

Guest Editorial

Cultural Competency - Best Intentions are not good enough

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Racism is a health care issue, a disease of the mind and soul and should be treated as such. Cultural competency improvement initiatives should not only address the symptoms (what most training does now), but also address causes. This guest editorial suggests developing instructional methodologies with a holistic approach. Described in the paragraphs below are the need for, and characteristics of, an alternative paradigm to the Western European centric frame that most healthcare systems in developed nations currently use as a guiding heuristic. A broader more inclusive perspective is required to clarify foundational issues, expand understanding and intrinsically incentivize attitude and behavior change. While there are multitudes of noble efforts underway to address inequities in healthcare (in policy, resource allocation, and provider training to name a few) some of this work misses the mark. The primary reason, "No problem can be solved from the same level of consciousness that created it" as Albert Einstein (N.D.) so adeptly warns.

The need: Efforts to reduce inequities and enhance cultural competence fall short of goals.

Contributing Factor: The invention of the five categories of race and ethnicity.

*"Race is a pigment of our imagination..... a social status, not a zoological one; a product of history, not of nature; a contextual variable, not a given. It is a historically contingent, relational, intersubjective phenomenon—yet it is typically misbegotten as a natural, fixed marker of phenotypic difference inherent in human bodies, independent of human will or intention." (*Rumbaut, 2009, p. 15)

The five racial groups (American Indian/Eskimo, Asian/Pacific Islander, black, Hispanic and white), which commonly occur as demographic check boxes on surveys, were a creation of President Richard Nixon in the early 1970s (Rodriquez, 2003). To be more specific, these terms were a derivation of the Office of Management and Budget (OMB). At that time, President Nixon directed the OMB to come up with classification terms for ethnic groups in the United States for the census and other governmental research purposes. The OMB readily declares the manufactured nature of the groups and describes the good intentions for which they were developed,

Development of the data standards stemmed in large measure from new responsibilities to enforce civil rights laws. Data were needed to monitor equal access to housing, education, employment opportunities, etc., for population groups that historically had experienced discrimination and differential treatment because of their race or ethnicity. The categories that were developed represent a political-social construct designed to be used in the collection of data on the race and ethnicity of major broad population groups in this country, and are not anthropologically or scientifically based. (US Office of Management & Budget, 1997)

However despite the best of intentions, unintended negative consequences can occur with the use of these broad terms in research and training. My primary criticism is that these classifications wipe out unique cultural distinctions within the identified racial groups. Therefore distinctions central to an individual's identity, perspectives on health (physical & mental) and preferences in healthcare services are not recognized.

Four Examples from the field.

Unintentionally grievous is the use of the word “Hispanic,” initially coined by the US government to refer to populations with Spanish speaking comprehension and speaking ability. Individuals who fall under this description are a substantially diverse people who hail from all over the world; Mexico, Puerto Rico, Cuba, Spain, Portugal and most of the continent of South America to name a few areas. The current use of this term is flawed and does not provide compassionate comfort in the context of healthcare services. To explain, "Hispanic" carries with it the historical baggage of the Spanish colonial assaults on the indigenous cultures of Central, South, and North American and the with subsequent slavery, genocide and coerced religious conversion. Thus, using the term "Hispanic" to describe Spanish speaking people of the Americas is in effect, identifying them as their conquerors and captors.

As Richard Rodriquez (2003, p. 12) describes,

The interesting thing about Hispanics is that you will never meet us in Latin America. You may meet Chileans and Peruvians and Mexicans. You will not meet Hispanics. If you inquire in Lima or Bogotá about Hispanics, you will be referred to Dallas. For "Hispanic" is a gringo contrivance, a definition of the world according to European patterns of colonization.

Hence this “catch” all identification of "Hispanic" not only wipes out the unique and distinctive cultures of these varied populations, but also provides insult. How comforting is this approach?

Example 1.

An example of how the best of intentions are not good enough comes into play when these limited race classifications are used to solve health access challenges. Dr. James Sauceda, the founding director of the California State University, Long Beach Multicultural Center is often contacted to offer his expertise to organizations on cultural competence. Dr. Sauceda was invited to a behavioral health clinic in the neighborhood of East Los Angeles, a predominantly Mexican American area. Although there was a clearly identified need in the area for

mental health services, the clinic was not successful in attracting clients. At first Dr. Sauceda was perplexed as to why there were reported disconnects between the clinic and the community as the facility was managed by two Latino doctors. That is until he showed up for his visit and noticed the large sign above the building entrance, "Mental Health Clinic." From this point forward the mystery continued to unravel as his tour revealed a multitude of barriers to access. Starting with the signage, mental health issues are viewed as weaknesses of character and any self-respecting Chicano (person of Mexican descent, usually referring to males) would not be caught walking into a place so named. Chicanos have a strong identity, associated with being the primary source of safety, wisdom and authority for the their families. To admit mental "illness" is diametrically opposed to their identity.

The disrespect of Mexican culture continued into the waiting room and throughout the clinic facility. Rooms were sterile and void of signs of life. Magazines, while written in Spanish, were out of touch with the local population and not what they would read. Upon meeting the directors, it became clear to Dr. Sauceda that they were not from the area, or even Mexico, but were born in South America and trained in the Western European discipline of Psychiatry. From his perspective, (a Chicano himself), although the Latino Psychiatrists tried with sincerity to provide a service to the neighborhood, they were clearly detached from the local culture and people.

In light of these observations, recommendations to help the client population feel more comfortable and trusting of the clinic setting were made. First, start by changing the name of the clinic to something more familiar and welcoming. Examples would be "La Familia Casa" (The Family House) or "Casa de la Paz"(House of Peace). Second, the waiting rooms could be furnished more like a family living room with a sofa, some soft chairs and a TV tuned to *Novellas* (Soap Operas in Spanish). Images of "La Virgin de Guadalupe" a powerful figure of comfort and healing for people of Mexican heritage, should be present in the waiting room and throughout the clinic. Clinic staff should be educated as to the mythos and meaning of this figure. She is uniquely reassuring for Mexican people. Seeing her image calms the room, provides comfort and inspires hope. This kind of resonance and respect for culture could be a welcoming practice with positive effects of engendering trust and safety. The impact of these changes could be valuable future topics for research on patient compliance and provider/patient communication and the lesson is a worthy one. Although a clinic can be located in the population center of a specific cultural population in need and run by a staff perceived to be of the same culture, there is no guarantee that cultural competence will be demonstrated and access challenges resolved. In other words, if you build it, they will not necessarily come. Efforts to decrease inequities and increase access need to go deeper than the surface to truly be culturally competent and effective.

Another example of wiping out cultural distinctions is the term "Asian/Pacific Islander" which includes ancestry from over 50 different regions around the globe, to name a few; Bangladesh, Burma, Cambodia, China, India, Japan, Korea, Laos, Philippines, Samoa, Thailand, Vietnam. Reflect for a moment on what you know about these distinct cultures? Are you acquainted with at least 3 people with different Asian heritages? If so how similar or different are these individuals? Are their perspectives on health the same? Do you even know what their heritage is? Below are a couple examples of "mistakes" well-intentioned health providers make when providing care to Asian Americans.

Example 2

A son brings his mother visiting from China into the urgent care center for treatment of a worrisome cough. He has serious concerns about his mother's condition and insists his mother is seen right away. The front office staff, wanting to oblige, processes her paperwork as quickly as possible and the nurse shows her to the first available room, treatment room #4. The son becomes irate, stopping his mother from entering the room, in a loud voice exclaims, "How could you insult my mother in this way?" The confused nurse replies, "What do you mean? We tried to get her in a room as soon as possible." What is the problem here? The problem is that his dear mother was assigned to the "death" room. The number 4 is a symbol of death in Chinese culture.

Example 3

A Cambodian distraught mother brings her asthmatic child into the Emergency Room for treatment. Upon examination, the doctor finds red markings across the child's back with some deep bruising. Immediately concerned for the safety of the child, social services are contacted and the incident is reported as child abuse. The mother doesn't understand why she is being treated this way as her child is removed from her custody. What is the misunderstanding here? The mother was practicing a common Southeast Asian treatment of "cao gio" (pronounced "gow yaw") otherwise known as "coining." The practice entails rubbing heated oil over the back, chest and shoulders. Then with the use of a coin, strong linear strokes are administered over the oiled areas, continuing until read marks are seen. The literal translation of term "cao gio" is "catch the wind." In this tradition the cause of an illness is understood as too much wind in the blood. Coining provides an avenue for the bad wind to be released. (Zamani, 2010)

Example 4

Our fourth and final example is in the international arena, where best intentions so often fall short and in some cases result in unintended consequences that can do more harm than good. The current research of Dr. Roger Mendoza (2016) describes a mismatch between the policy recommendations of the World Health Organization (WHO & WPCA, 2014) and the socio-cultural milieu in developing countries. A case in point is illustrated by his work in Jamaica. It reveals that crafting policies and allocating substantial resources for the development of hospice and palliative care in that country (as well as in many other developing countries) do not necessarily enhance people's interest in, and demand for, such services. A multitude of factors are identified as barriers. Among the most obvious is distance, as Jamaica is quite mountainous. Land travel is often difficult and the vast majority of the population reside in rural and semi-rural areas. Yet, all of Jamaica's hospices are concentrated in two of its largest cities, Kingston, the capital, and the resort city of

Montego Bay, locations that are prohibitive to most Jamaicans. It is equally costly for cash-strapped hospices to deliver in-home care, especially outside of those two cities. Considering their distance, the risks of transporting medical equipment over rough geographic terrain are great. Facilities for cold storage of pain and other medications, which are by themselves in short supply, are extremely limited. Even if local palliative care was made more accessible to the terminally ill, there is generally great discomfort in the Western model of healthcare provision, and for good reason.

In Jamaica, a matrifocal, extended family system binds together the immediate family of the terminally ill and distant relatives, neighbors, friends, community elders, spiritual and religious leaders in a closely-knit support network down to the grassroots level. Elderly people are respected and adult children look forward to the opportunity to give back to their aging parents and take care of them at home in their senior years. To place a mother or father in a hospice facility so far away from home and family to die with a bunch of strangers, who poke and prod for the sake of providing "comfort," is often unthinkable. While family-centered emotional and spiritual care might not be as "clinically" sound, being surrounded by the love of one's extended family in a familiar environment can compensate and provide immeasurable "comfort" at the end-of-life stage, compared to the relief of morphine administered by strangers in sterile and often crowded communal rooms. Home-based family care also helps the terminally ill feel less of a financial, psychological, and emotional burden to their families who would otherwise have to give up many days or weeks of work in rural and remote areas to accompany them to a distant hospice and pay for related expenses. Unfortunately, in-home hospice programs remain the exception (unlike in the US, Europe and other industrialized countries) rather than the rule, in Jamaica. The country's experience in hospice administration offers a tragic example of "If you build it, they won't necessarily come." Mendoza's work suggests that informal provisions for care, even at the critical end-of-life stage, are not necessarily inefficient or inferior to formal, regulated systems. Although non-hospice, family care may carry with it many risks, these can at times be outweighed by the costs of dealing with distant, formal healthcare institutions and providers. Rather than a "one size fits all" solution, culturally appropriate models in healthcare delivery should be designed and promoted, especially in developing countries.

Solutions/recommendations: Tips to train and promote cultural competence.

"We are not the creators of tension. We merely bring to the surface the hidden tension that is already alive! We bring it out in the open where it can be seen and dealt with." - Martin Luther King, Jr. "Letter from Birmingham City Jail" April 16, 1963.

As Dr. King's quote suggests, we must get out from behind the veils of denial, fear and political correctness and deal with real issues where they are located. Presented here are three recommendations critical to successful learning and practice of cultural competence; 1) Training at foundational levels of an individual's held values, inspiring an internal shift from apathy and/or fear to a genuine appreciation of difference, 2) Understanding and respecting the social/cultural milieu of your patient population, 3) Developing and maintaining systems that reinforce culturally competent behaviors and practices. Leaders must walk the talk. The appreciation and value of diversity must be institutionalized in organizational policy, process and culture.

Training Recommendations

Unfortunately much of the diversity training in institutions today focuses on limiting liability for the organization. Should an institution be accused of discrimination, their legal counsel needs to be able to prove that employees have passed a basic diversity training to avoid culpability. However, knowledge is only the first and most primitive of four levels of learning objectives for diversity training described here. Concluding this section is an appeal that the fourth and most foundational level (value and appreciation) is the set of learning objectives that would be most helpful in equipping a healthcare workforce to achieve true cultural competence.

There are four depth levels of learning objectives a training program can seek to achieve with respect to cultural competence. The first and most basic level is the knowledge of current laws regarding protected classes and the legal implications. The consequences for the organization and individuals who are found guilty of negligence and/or discriminatory behavior are covered. These trainings inform employees of what to do and what not to do when working with colleagues or treating patients who are different from themselves. The focus is on "protected" classes. Federally protected classes include; race, color, religion or creed, national origin or ancestry, sex, age, physical or mental disability and veteran status (U.S. Equal Employment Opportunity Commission). Additional protected classes can vary from State to State. Training at this level can allow the organization to "check the box" and claim that their employees know the law if any accusation should arise. Hence protecting the enterprise from liability. The downside of this most basic understanding is that while offending behaviors might be curtailed, perceptions and attitudes are not improved. In fact they can even decline and backlash can occur. This level of training can increase fear and cause people to prefer to avoid members of a protected class, rather than engage with or care for them.

The next depth level occurs when learning objectives focus on ***cultural awareness*****.** These programs attempt to build a greater understanding of the norms, traditions, and behaviors of various cultural backgrounds. This level can be very helpful in providing personnel with increased awareness of potential misunderstanding and misinterpretations of cultural norms. For example, in the U.S. a lack of eye contact is often interpreted as a result of shyness or disinterest, however in many eastern cultures, not looking someone directly in the eyes is a sign of respect. While this level of training would indeed be critical and might clear up misunderstandings as in the room #4 faux pas and the coining examples above, it doesn't approach attitude change. The fundamental dynamics of racism and bias in a person's value system remain unquestioned. Hence backlash, conscious and unconscious discriminatory actions and policies might still occur.

Where biased value systems might begin to change is with the next or third level of learning objectives, **sensitivity**

training. Programs at this depth aim to sensitize employees to how words and behaviors are experienced by others and the impacts on emotional, cognitive, and spiritual dynamics within an individual. In order for these trainings to be successful, a safe environment and highly skilled facilitator is essential, in addition to a certain "readiness" on the part of the learners. In this setting participants recognize their own biases and their personal experiences of discrimination, including when they were victims as well as when they were perpetrators. It is not hard to imagine the emotional challenges that might arise. Hence the absolute necessity of the skilled trainer and a safe and intimate setting would be required. This is the first point of entry where true empathy (not just sympathy) can begin to develop and long held biases can begin to release their grip on an individual's perceptions of reality.

The fourth depth level of learning objectives are programs designed to achieve **values realignment** of "appreciating" rather than "tolerating" diversity. During these trainings one's intellect, emotions, and spirit engage in experiential activities that go beyond understanding to demonstrate the value that a diverse workforce and patient population can bring to the healthcare system. When cultural differences are respected and appreciated, individual and community health can be enhanced. Again an expert facilitator as well as a ready and willing audience are two basic requirements for improvement. The link between responsibility for self, others, and population health will need to be made for employees at the level of their job description and supported by the culture and climate of the organization as a whole. If a small group of individuals are successfully trained at this level, and the health system managers and leaders do not demonstrate the value of diversity and align policies accordingly, any gains in values realignment could be quickly undermined and unlearned.

Understanding and respecting the social/cultural milieu of your patient population.

The holistic approach we are recommending takes into account an individual patient's community setting, personal resources, and respects traditional healing methods. The whole person mind, body, and spirit is involved in optimizing health service delivery. A culturally competent provider would respect all these human aspects. And as long as a "folk" healing method does not cause harm, clinicians are best counseled to listen, seeking to understand what the method is and why it is use as a form of cultural exchange. Not necessarily needing to approve of, but at the very least accepting the traditional practice as one part of a patient's healing regimen. Skilled providers will bridge the comforting traditional cultural practice terms to the allopathic treatment they are prescribing. An example can be found using analogies between the concepts Yang (heat) and Yin (cool) in Traditional Chinese Medicine (TCM) to allopathic terms. To briefly explain, a predominate approach to optimum health in TCM is to balance life energy, or "qi" in one's body. Balance is achieved through the use of foods and herbs that have either Yang (heat) vs. Yin (cool) properties. Yang foods increase a body's heat, hastening metabolism while Yin foods are believed to lower heat (lowering metabolism) and are used to balance the hot foods. The approach is to nurture the body with both types of energy in the proper balance (Torssell, 2010). Allopathic medicine speaks about fever and inflammation (heat in the body) and low energy, and lack of circulation (cooler dynamics). Depending on the patient's needs, a culturally competent provider can use these familiar terms to describe the allopathic approach. Hence when speaking about "inflammation" the analogy can be made to "heat" in the body, and the prescription and protocol advised will help reduce the inflammation and "cool" the body.

"Racial understanding is not something that we find, but something that we must create. Create by the fact of contact." - Martin Luther King, Jr. Where do we go from here? 1967

The best way to learn about a community is through engagement. The health care industry has now come to accept the links between mental health and physical illness, and understanding a patient's environment is key to being able to intervene in meaningful ways. Perhaps no one articulates this better than Father Gregory Boyle, founder of the extraordinary empowerment agency Home Boy Industries. Father Boyle is highly regarded for his success in reducing gang violence in dangerous communities. When asked about the advice he would give to people eager for peace in their neighborhoods he responds,

"....It's about delivering mental health services in a timely and appropriate manner to the troubled young among us. Above all, it's about reverence for the complexity of this issue and a singular insistence that human beings are involved...." (Simon & Schuster, N.D.)

A committed healthcare organization needs to be contributing positively to the community through service and engagement. To develop a genuine understanding of the patient population, providers need to get to know their patients, understand their challenges, and humanize the differences that separate us to build a bridge of compassion and understanding. Direct experience of service addressing a local challenge with its trials and rewards is an excellent avenue for this development. Provider organizations can organize and support volunteer service efforts in their community's area of most need. This of course will depend on the location of your facility, but no matter where you are located, there is a population or cause that could benefit from your workforces volunteer service.

Developing and maintaining systems that reinforce cultural competent behaviors.

While the previous two recommendations focus on developing skills of cultural competence for an individual provider, the final recommendation is for the organization as a whole. Enterprise wide cultural competence needs to be modeled and supported for the appreciation of difference to be an integral part of an organization's culture. This means the human resource strategies for every function need to align with cultural competence as a goal. Beginning with cultural communication skills specifically mentioned in job descriptions which are then, tracked through performance management and tied to compensation or rewards. This level of integration within an organization's HR approach can support continual learning and incentivize culturally competent behavior. Of course, the corresponding training and resources will need to be available to support these efforts. At each stage of an employee's

career within an organization he or she should know what the expectations, rewards, and consequences are with respect to developing cultural competence. Tactics like paid time off for employees who volunteer for community service projects can assist with these efforts. For contracted health providers, the organization will have less direct leverage. However even with independent contractors, behaviors can be tracked through patient satisfaction surveys, and incentivized and rewarded for demonstration of growth and competence.

Conclusion

A final point to make is that throughout any given day, an individual may go from being very culturally aware, acting with empathy and compassion and then minutes later, suffer from cultural blindness or even worse, discriminate against a colleague or a patient. Humans are human, we falter, we error, we take two steps forward and one step back on our learning curve of self-development. Hence when organizations consider their training and processes to enhance the cultural competence of their workforce, the keys are persistence, continual learning, leadership support and open dialogue in an environment of trust, safety and respect. Seeking always to strive for the highest goals of patient care and population health.

In conclusion, we encourage health professionals from all segments of the industry to consider the unique cultural distinctions their patients and providers might hold with respect to their views on wellness and health services. Cultural competency training should debunk the myths of the five group classification and encourage gaining knowledge on the attitudes, customs, and basic language terms of the predominate heritage populations in their service area. And to do this by getting to know people directly, Go to cultural centers, experience the holidays and meals, host multi-cultural learning events, invite guest speakers, become involved in community service projects. Many of these activities might already be occurring in your organizations. But do not engage in the activities with the mindset of putting people into one of the five boxes and assume you know about that "group." Instead learn to treat every patient as an individual, a unique soul, whose wellness is deeply integrated in a complex context. Each person's health status is embedded in his or her life circumstance, which includes physical, mental, spiritual, familial, economic, social, historical, and environmental factors. Learn from your patients with an attitude of gratitude. Embrace challenges and differences, relish in the joy of expanding your perceptual frame. If you Seek to understand their context every day, your life will be richer for it.

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