Enhancing Client-Centered Communication Through Cultural Competence

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Disclosure

- I have no real or perceived vested interests that relate to this presentation nor do I have any relationships with pharmaceutical companies, biomedical device manufacturers, and/or other corporations whose products or services are related to pertinent therapeutic areas.

Session Objectives:

- Understand cultural context of client communication
- Identify individual biases and attitudes that inhibit/facilitate effective client communication
- Develop a personal strategy for enhancing communication through cultural competence
PART I: COMMUNICATION and CULTURE

Communication and Healthcare

- "Everyone knows that a big part of nursing is about communication, there are more books on the shelf about communication than almost anything else. Everyone remembers something about active listening and body language and posture and everyone knows that stuff easily gets lost in busy clinical settings... But, without the capacity to communicate – well, you are a rubbish nurse. That’s it. You may think you are clever and have a diploma in nursing things, but if you cannot be understood by your patients, let them feel listened to or cared about, you are not doing your job."


Client-centered communication

- Communication that places the client’s needs and concerns first and encourages greater participation in the decision making process
Benefits of client-centered communication

- Increased patient satisfaction
- Improved clinical outcomes
- Increased clinic efficiency

Communication objectives:

- Provider-centered: to get the patient to adhere to an existing plan of action based on the medical expertise of the provider
- Client-centered: to work with the patient to develop a mutually acceptable plan of action based on the provider’s medical expertise and the patient’s values, preferences, and culture

So why don’t we all do it?

- Failure to recognize and acknowledge “cultural” differences
- Unable to integrate client’s personal beliefs, preferences, and values into the decision making process
Activity 1: Cultural Introduction

- The meaning of your name
- How and when your family came to the United States
- Why you chose to work in family planning

Cultural Identity

- SELF
- RACE/ETHNICITY

Cultural Identities

- SELF
- RACE
- LANGUAGE
- GENDER
- AGE
- DISABILITY
Visible differences

- Race
- Gender
- Age
- Language
- Disability

Invisible differences

- Religion/Spirituality
- Educational attainment
- Sexual Orientation
- Gender Identity
- Immigrant status
- Many, many, more…

CULTURE

YOUR PERSONAL STORY
Reasons for communication failure in health care settings

- Failure to recognize invisible differences
- Failure to appreciate and integrate culture of patient
- Failure to acknowledge personal biases

PART II: EXPLORING DIFFERENCES and BIAS

Why are some differences invisible to us?

- Conscious or unconscious assumptions:
  - Everyone who looks and sounds the same IS the same
  - Everyone who looks and sounds like us IS like us
Invisible differences: LEP

- Limited English Proficiency: limited in ability to speak, read, or write English

- 21-23% of people living in the United States are LEP
- 75% of people with written LEP are born in the U.S.
LEP Considerations

- Someone who **does not** speak English may **be** proficient in reading and writing English.
- Someone who **speaks** English **may not be** proficient in reading and writing English.

Patient encounters

- Do I assume that if someone sounds literate, they are literate? Do I expect that they **should** be?
- What do I do to verify that my patients understand the written directions or print material? Do I assume that they will tell me if they don’t understand?
- Do I make judgments about the literacy or intelligence of a patient based on their accent?

Are we BIASED?
ACTIVITY 2: Stereotypes

• Visualization exercise

Why do we stereotype

• A "stereotype" is a generalization about a person or group of persons. We develop stereotypes when we are unable or unwilling to obtain all of the information we would need to make fair judgments about people or situations. In the absence of the "total picture," stereotypes in many cases allow us to "fill in the blanks."

Culture: an iceberg

VISIBLE DIFFERENCES

INVISIBLE DIFFERENCES
Bias
• Having bias is not what causes most harm
• People are hurt when we fail to “see” our biases, understand them, and then use our improved self-understanding to become more effective in adapting our views and behaviors to the needs of others

Communication objectives:
• Provider-centered: to get the patient to adhere to an existing plan of action based on the medical expertise of the provider
• Client-centered: to work with the patient to develop a mutually acceptable plan of action based on the provider’s medical expertise and the patient’s beliefs, value, and culture

PART III:
ACHIEVING CULTURAL COMPETENCE
**Definition of cultural competence**

- Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations

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**What Cultural Competence is NOT**

- Knowing things about other cultures
  - Not a laundry list of do's and don'ts

- The goal of cultural competence is NOT tolerance
  - Tolerance results in predictability, NOT understanding

- Blaming “dominant” cultural groups

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**Goal of Cultural Competence**

- The goal of cultural competence is to facilitate the *acculturation* of diverse individuals and groups in a society
Acculturation vs. Assimilation

- **Assimilation**: process whereby one group within a society adopts the values and behaviors of the dominant group.

- **Acculturation**: interaction between different groups within a society that results in changes in behaviors, and values of both groups.

Client versus provider-centered:

- **Provider-centered**: to get the patient to adhere to an existing plan of action based on the medical expertise of the provider.

- **Client-centered**: to work with the patient to develop a mutually acceptable plan of action based on the provider’s medical expertise and patient’s values and beliefs.

Model 1
EVERYONE acculturates

- "there is no people whose customs have developed uninfluenced by foreign culture, that has not borrowed arts and ideas which it has developed in its own way,…the steel harpoon used by American and Scotch whalers is a slightly modified imitation of the Eskimo harpoon”.

– Franz Boas, 1888
Power and Privilege

In a society, the privileged group has the power to:

- Act and define reality
- Determine what is normal and what is not
- Institutionalize and systematize discrimination

### Ways the Privileged Culture Uses Power

<table>
<thead>
<tr>
<th>Structures and Organizations</th>
<th>Decision-making</th>
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<tbody>
<tr>
<td></td>
<td>Power over the distribution of capacity to make and enforce decisions</td>
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<td></td>
<td>Resources</td>
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<td></td>
<td>Provision of unequal access to money, education, information, and opportunities</td>
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<tr>
<td>Cultural values</td>
<td>Standards</td>
</tr>
<tr>
<td>Parameters for appropriate behavior are set such that they reflect and give privilege to the norms and values of the dominant culture</td>
<td></td>
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<tr>
<td>Ideology</td>
<td>Naming reality</td>
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<tr>
<td>Involves defining reality by naming “the problem,” “the solution,” the institution incorrectly or too narrowly as having “a root of blame,” with a bias</td>
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Power Dynamics

• People who are privileged typically do not feel powerful; they feel ‘normal’.
  – ENTITLEMENT

• Multiple cultural norms = multiple dimensions of power.

Who’s more privileged?

Who’s more privileged?
Who’s more privileged?

Cultural Evolution

LANGUAGE
DISABILITY
AGE
GENDER
RACE
SELF SEX ORIENT
RELIGION
EDU
SES
JOB

Cultural Evolution
Social Dynamics

- Power and privilege are relative
- Power dynamics exist in every social interaction we engage in
- Power/powerlessness is a part of ALL cultural identities
Everyone experiences in their lives moments when they are within social norms (privileged) and moments when they are outside social norms (unprivileged).

“Every human interaction is a cross-cultural interaction”

Cultural Competence Continuum

- Fear
- Denial
- Minimization
- Acceptance
- Adaptation
- Integration
Cycle of Cultural Competence

Activity 3: Self-Assessment

- Identify where you are on the cultural competence continuum for each of the five cases

- Reflections
OSFA

- One size does NOT fit all
- Client-centered approaches require custom tailored solutions
- All people are NOT created equal and should NOT be treated equally

Equality versus Equity

- EQUALITY: When we treat people equally we ignore differences
- EQUITY: When we treat people equitably we recognize and respect differences

Client-Centered Communication

Cultural Competence

Improved Outcomes

Acculturation

Two-way sharing, adoption, and integration of knowledge, values, and beliefs
Simply put Cultural Competence is

PERSONAL STORIES  VALIDATION  PERSONAL STORIES

All human relationships cultural evolution