APPENDIX B: FRAMEWORKS AND KEY ASPECTS OF CULTURALLY COMPETENT CARE

(BERLIN & FOWKES, 1983)

Berlin and Fowkes' LEARN model is a well-established approach for communication that consists of a set of guidelines for health care providers who serve multicultural populations. The model is intended as a supplement to the history-taking component of a normal structured medical interview. LEARN consists of five guidelines:

- **Listen** with sympathy and understanding to the patient's perception of the problem.
- **Explain** your perceptions of the problem.
- **Acknowledge** and discuss the differences and similarities.
- **Recommend** treatment.
- **Negotiate** agreement.

(BOBO, WOMEODU, & KNOX, 1991)

Learning objectives for cross-cultural training of family medicine residents:

INTERCULTURAL CONCEPTS

- Culture is important in every patient's identity.
- Communication of cultural understanding and respect is essential for establishing rapport and confidence.
- Culture-related stresses and tensions can induce illness.
- Culture-related behaviors (e.g., religion, diet) affect patient's acceptance of and compliance with prescribed therapy.
- Nonverbal and verbal communication may differ from culture to culture.

INTERCULTURAL KNOWLEDGE

Should be specific for each culture represented and includes the following:

- Common dietary habits, foods, and their nutritional components
- Predominant cultural values, health practices, traditional health beliefs

- Family structure—patriarchal vs. matriarchal; nuclear vs. extended; role of individual members
- Effect of religion on health beliefs and practices
- Customs and attitudes surrounding death
- Significance of common verbal and nonverbal communication
- Awareness of the "culture shock" experienced by the very poor and immigrants upon entering modern health centers
- Awareness of prevailing cross-cultural tensions and psychosocial issues

INTERCULTURAL SKILLS

Should be specific for each culture represented and includes the following:

- Communicate an understanding of patient's culture.
- Elicit patient's understanding of patient's culture.
- Recognize culture-related health problems.
- Negotiate a culturally relevant care plan with patient as partner.
- Interpret verbal and nonverbal behaviors in culturally relevant manner.
- Have basic or essential language proficiency.
- Apply principles of clinical epidemiology to common illnesses.

INTERCULTURAL ATTITUDES

- Recognize importance of patient's cultural background and environment when constructing an approach to an illness.
- Acknowledge patient's role as an active participant in his or her own care.
- Accept responsibility for the patient who has few support systems; avoid the "what can I do?" attitude when facing a patient in abject poverty or with language barriers.

(BORKAN & NEHER, 1991)

Seven stages of a developmental model of ethnosensitivity for family practice training from "ethnocentric" to "ethnosensitive":

- **Fear.** Family physicians may fear a specific group and idea or have a general mistrust of differences. Fear is an incredibly problematic response because it is a powerful motivator. The goal is to decrease or eradicate fear by using basic approaches and understandings.

- **Denial.** In this stage, "culture blindness" or "over-generalization" are displayed. Trainees have little understanding of cultural variation and behave as if cultural differences do not exist. The goal at this stage is to "promote recognition of ethnicities" through fostering the simple awareness of cultural differences. The medical trainee must learn that "everyone has an ethnicity."
- **Superiority.** This stage is characterized by negative stereotyping, which results from "ranking" cultural differences according to one's own culture, or "reversal," which results in denigrating of one's culture as a result of identifying with another group's attitudes, beliefs, and practices to the point of seeing it as superior. The goal at this stage is to promote the recognition of similarities between cultural groups.
- **Minimization.** The trainee acknowledges that cultural differences exist but views them as unimportant compared with similarities. The characteristics of this stage are "reductionism" and "universalism." Reductionism, which most medical training promotes, stresses "biochemistry and pathophysiology models while de-emphasizing the medical effects of personality, family structure, and socio-cultural factors." Universalism is the idea that universal laws and principles of human behavior exist that transcend human differences. At this stage, it is important to stress individual and group differences by stressing bio-psychosocial awareness and by debunking the belief that "common sense" is all that is needed to establish good therapeutic relationships.
- **Relativism.** This stage is characterized by the acceptance of ethnic and cultural differences, but a naiveté regarding actual knowledge of specific differences and their implications on providing care. The goals for this stage are to gain experience through cultural exploration and education and to foster empathy.
- **Empathy.** This stage involves a framework shift to be able to experience events as a patient might. Trainees exhibit "pluralism" when they are able to come outside their own worldview to come to an understanding of the patient's value system and worldview. However, ethical decision making requires more than empathy; it requires an enrichment of cultural experiences.
- **Integration.** The culturally integrated practitioner "stands both inside and outside a culture, having both deep understanding and a critical viewpoint." The integrated physician is able to make ethical decisions through a contextual evaluation of critical cultural and individual factors. The refinement of cultural integration can continue through fostering integrative skills and multiculturalism.

(CAMPINHA-BACOTE, 1999)

This model presents five interdependent constructs that make up cultural competence.

- **Cultural Awareness**—"The deliberate, cognitive process in which health care providers become appreciative and sensitive to the values, beliefs, lifeways, practices, and problem solving strategies of clients' cultures." The process includes examining one's own prejudices and biases toward other cultures and exploring ones' own cultural values.
- **Cultural Knowledge**—"The process of seeking and obtaining a sound educational foundation concerning the various world views of different cultures." In addition to knowledge concerning worldviews of different cultures, knowledge regarding specific physical, biological, and physiological variations among ethnic groups is important to the process.
- **Cultural Skill**—"The ability to collect relevant cultural data regarding the clients' health histories and presenting problems as well as accurately performing a culturally specific physical assessment." This process involves using a culturally sensitive approach to interviewing clients about their perceptions of the health problem and treatment options.
- **Cultural Encounters**—"The process which encourages health care providers to engage directly in cross-cultural interactions with clients from culturally diverse backgrounds." It is important to prevent stereotyping through repeated direct interactions with clients from diverse cultural groups to "refine or modify one's existing beliefs regarding a cultural group."
- **Cultural Desire**—"The motivation of health care providers to 'want to' engage in the process of cultural competence." Only a genuine desire to work effectively with culturally diverse clients will make a successful culturally competent health care provider. Caring is central to the construct of cultural desire. The goal of the health care provider should be to reflect true caring to the client

(CARRILLO, GREEN, & BETANCOURT, 1999)

A patient-based approach to cross-cultural curricula, consisting of five content areas:

- **Basic Concepts**—Includes the meaning of "culture" and "disease," the subjective concept of "illness," and the attitudes that are fundamental to a successful cross-cultural encounter—empathy, curiosity, and respect.
- **Core Cultural Issues**—Includes "situations, interactions, and behaviors that have potential for cross-cultural misunderstanding," such as issues of authority, physical contact, communication styles, gender, sexuality, family dynamics issues, among others.

- **Understanding the meaning of the illness**—Encompasses the patient's explanatory model, which is "the patient's understanding of the cause, severity, and prognosis of an illness; the expected treatment; and how the illness affects his or her life." In addition to cultural factors, social factors may shape a person's explanatory model, such as socioeconomic status and education. Another important related aspect is eliciting a patient's explanatory model through specific methods for interviewing.
- **Determining the patient's social context**—Includes socioeconomic status, migration history, social networks, and other factors. Social context is explored through four avenues: "1) control over one's environment (such as financial resources and education), 2) changes in environment (such as migration), 3) literacy and language, and 4) social stressors and support systems."
- **Negotiating across cultures**—Describes cross-cultural negotiation as a skill that is enhanced by the skills and knowledge learned in the previous four modules. Reaching a mutually acceptable agreement consists of six phases: relationship building, agenda setting, assessment, problem clarification, management, and closure. Negotiation skills can be used in addressing both explanatory models and treatment management options.

(CROSS ET AL., 1989)

Developmental continuum ranging from "cultural destructiveness" to "cultural proficiency." The six possible points on the continuum follow:

- **Cultural Destructiveness**—Attitudes, policies, and practices that are destructive to cultures and consequently to the individuals within the culture. "A system which adheres to this extreme assumes that one race is superior and should eradicate 'lesser' cultures because of their perceived subhuman position."
- **Cultural Incapacity—**Lack of capacity to help minority clients or communities, remaining extremely biased. Characteristics include "discriminatory hiring practices, subtle messages to people of color that they are not valued or welcome, and generally lower expectations of minority clients."
- **Cultural Blindness**—Provision of services with the express philosophy of being unbiased, functioning with the belief that all people are equal and the same. Characterized by the erroneous belief that approaches used by the dominant culture are universally applicable, resulting in ethnocentric services that "ignore cultural strengths, encourage assimilation, and blame the victim."

- **Cultural Pre-Competence**—Recognition of weakness in serving minorities and attempt to improve services to a specific population. Characterized by the desire to deliver quality services and a commitment to civil rights, but with a lack of information on the function of culture and its impact on client populations and how to proceed.
- **Cultural Competence**—"Characterized by acceptance and respect for difference, continuing self-assessment regarding culture, careful attention to the dynamics of difference, continuous expansion of cultural knowledge and resources, and a variety of adaptations to service models in order to better meet the needs of minority populations."
- **Cultural Proficiency**—The most advanced point on the continuum is characterized by holding culture in high esteem, always seeking to increase knowledge of culturally competent practice.

(CULHANE-PERA, REIF, EGLI, BAKER, & KASSEKERT, 1997)

Five levels of cultural competence:

- Level 1—No insight about the influence of culture on medical care
- Level 2—Minimal emphasis on culture in medical setting
- Level 3—Acceptance of the role of cultural beliefs, values, and behaviors on health, disease, and treatments
- Level 4—Incorporation of cultural awareness into daily medical practice
- Level 5—Integration of attention to culture into all areas of professional life

Each of the levels has specific objectives for knowledge, skills, and attitudes.

(LEININGER, 1978)

The holistic "sunrise model" presents nine main domains that influence the care and health status of individuals, families, groups, and sociocultural institutions:

- Patterns of lifestyle
- Specific cultural values and norms
- Cultural taboos and myths
- World view and ethnocentric tendencies
- General features that the client perceives as different or similar to other cultures
- Caring behaviors
- Health and life care rituals and rites of passage to maintain health
- Folk and professional health-illness systems used

- Degree of cultural change

(LEVIN, LIKE, & GOTTLIEB, 2000)

ETHNIC: A framework for culturally competent clinical practice.

E: Explanation	What do you think may be the reason you have these symptoms? What do friends, family, others say about these symptoms? Do you know anyone else who has had this kind of problem? Have you heard about/read/seen it on TV/radio/newspaper? (If patient cannot offer explanation, ask what most concerns them about their problems).
T: Treatment	What kinds of medicines, home remedies or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?
H: Healers	Have you sought any advice from alternative/folk healers, friends or other people (non-doctors) for help with your problems? Tell me about it.
I: Intervention	Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g. foods eaten or avoided in general, and when sick).
C: Collaboration	Collaborate with the patient, family members, other health care team members, healers and community resources.

(LURIE & YERGAN, 1990)

Seven key objectives for learning to deliver care to vulnerable populations:

- **Have direct experience serving as the primary physician for patients from several vulnerable population groups.** Medical residents should be given enough time with patients to adequately deal with different issues and should have the opportunity to serve patients from as many different backgrounds and with as diverse conditions as possible.
- **Become familiar with and sensitive to socio-cultural issues affecting various population groups, particularly those in geographical areas where they are likely to practice.** It is important for residents to learn how to be sensitive to patients' view of medical problems and their treatment, including information about "concepts of illness in different cultures, the

historical relationship between the population under study and the health care system, the nature of the sick role, the roles of the family, society, and religion on illness and health, the use of lay and traditional beliefs and healing methods, and patterns of interaction with the health care community."

- **Explore their own responses to patients who differ from themselves socially and culturally or who have lifestyles or value systems incongruent with their own.** Physicians should be given self-examinations to reflect on their own biases and should learn about the possible implications of these biases.
- **Acquire the skills needed to care most effectively for patients in vulnerable population groups.** These skills include good communication skills, understanding important tenets of communicating through interpreters, and strategies for related health issues such as managing mental illness, chemical dependency, illiteracy, violence, and sexual abuse. Such skills will help them derive satisfaction from caring for such patients.
- **Learn about the unique epidemiologies and presentations of diseases in major population groups in the United States and groups specific to their geographical areas.** Certain diseases have patterns in vulnerable populations. These patterns, as well as the role of poverty in the epidemiology of disease, should be part of the curriculum.
- **Become familiar with major health care financing programs and their effects on access to care and the practice of medicine.** Basic curriculum should cover eligibility criteria and benefits of the Medicare and Medicaid programs as well as information on other major state and local programs.
- **Develop a sense of themselves in relation to society at large.** Medical residents feel dissatisfied when they do not have success with patients. They should learn to set realistic goals for situations dealing with patients with multiple problems.

(MARVEL, GROW, & MORPHEW, 1993)

The core objectives for teaching concepts of culture in a family block rotation follow:

- Conducting a family conference (including conference structure, family dynamics, and negotiating a treatment plan)
- Identifying developmental tasks in the family life cycle (including cultural variations)
- Understanding how one's own cultural and family background influences the doctor-patient relationship
- Understanding basic family systems concepts

- Identifying cultural factors that affect health care
- Recognizing the family role in chemical dependency

(PACHTER, 1994)

Three requirements for a culturally sensitive clinician:

- **Become aware of the commonly held medical beliefs and behaviors in his or her patients' community.** Sources of ethnomedical information can be the patients themselves, office staff who reside in the community, and social science and clinical literature.
- **Assess the likelihood of a particular patient or family acting on these beliefs during a specific illness episode.** The individual's level of acculturation is likely in part responsible for his or her level of adherence to folk beliefs and behaviors. The clinician should be prepared to ask about the patient's thoughts and expectations concerning the course of illness.
- **Arrive at a way to successfully negotiate between the two belief systems.** The type of approach to treatment depends on the potential effects of the patient's belief system on the treatment outcome, as well as the ongoing physician-patient interaction. If possible, the clinician should work with the patient to combine the folk and medical therapies and not attempt to dissuade the patient from the folk beliefs and practices. The collaboration between folk healers and medical practitioners can also be effective in negotiating belief systems.

(SCOTT, 1997)

Practical guidelines for a culturally appropriate approach to health care that can be individualized for each patient:

- Recognize intraethnic variation.
- Recognize ethnic- and culture-bound gender role norms.
- Elicit and understand the patient's concept of the sick episode.
- Identify sources of discrepancy between physician and patient's concept of disease and illness.
- Validate the patient's perspective.
- Provide education and work within the patient's conceptual system.
- Negotiate a "clinical reality" on which patient and physician can base an approach to treatment.
- Validate resolution of the patient's concerns about illness and disease at the end of the encounter.

- When the assistance of a translator is required, encourage the use of the patient's own words.
- Ensure that employees who will serve regularly as translators, but who are not trained in biomedicine, should complete a brief program in cultural sensitivity/competence.
- Provide patients with cards printed with routine requests in English and their native language.
- Consider ethnically and culturally acceptable diets, food preferences, and religious beliefs.

(SHAPIRO & LENAHAN, 1996)

A solution-oriented approach to cross-cultural training for family practice residents, identifying four general strategies:

- **Evidence-based evaluation of cultural information**—Evidence-based research attempts to specify particular cultural constructs that have clear linkages to social behavior, rather than making broad generalizations about cultural differences. Understanding evidence-based research is important for residents to evaluate the quality and integrity of cross-cultural information.
- **Inductive models for learning about cultural differences**—An inductive model focuses on the patient and family, rather than on a theory, as the center of analysis. Information obtained directly from the patient through ethnographic techniques has the greatest importance, whereas general information about the patient's culture is considered, but requires further validation.
- **Narrative approaches**—This refers to building a life-history review of the patient, perhaps over a long period of time, to establish a sense of the patient's essential values, assumptions, and expectations and to communicate respect for the individual.
- **Cultural flexibility—**Residents must develop a flexible patient interaction style in which they learn to adapt between traditional and modern orientations. This involves acknowledging potential differences; for example, patients with a traditional orientation may value a strong family identity and loyalty, whereas a modern orientation may value individual autonomy.

(STUART & LIEBERMAN, 1993)

BATHE: A useful mnemonic for eliciting the psychosocial context.

B: Background A simple question. "What is going on in your life?" elicits the context of the patient's visit.

A: Affect	(The feeling state) Asking "How do you feel about what is going on?" or "What is your mood?" allows the patient to report and label the current feeling state.
T: Trouble	"What about the situation troubles you the most?" helps the physician and patient focus, and may bring out the symbolic significance of the illness or event.
H: Handling	"How are you handling that?" gives an assessment of functioning and provides direction for an intervention.
E: Empathy	"That must be very difficult for you" legitimizes the patient's feelings and provides psychological support.