distance, and alienation from the Native Hawaiian community. The survey also revealed that Native Hawaiian physicians recognized that they should be doing more to improve the health status of their people[1]. Physician members of the Native Hawaiian physician organization, 'Ahahui O Nā Kauka, who took part in the August 2000 *huaka'i* (journey) to the island of Kaho'olawe, expressed a desire to increase their cultural competency in order to enhance their ability to work with Native Hawaiian people as well as other peoples of Hawai'i.

This paper defines the concepts and terminology of cultural competency. In addition, the methods to achieve cultural competency will be presented to assist physicians

and health care practitioners to effectively work with peoples of diverse cultures. The principles and methods described will be applicable to the Native Hawaiian doctor-patient relationship. The links among culture, health, cultural competency in health care delivery, and how physicians and other medical care providers become culturally competent will be discussed.

Concepts and definitions

What is culture?

Although culture is often thought to be synonymous with race and ethnicity, these terms are not interchangeable. We recognize that there are ongoing academic debates about the meaning and significance of race and ethnicity. For the purposes of this discussion, and in order to provide a framework for medical "cultural competency," culture, ethnicity, and race are defined as follows.

Culture is a shared system of beliefs and learned behaviors [5-6] that the latter of which are often based in racial, ethnic, religious, and historical experiences. Norms and expectations of our traditions, institutions, gender, sexual orientation, age, class, and profession influence our perceptions and behaviors. Indeed, there is a culture of Western medicine and a culture of poverty. If each sphere of cultural influence can be thought of as a circle, then an individual's composite culture is where all of the circles intersect or overlap. A Native Hawaiian physician who is female, highly educated, wealthy, Presbyterian, and raised in Arkansas would have a different composite culture from a Native Hawaiian patient who is male, has an 8th-grade education, is Catholic, makes a marginal income, and lives on Kaua'i (i.e., a neighbor island of Hawai'i).

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Ethnicity is a social classification of a population with shared experiences through ancestral heritage, history, language, customs, and geography[2]. We often think about ethnicity in terms of Japanese, Chinese, Native Hawaiian, Marshallese, Iranian, and so on, as well as mixtures of each. When people in Hawai'i ask, "What nationality are you?" they are often asking about ethnicity. Ethnicity is often associated with a particular phenotype. Ethnicity is one sphere of an individual's composite culture. Native Hawaiian physicians and Native Hawaiian patients share the same ethnicity in that they have a common ancestral heritage.

Race is a Western social construct[7] in which, historically, the labels given to racial categories have been referred to as Mongoloid, Negroid, and Caucasoid—or the colors brown, black, and white. Hence, a person of Italian descent raised in New York would be of the white race and of Italian ancestry/ethnicity. There are suggestions that classifications by race are archaic, socially harmful, and should be abandoned[7].

How does culture relate to health?

Many health-related behaviors and perceptions are influenced by culture. The meanings of health and illness and how individuals choose to deal with them are culturally determined[8,9]. For example, health and ill-health may be culturally defined as a state of imbalance between *yin* and *yang*, an acquired biological malady, a punishment for inappropriate behavior, a result of variations in magnetic fields, or caused by extra corporeal/extraterrestrial energies. Although pathology, the morbid biological effect on the body, has a similar cellular effect in all cultures, the meanings that are given to the pathology and treatments that are pursued are filtered through cultural lenses. Diet and nutrition are culturally determined and are known to affect health[10,11]. Concepts about aging, death, and dying are culturally based[8]. Other health and lifestyle factors that are culturally determined include work, physical exertion, rest, recreation, sleep, and spirituality.

How an individual chooses to manage ill-health is culturally driven. One may seek a traditional healer or an allopathic physician, may rely on prayer, or may accept the consequences as fate. The process through which health care is delivered and how therapeutic interventions are prescribed and implemented is also influenced by culture[12-14].

What is cultural competency?

Cultural competency in the context of health is defined as the ability to understand and favorably influence health care behavior in diverse cultural patient populations. Becoming culturally competent relates to enhancing personal insight and empathy with peoples from diverse cultures[5]. Various terms in the press and medical literature that attempt to describe facets of cultural competency include cultural sensitivity, cultural efficacy, and cultural humility[5,15]. In academic circles, each of these terms adds to the dimensions of becoming culturally competent.

Starn describes cultural sensitivity as the awareness of and acceptance of cultural differences (i.e., realizing that it is acceptable to be culturally different)[16]. Leonard and Plotnikoff define cultural efficacy as self-awareness, understanding the dynamics of cultural differences, knowledge of the client's family culture, and adaptation to support the client's culture[13]. For example, cultural efficacy would entail

a Native Hawaiian physician who takes the responsibility to understand and learn skills to effect a meaningful change in patients' health behaviors. One must value both one's own and the other's perspectives. Cultural competency is more than an academic construct—it means that the physician or health care provider must truly adapt his or her intellectual, emotional, and attitudinal approaches toward culturally diverse patient populations.

A narrow and unwise approach to cultural competence is to stereotype behaviors of ethnic groups as a model for teaching[9]. Reading everything one can about Native Hawaiian culture will provide some insights into historical and anthropological perspectives. However, the knowledge one possesses about a culture does not by itself ensure a culturally competent patient encounter. Cultural competency is not about knowing everything there is to know about each sphere of influence. It is about recognizing how these circles of influence affect communication, trust, health, and therapeutic prescriptions in particular clinical situations.

Methods to achieve cultural competency

Becoming culturally competent

When a physician of Native Hawaiian or another ancestry enters into a doctor-patient relationship with a patient of Native Hawaiian ancestry, there is an immediate cultural interaction. The physician has brought multiple cultural influences, including his or her profession, gender, education, religion, class, ethnicity, and family into the clinic room—as has the patient[9]. The similarities and differences in cultures and behaviors will determine the type of initial patient-and-physician interaction. The ongoing relationship, which in part may influence the patient's health behaviors, will be largely determined by the physician's and patient's ability to find common ground, recognize differences, and come to an agreement that fits into both the patient's and physician's cultures[5,9].

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How do physicians find common ground, recognize differences, and come to agreements in multi-cultural settings—i.e., how do they become more culturally competent? There are three basic elements of cultural competency, which include becoming more aware about one's own culture (self awareness), increasing knowledge and learning more about other cultures (awareness of others), and developing the techniques and skills to apply that knowledge in clinical situations[9].

Self-awareness

Self-awareness means that the physician understands his or her own cultural values and biases. One should know what one's personal agenda and biases are before dealing with anyone else. As an example, a Native Hawaiian physician in Hawai'i may acknowledge that he or she has the following cultural values:

- accepted model of health is biomedical;
- must respond to illness only with Western therapeutic interventions;
- time and punctuality are of primary importance;
- unemployment has negative connotations;
- all people should want to work and be educated;
- patients should not question what the physician says; and
- drug abusers have no will power.

When the physician is not aware of these biases, and when both the patient and physician are Native Hawaiian, the patient-physician relationship may actually be strained because both expect the other to understand his or her perspective because they share a similar ancestry. However, the circumstances would likely be different if the physician knows of the "baggage" or biases that he or she brings to the patient encounter and a client comes to the office who is unemployed, is a drug abuser, is two hours late for the scheduled appointment, argues about therapeutic options, wants to obtain some traditional medicine, and is Native Hawaiian.

Awareness of others

Having an awareness of others means developing a knowledge base about other cultures, accepting different ways of thinking, entertaining varying views of health, and being open to a variety of therapeutic options. Understanding and empathizing with the social dilemmas that the cultures of poverty and drugs present as well as developing an understanding, tolerance, and ability to work with those whose values conflict with one's own embraces the concept of being aware of others. Awareness between the provider and patient regarding knowledge of health system values and therapeutic health options increases the chances of a meaningful and successful therapeutic outcome.

Developing a cultural knowledge base

Developing a basic knowledge about the different cultures that one interacts with should be helpful for the therapeutic interaction. One may learn about particular cultural perspectives of illness and health, traditional medical therapies, concepts of death and dying, history, foods,

acceptable styles of communication, and greetings. Deeper understanding about the culture would entail learning the language and immersion in the environment of those who live that culture[9]. One example or form of cultural immersion entailed the meeting of Native Hawaiian physicians in August 2000 on Kaho'olawe — a historical and spiritual island in Hawai'i. Learning cultural history provides a context for one's ethnic or ancestral values. Recognizing core cultural issues and protocols involving authority, physical contact, and gender are important. Learning every nuance of a particular culture is not the objective; rather, the goal is to identify, explore, and resolve with patient interaction, problems that could arise[9].

Application of skills

An example of a conflict between culturally based family values and health systems is presented. An awareness of how different cultures view family and autonomy would enhance the physician's ability to address this issue appropriately.

> A 14-year-old Native Hawaiian schoolgirl seeks birth control pills. The parents feel that she is not emancipated and cannot make autonomous decisions as a member of the family. The girl wishes to obtain birth control pills without her parents' knowledge and state law and the American standards support her autonomy in this situation. What are the culturally competent therapeutic options the physician should pursue?

Appropriate skills entail being able to implement an appropriate intervention, at the right time, in a culturally sensitive manner, in a given situation. Skill-building includes learning the arts of listening, empathizing, adapting to different communication styles, finding common ground from which to center a discussion, and building mutual trust and respect. Such skills can be assessed through patient feedback, through patient satisfaction surveys, and by having a critical observer evaluate one's performance.

Listening means making the time to hear and process concerns without interrupting the patient with solutions or value judgments. Listening means entering into a discussion in a manner that takes into account the patient's level of understanding and the power structure between patient and physician. The physician must maintain an open mind.

Methods utilized in the "patient-centered" clinical encounter facilitate cultural competence in physician-patient relationships[6]. The interviewing technique is less authoritarian. The clinician listens for a longer period of time. The encounter is marked by empathy, curiosity, and respect[6]. The patient-centered visit focuses on reaching a mutually acceptable agreement, building a relationship, setting an agenda, assessing the situation, clarifying problems, putting closure to problems, and providing medical care in the patient's cultural context[17]. One useful mnemonic for the patient-centered encounter is, *FIFE*—empathizing with the patient's *F*eelings, acknowledging the patient's *I*deas, understanding how the illness affects the patient's *F*unction, and knowing the patient's *E*xpectations[18].

Challenges for medical education

Developing a curriculum for cultural competency should be done in a planned and structured manner in medical school, in residency training, and as part of a continuing medical education process for physicians who have completed their formal training. Discussing the multiple facets of developing curricula for training physicians to be culturally competent is beyond the scope of this article. However, several ideas of what has been and can be done will be briefly mentioned.

A comprehensive faculty development plan is needed and should be linked to medical school student and residency training curricula. Training should include workshops in basic preceptor skills and principles of self-awareness through the use of reflective practices, listening, recognizing biases, and other principles of ethnomedicine. Important components in the curricula should be traditional beliefs and value systems of Hawai'i's cultural groups. Resource people from the various ethnic groups could be engaged to present such information.

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Evaluation of learners is always difficult and in this situation, the patient should be the ultimate evaluator of a physician's cultural competence. As part of faculty curriculum development, a set of standardized patients would serve as a learning and evaluating tool. A well-developed standardized patient will be able to tailor and change his or her response to the physician's inquiries (thus making the encounter more realistic), assess the physician's interactions, and offer suggestions on how to improve the clinical situation[19].

At the University of Hawai'i John A. Burns School of Medicine (JABSOM), much of the learning in the first two years of medical school is case-based—also referred to as problem-based learning (PBL) that is either with paper cases (based on real patients) or by direct patient encounters. Incorporated in the JABSOM curriculum is case-based learning that occurs in a multidisciplinary setting at a community health center. These cases provide opportunities for medi-