Cultural competence has become a ubiquitous catchphrase as health care providers confront inequalities in care, particularly those prompted by differences in race, ethnicity and socioeconomic status. It can affect everything from institutional policies and procedures to personal interactions between patients and providers. Cultural competence is not simply a matter of social pleasantries; rather, it has real-life consequences for health outcomes. Studies show that integrating ethnic and socioeconomic considerations into a practical care plan improves patient compliance [1,2]. Providers everywhere have an obligation to integrate cultural competence into practice to improve, if not save, their patient’s lives. Providers must examine their own practices, looking inward to understand how their biases and perceptions affect care, and looking outward to identify how they can improve their patient’s experience and outcomes.

Many hospitalized indigenous Guatemalan women suffering from maternal complications endure terrifying experiences due to inadequacies in culturally competent care. Native communities such as Mayans, K’iche and Kaqchikel account for approximately 40% of Guatemala’s 13 million people, but the country’s difficult history of inequality and racism has created significant barriers for these populations [3]. Historically, Guatemala’s stratified society with a Ladino (citizens of European descent) majority in social and economic control has left the indigenous populations marginalized. Native Guatemalan women visiting hospitals fear being sterilized without consent, a method of maintaining authority sometimes utilized by powerful majorities in socially unbalanced cultures. Guatemala recognizes 23 distinct Amerindian languages, most of which are markedly different from the Spanish spoken by Ladinos, making communication impossible at times. These collective barriers, in the absence of culturally competent care, make receiving medical attention an alienating and frightening, if not impossible, experience for countless women.

As globalization broadens diversity worldwide, cultural competency training for providers is essential. A 1997 study found that 68% of United States medical schools offered some formal cultural competency training and an additional 14% planned to introduce the topic in the curriculum, but provider bias continues to affect care [4]. Minorities in the United States experience significant variation in rates of medical procedures and quantity and quality of routine medical care [5]. One study found that while Black and Hispanic women are significantly more likely to be counseled by physicians about sexually transmitted diseases than are white women, they are less likely than white women to be counseled about hormone replacement therapy, a pertinent issue to all menopausal women [6]. In New Zealand, one study found that the indigenous Maori minority receives poorer care within the predominantly public hospital system than citizens of non-Maori/non-Pacific heritage [7]. Inequality in care continues even while a majority of recently surveyed US physicians believe that disparities within the health care system “rarely” or “never” happen based on factors such as income, fluency in English, educational status, or racial or ethnic background [8].

Health care inequalities must be rectified to give the best patient care; one strategy for doing so is for providers worldwide to improve their cultural competence. Providers should examine their cultural beliefs and values, particularly those related to health, and biases and assumptions affecting care. Cultural competence applies to groups of people based on any criteria — age, marital status, sexual orientation — not solely on ethnic differences. A prevailing mindset in the United States suggests that seniors cease to be sexual beings, yet half of all men over age 80 remain interested in sexual activity [9]. Increasing STI and HIV infection rates among older populations confirm it is unwise to assume these individuals are sexually inactive [10]. A study of 2047 northern Thai male military conscripts found that the 6.5% of participants who identified as having sex with men were more likely to be married and to have a girlfriend with whom they had sex than their heterosexual counterparts [11]; marriage is not an infallible predictor of sexual orientation or activity. Providers must overcome assumptions about their patients to provide appropriate care.

Providers should be cognizant of patients’ beliefs and practices and provide care accordingly. Among some Russian populations, prenatal care is only sought if the woman feels there is a problem with the pregnancy, and
heavy exercise or exertion, particularly in the third trimester, is strongly discouraged; some Asian cultures advocate strongly for physical activity up until birth [12,13]. An Orthodox Jewish woman will keep her head covered at all times, either with a cloth or a wig, and a provider should ensure that her head stays covered during any procedure, such as a cesarean birth. Orthodox men may refrain from touching their wives during labor due to biblical laws restricting contact with vaginal bleeding and may provide verbal encouragement instead [14]. Providers must recognize that these cultural values will impact a patient’s care and find ways of working within them.

A patient’s cultural background also affects the patient/provider relationship. Many Latino communities greatly value simpatia, or kindness, which may lead patients to expect a positive and encouraging approach to care. The clinical tone taken by many US providers may be perceived as negative and affect a patient’s willingness to seek follow-up care or follow recommendations [15]. Providers should also be mindful of the value placed on family in Latino cultures and recognize that families, rather than individuals, often make health care decisions. Health care providers are viewed as authority figures within Chinese culture; if patients do not agree with the recommended treatment, they may disregard it without telling the provider out of respect [16]. Providers can improve the impact of their patient visits by being mindful of these cultural values in their interactions.

Cultural competence approaches can be creative and grassroots. Yadira Villaseñor de Cross, a Ladina physician in Guatemala, recognized indigenous women’s barriers to care and founded a program to improve cultural competency at a local hospital. The program bridged Mayan culture and the hospital via an indigenous traditional birth attendant or comadrona, who acted as a linguistic and cultural translator. The comadronas helped the hospital staff adapt indigenous traditions into their practice. Providers modified the faja—a piece of Mayan textile holding warm ashes which is wrapped around the abdomen to soothe pain during labor. Providers now wrap the abdomen in a cloth containing a sock of warm rice to simulate the tradition.

The hospital staff fully integrated the comadronas into their practice. Seven comadronas, bilingual in Spanish and at least one local indigenous language, rotate 24-h shifts on the maternity ward, 365 days a year. Both parties sign formal letters of agreement committing to an integration of practices. To address each other’s misconceptions and concerns, comadronas and Ladino providers hold roundtable discussions, an essential step in overcoming biases.

Since implementing the program, hospital records indicate decreased maternal mortality rates and increased numbers of births attended, complications treated and number of patient referrals to the hospital by comadronas. Qualitative patient exit interviews suggest that the comadrona program has improved the hospital’s perception in the Mayan community. The comadrona program is an exceptional example of cultural competence and the importance of overcoming personal biases, implementing small changes in clinical practice and incorporating guidance from cultural ambassadors.

Health care providers everywhere can take small steps to improve cultural competence in clinical care:

- **Work toward self-awareness and education** — Become aware of your own biases and assumptions about your patients and proactively learn about their cultural values. While no provider can be expected to know everything, educate yourself about the lives of patients you often see in your practice.

- **Define health and well-being in the broadest possible sense** — Try to understand and accommodate definitions of health that are different from your own. Example: Jehovah’s Witnesses will not accept blood transfusions and will request nonblood alternatives; however, autotransfusion is considered a personal decision [17].

- **Make no assumptions about your patients** — Instead, ask questions about their health, including a complete sexual history, and provide care accordingly. Example: youth in Germany, France and the Netherlands are encouraged to discuss sexual activity with their provider and are given convenient and low-cost access to contraception, contributing to some of the lowest rates of pregnancy, teen birth and abortion in the developed world [18].

- **Make the clinical setting, educational materials and office visit culturally sensitive and relevant to your patients** — Cooperation from your office, institution and staff is essential. Example: conservative Muslim women greatly value modesty. To make a patient as comfortable as possible, provide long-sleeved, ankle-length gowns and ask her permission and assistance to pull clothing aside if necessary in the exam.

- **Reach outside your office or institution for help** — Local community-based organizations, patient representatives and colleagues can be valuable resources; reach out to them for assistance navigating differences.

Improving cultural competence in care is something that is easy to put off for another day, yet has serious implications for the care patients are receiving today. By making small steps toward self-awareness, education and culturally relevant care, providers have an opportunity to better serve their patients and reverse the trends in health care inequality.

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