

Cultural competence: a conceptual framework for teaching and learning

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OBJECTIVES The need to address cultural and ethnic diversity issues in medical education as a means to improve the quality of care for all has been widely emphasised. Cultural competence has been suggested as an instrument with which to deal with diversity issues. However, the implementation of culturally competent curricula appears to be difficult. We believe the development of curricula would profit from a framework that provides a practical translation of abstract educational objectives and that is related to competencies underlying the medical curriculum in general. This paper proposes such a framework.

METHODS The framework illustrates the following cultural competencies: *knowledge* of epidemiology and the differential effects of treatment in various ethnic groups; *awareness* of how culture shapes individual behaviour and

thinking; *awareness* of the social context in which specific ethnic groups live; *awareness* of one's own prejudices and tendency to stereotype; *ability* to transfer information in a way the patient can understand and to use external help (e.g. interpreters) when needed, and *ability* to adapt to new situations flexibly and creatively.

DISCUSSION The framework indicates important aspects in taking care of an ethnically diverse patient population. It shows that there are more dimensions to delivering high-quality care than merely the cultural. Most cultural competencies emphasise a specific aspect of a generic competency that is of extra importance when dealing with patients from different ethnic groups. We hope our framework contributes to the further development of cultural competency in medical curricula.

KEYWORDS clinical competence/*standards; teaching/*methods; *culture; *education, medical; curriculum; humans; attitude of health personnel; prejudice.

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 INTRODUCTION

In societies that are rapidly becoming multicultural, doctors deal increasingly with patients from a variety of ethnic backgrounds. Hence, 'cultural competence' has been suggested as an instrument that can be used to prepare doctors and to support them in dealing with issues such as ethnic diversity. Cultural competence is generally defined as a combination of knowledge about certain cultural groups as well as attitudes towards and skills for dealing with cultural diversity.¹ However, as a concept or strategy, cultural competence is not yet fully developed. For example, the terminology of the concept suggests that culture and ethnicity, two different notions, are equivalent or interchangeable.² In addition, although it is clear that cultural competence is a combination of attitudes, knowledge and skills, it is not evident how and when the right balance between these elements can be achieved.

The need to address cultural and ethnic diversity issues in medical education as a means of improving quality of care for all and of eliminating ethnic and racial disparities has been widely emphasised. In several countries, educational objectives that address cultural or ethnic diversity in one way or another have been outlined for medical faculties (e.g. in the UK,³ Sweden⁴ and the Netherlands⁵). However, the practical implementation of these objectives appears to be problematic. In particular, it seems to be difficult to ensure that cultural competency is fully integrated into the curriculum. Frequently, teaching about this subject is fragmented.^{3,5} In addition, for teachers and curriculum developers unfamiliar with the subject, it is not always clear what should be taught.^{5,6}

We believe the development of culturally competent curricula would profit from a framework that provides a practical translation of the vague and abstract terms used in the outlined learning objectives. This paper proposes such a framework. It draws upon what is already known in the literature and is related to competencies that underlie the medical curriculum in general. Two basic assumptions are fundamental to the conceptual model. Firstly, we use a broad conceptualisation of cultural competence, which relates not only to cultural issues, but also to other elements that pertain to care for patients from various ethnic backgrounds, including epidemiological differences, patients' social contexts, and prejudice and stereotyping. Secondly, we do not assume that doctors are culturally and ethnically neutral, but we start instead from the premise that the learning environment of most medical students is predominantly 'White' and

'Western'. 'By embedding cultural competence information within the typical problems clinicians grapple with daily', as Vega⁷ puts it, we will specify which aspects are important in an ethnically and culturally diverse health care setting. This results in a conceptual framework of cultural competence that is based on the competencies of medical doctors in general. It also provides specific focal points for the integration of cultural competency in medical education.

The framework presented here is based on our experiences in developing educational material for medical students. It was developed over a 3-year period, during which we studied national and international literature extensively. We began to identify and to analyse difficulties (experienced by doctors as well as patients) that arise in providing health care in an ethnic or culturally diverse setting. We then defined competencies that are necessary to solve or to manage these kinds of difficulties. These competencies were compared with the literature on cultural competence. Initially, we operationalised the term 'cultural competence' very broadly as representing the attitudes, knowledge and skills necessary to deliver high-quality care to an ethnically and culturally diverse patient population. (Attitudes include a cognitive [knowing what is important] and an evaluative [an individual's affective evaluation of this knowledge] component. We describe attitudes in terms of 'awareness', but we would like to stress that after becoming aware of, for example, the influence of culture on individual behaviour, the next step within this competency is to appreciate and value the importance of this influence.)

We arranged the competencies accordingly (Fig. 1). In the next section we will specify each competency and show why it is important in everyday practice because this framework focuses on patient–doctor interaction. The competencies are illustrated with cases from educational material that we have compiled.⁸ These cases are based on real-life medical situations, and the material was gathered by interviewing doctors from several specialties and patients from a number of ethnic backgrounds.

 CONCEPTUAL FRAMEWORK OF CULTURAL COMPETENCIES

Knowledge of epidemiology and manifestation of diseases in various ethnic groups

From a prescriptive perspective, doctors should base their clinical decisions on two components: namely,

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| <p><i>Knowledge</i></p> <ul style="list-style-type: none"> • Knowledge of epidemiology and manifestation of diseases in various ethnic groups • Knowledge of differential effects of treatment in various ethnic groups <p><i>Attitudes</i></p> <ul style="list-style-type: none"> • Awareness of how culture shapes individual behaviour and thinking • Awareness of the social contexts in which specific ethnic groups live • Awareness of one's own prejudices and tendency to stereotype <p><i>Skills</i></p> <ul style="list-style-type: none"> • Ability to transfer information in a way the patient can understand and to know when to seek external help with communication • Ability to adapt to new situations flexibly and creatively |
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Figure 1 Cultural competencies

the symptoms presented and the probability of a disease.⁹ Ethnic background might influence this in two ways. Firstly, the presentation of symptoms can be influenced by a patient's culture, as in the case of schizophrenia,¹⁰ or clinical presentation may differ, such as in dermatological diseases, which may present differently in people with darker and lighter skin colours.¹¹ Secondly, the incidence of a disease may vary between ethnic groups: a well-known example is diabetes mellitus, which has a high prevalence among South Asians.¹² This affects the probability of a diagnosis in the presence of certain symptoms. In order to promote a timely diagnosis for all patients, it is necessary for doctors to be aware of these kinds of differences in the presentation and epidemiology of diseases,¹ as illustrated in Case 1 (Fig. 2).

Knowledge of differential effects of treatment in various ethnic groups

Although research in this area is still quite recent, it suggests that biological differences can be related to genetic differences that may influence the ways in

which certain drugs are metabolised. Until now, this kind of research has focused primarily on psychotropic and antihypertensive agents.¹³ However, this research focuses mainly on racial rather than genetic differences. Thus, it should be viewed with caution because research has also shown that genetic differences are greater within socially defined racial groups than between groups,¹⁴ which implies there is no biological basis for 'race'.¹⁵ Therefore, it is important for doctors to stay abreast of developments in this area, yet to view them critically at the same time.¹⁶

Awareness of how culture shapes individual behaviour and thinking

Culture is defined in many different ways, but most definitions agree that culture constitutes a set of behaviours and guidelines that individuals use to understand the world and how to live in it.¹⁷ Nevertheless, culture should not be seen as homogeneous or static. Culture may differ for members of the same ethnic group (e.g. according to differences in

Mrs Ismael, a 45-year-old woman, moved from Somalia to the Netherlands 5 years ago. She wears a headscarf because she is a Muslim. She visits her general practitioner (GP), complaining of tiredness and difficulty in walking, getting up out of a chair and climbing stairs. The doctor confirms that Mrs Ismael is indeed walking somewhat stiffly and with difficulty and he prescribes painkillers. He believes her vague complaints probably have a psychosomatic cause, like homesickness or adaptation problems. Later, he learns about the pain that can accompany vitamin D deficiency and that resembles Mrs Ismael's complaints. Causes of the deficiency can be a lack of exposure to sunlight or a lack of vitamin D in food. The GP checks Mrs Ismael's vitamin D level during her next visit and the test confirms this deficiency.

In the Netherlands, the prevalence of vitamin D deficiency is higher among women from certain non-western ethnic groups than among the general Dutch population. If the doctor had known about this unequally distributed prevalence and the complaints that accompany this deficiency (which would probably be better known if the prevalence among the general population were higher), he could have given this woman proper treatment earlier.

Figure 2 Knowledge of epidemiology and manifestation of diseases in different ethnic groups: Case 1^{8,37}

age, gender, class, religion, personality)¹⁸ and it changes over time.

Illness is culturally shaped in the sense that how we perceive, experience and cope with disease is based upon our explanations of sickness. These explanations are specific to the social positions we occupy and to the systems of meaning we employ,¹⁹ as shown in Case 2 (Fig. 3). Culture may influence many other aspects of the patient–doctor relationship, such as mutual expectations or ethical norms.

When we make contact with people from other cultural backgrounds, it is easy to attribute differences to the other person's culture. This also accounts for how doctors treat patients from other ethnic backgrounds: they tend to ascribe difficulties primarily to cultural differences.²⁰ Clearly, this is not always justified. Doctors also have their own cultural backgrounds – personal and professional – which

influence the way they interpret their patients' behaviour as well as the medical and other decisions they make, as seen in Case 3 (Fig. 4).

Clearly, cultural background, among other factors such as religion, influences peoples' perceptions of health and health care, their frames of reference, and their expectations. Awareness of how this might be of influence – instead of mere knowledge about the cultural practices or beliefs of specific ethnic groups – and an appreciation of this factor helps doctors deal effectively with cultural issues. The same applies to doctors' awareness of their own cultural frames of reference.

Awareness of the social context in which specific ethnic groups live

According to Green *et al.*,²¹ most cultural competency initiatives underemphasise the importance of

An 8-year-old girl of Moroccan descent visits the emergency room. Over a 1-month-period, the girl had experienced speaking difficulties, walking disturbances, problems with writing, and moments of being mentally absent. The physical examination does not show any abnormalities. The conclusions from the neurological examination are 'no signs of meningeal irritation, walking disturbed, muscle tone diminished'. Several additional examinations provide no further information and the doctor decides to do a lumbar puncture to exclude encephalitis. The child's mother refuses, but the reason for this refusal is unclear to the doctor. Therefore, they request the assistance of a doctor of Moroccan descent. She asks the mother, 'What do you think is wrong with your daughter?' The mother answers, 'I think it is a djinn [a spirit in Islamic folk belief]. That is what the imam told me.' She believes that if her daughter is given a puncture or a drip, it will upset the djinn and her daughter will become more seriously ill.

Although in this case it remains unclear why the mother took her child to the hospital when she had already sought help elsewhere, it does show how the cultural-religious background of this mother influenced her decision-making with regard to her daughter's health.

Figure 3 Awareness of how culture shapes individual behaviour and thinking: Case 2⁸

Mrs Tünay, a 26-year-old woman of Turkish descent, has diabetes that is difficult to regulate. She has just told her internist she is 5 weeks pregnant, which came as a surprise to the internist. Although she knew that for the last 4 years Mrs Tünay has wanted to have a baby, the internist thought it was better to regulate her diabetes first. After all, Mrs Tünay is young enough.

In this case, the doctor's reasoning comes from her medical background, and she believes the medical risks for mother and child are more important than the patient's wish to have children. Furthermore, because the average Dutch woman is 29 years old when she has her first child, although the average Turkish woman is aged 21 years, the internist is also reasoning from a 'Dutch' perspective when she claims that Mrs Tünay is still young enough to postpone a pregnancy.

Figure 4 Awareness of how culture shapes individual behaviour and thinking: Case 3^{8,38}

social factors in providing health care to diverse populations. Addressing only cultural factors may lead doctors to think that culture can explain issues that are fundamentally social.²¹ Green *et al.*²¹ distinguished four domains of social context that are particularly important for ethnic minority patients: social stressors and support networks; change in environment; life control, and literacy. Generally, in Western European countries and the USA, all these domains are less favourable for ethnic minority patients than for the host population. For instance, the income and educational levels (which are lower on average) of ethnic minorities,²² higher vulnerability to discrimination²³ and the process of becoming familiar with a new society may all serve as stressors, as may distress caused by the migration itself. In Excerpt 1 (Fig. 5), a Moroccan woman we interviewed speaks about her limited options when it comes to her children's health. The final domain distinguished by Green *et al.* is

literacy; minorities have disproportionately high levels of illiteracy.^{21,24} Difficulties in reading prescriptions and understanding instructions or appointment reminders are some of the possible consequences.

The rules and regulations that might be challenged with regard to caring for ethnic minority patients also directly influence health care. Three important issues in this regard are care for undocumented patients, legislation about residence permits on medical grounds, and informed consent.

All these factors indicate the importance of taking patients' social contexts into account. If a doctor is unaware that ethnic minority patients have fewer opportunities in life compared with the host population, he or she may interpret a particular situation as reflective of unwillingness on the part of the patient, rather than as indicative of

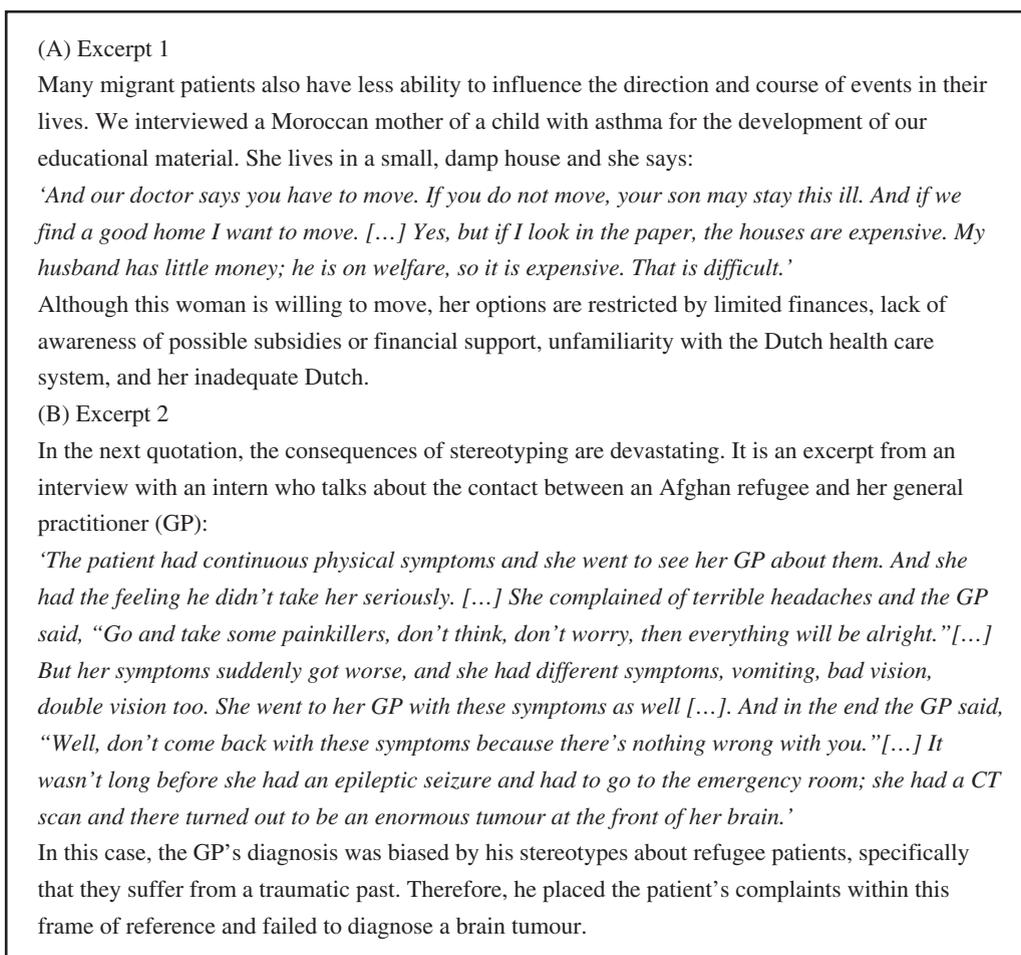


Figure 5 Attitudes. (A) Awareness of the social contexts in which specific ethnic groups live. (B) Awareness of one's own prejudices and tendency to stereotype

circumstances where certain responses are impossible. If a doctor is not aware of the stress related to a patient's position as a migrant (e.g. as a result of discrimination), he or she may not recognise or acknowledge this distress and will thus ignore it.

Awareness of one's own prejudices and tendency to stereotype

Stereotyping is a mechanism by which we give structure to the world that surrounds us.²⁵ Patients with different ethnic or cultural backgrounds can more easily invoke bias as a result of stereotyping or prejudice. For the doctor, several mechanisms may influence this.²⁶ For example, doctors may have lower regard for, or even prejudice against, certain ethnic groups. Clinical uncertainty can also play a role: doctors must make judgements about patients' conditions under time pressures and resource constraints. It can be more difficult to obtain the necessary information or to interpret the given information when a patient has a different ethnic background. The doctor's a priori attitudes (e.g. about ethnic background, socio-economic position, age or sex) may then shape his or her interpretation

of the information provided by the patient. In the case of stereotyping, doctors use social categories (e.g. race, sex or class) to acquire, process and recall information about others (Excerpt 2, Fig. 5). As a first step towards avoiding this pitfall, it is essential to be aware of one's own prejudices and tendency to stereotype. This concerns obvious prejudice as well as subtle stereotyping, as reflected in patronising or avoiding patients.

Ability to transfer information in a way the patient can understand and to know when external help with communication is needed

Nowadays, although good doctor–patient communication is accepted as an important condition for quality of care,²⁷ it is not always self-evident. Problems in this regard may result in incorrect diagnoses, non-compliance with treatment, or inappropriate use of health services. Problems in communication and mutual understanding occur more often between doctors and migrant patients than with native-born patients.²⁸ These difficulties can be caused by a number of factors. The most obvious is language, but cultural differences and level of knowledge can also play a role (Case 4, Fig. 6).

This dialogue was transcribed from an actual consultation on videotape:

A Moroccan man and woman visit a general practitioner (GP). The man nervously speaks to the doctor and explains that he and his new wife are going to have intercourse for the first time. She is still a virgin and he wants a tablet so that she doesn't get pregnant. The GP explains about contraceptives.

GP: 'But these tablets, she has to start with them on the first day she has a loss of blood, you know?'

Man: 'Yes, only, so she is still a virgin. I know first the blood will come but I think before the blood comes she has to eat tablets? I think so?'

GP: 'Well the, ummm, no you have to start the first day the blood comes, then she has to start; then she has to take the first tablet.'

Man: 'Before the blood comes or after?'

GP: 'No, the first day, blood always comes 4 days 5 days but the first day she has to start and must take the first tablet.'

Man: 'An example, I'm sorry I go sleeping with her at night, yes? She goes taking a tablet before?'

The language barrier makes it difficult for both parties to express themselves. A misunderstanding arises when the man and the GP attribute different meanings to the word 'blood' (as a synonym for menstruation versus the blood that is apparent at the loss of virginity). Furthermore, this man has scarcely any knowledge of contraceptives or the menstrual cycle, so he cannot place the doctor's information within his own frame of reference.

Figure 6 Skills. Ability to transfer information in a way the patient can understand and to know when to seek external help with communication: Case 4⁸

Because of the negative consequences of inadequate information, the ability to transfer information in a way the patient can understand is essential for doctors. Formal training in intercultural communication competence may support doctors in this.²⁹ Additionally, because it is both impossible and undesirable for doctors to master the native languages of all their patients, it is important that doctors acknowledge the limits of their competency. It has been proved that external help such as medical interpreting services improve the quality of care for patients with limited language proficiency,³⁰ but these services are not consistently used in practice.³¹ Doctors should know how to call in this external help and should be able to use it constructively.

Ability to adapt to new situations flexibly and creatively

The competencies described thus far emphasise the importance of certain knowledge, awareness, and skills, but these are not ready-made solutions for difficult or unfamiliar situations. When handling new situations, doctors cannot always fall back on standard solutions. Sticking to usual habits and principles, or disapproving of certain preferences (including cultural ones), may create conflicts or frustration, or may damage the doctor–patient relationship. Instead, doctors have to find new and versatile solutions, and this requires creativity and flexibility. This can be seen as part of patient-centredness, the approach advocated today in medicine.³² The literature and the interviews we used to develop our educational material illustrate that patients are usually highly appreciative when doctors are prepared to think along with them, to step outside their usual way of doing and to demonstrate versatility in dealing with ethnic minority patients.^{8,33}

DISCUSSION

In this paper, we have presented cultural competencies we believe are essential for medical practice in an ethnically diverse setting. A versatile conceptualisation is a prerequisite if we want to use cultural competence as a means to improve quality of health care for all, to eliminate health disparities in general and as a strategy to educate future doctors as culturally competent practitioners.

Our framework anticipates two important criticisms of the concept of cultural competence. Firstly, the term ‘cultural competence’ incorrectly suggests that the concepts ‘ethnicity’ and ‘culture’ are interchange-

able. This does not do justice to the complex socio-cultural context in which patients live,¹⁷ and which we must acknowledge if we are to care for an ethnically diverse patient population. Therefore, the competencies we distinguished in our conceptual framework also relate to elements other than cultural, such as epidemiological differences, patients’ social contexts, and prejudice and stereotyping. Secondly, it has been noted that cultural competence tends to focus on the ‘otherness’ of patients as the cause of experienced problems, while assuming doctors to be culturally neutral human beings.² Therefore, the framework acknowledges that not only patients, but also doctors and health care systems, are culturally influenced.

When describing the competencies, we distinguished between the elements of knowledge, attitudes and skills. Yet it is the integration of these that make up a competency,³⁴ described by Betancourt as a three-legged stool.¹ Thus, for instance, if a doctor is knowledgeable about epidemiological differences, he or she must also possess the appropriate disposition and value system and must be skilled in order to apply this knowledge in practice. In our description, we emphasised the most important aspect of a competency, but it is fully constituted by the interaction between knowledge, attitudes and skills. Developing such competencies requires an educational design that balances and continuously shifts between the acquisition of knowledge, attitudes and skills, and that offers opportunities to integrate these aspects.³⁴

It might appear that the competencies described represent a striving for an ideal situation. Indeed, we believe it is necessary to aim for this in order to assure high-quality care (e.g. doctors should never rely on their stereotypes). However, this is more complex in terms of skills in communication and flexibility because, although a doctor may have highly developed abilities in this regard, the provision of care always involves interaction with the patient. Both are responsible for the outcome of the interaction, but a doctor has to act within the limits of his or her profession and organisation. Sometimes there may be no solution other than to accept an unsolvable or unsatisfactory situation.

If we take a close look at the cultural competencies defined, it becomes clear that they are not very different from those competencies every doctor already needs to possess. Most of the cultural competencies emphasise a specific aspect of a certain generic competency that is of extra importance when dealing with patients from different ethnic groups. Interaction with ethnic minority patients magnifies

problems that already exist, although communication difficulties are more obvious when neither partner speaks the other's language. However, it does not mean these kinds of problems do not exist with other patients. Therefore, cultural competencies might be expected to benefit health care in general.¹

The framework of competencies could be interpreted as a list of educational goals, which suggests that if one has 'completed' the list, one is culturally competent. We do not consider cultural competence to be an end in itself, however, but a means to the provision of a better quality of care. Like any other medical competency it needs continuous attention. In this manner, the framework fits the concept of reflective practice, the importance of which is increasingly recognised within medicine. Reflection helps professionals and students to make sense of complex situations and enables them to learn from experience.³⁵ When a doctor reflects on his or her medical performance, the aspects of cultural competency should be a recurring focal point.

We believe this framework can be used by teachers and curriculum developers to examine whether all these aspects of cultural competence are being given proper attention and to find out whether there are any blind spots to, or underemphasised aspects of, cultural competence in medical education.¹⁸ In order to assess students' cultural competency, the competencies need to be developed further. For example, they might be expressed in terms of measurable behaviour and they should inform learners about what is expected from them.³⁶ However, like Govaerts,³⁴ we want to stress that competencies derive meaning in practice and that the foremost concern of education and assessment should be to facilitate the understanding of practice and understanding *in* practice. We hope our framework can contribute to the further development of an integrated approach to cultural competence in medical curricula.

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