Cultural Competency Becomes Curricular Cornerstone

—By Elissa Fuchs

Cultural competence is becoming a mainstay in medical education.

The U.S. Department of Health and Human Services defines cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations," or instances where parties differ in their language, customs, beliefs, race, ethnicity, or religion. On a practical level, cultural competence allows patients and doctors to discuss health concerns without any cultural differences hindering their conversation. More culturally attuned doctors can consider a patient's background and collaborate with them on a treatment plan that appeals to both parties and respects individual traditions and beliefs.

Many believe culturally appropriate practices can improve trust in the health care system. A 2008 *Journal of Occupational Medicine and Toxicology* article showed that Native Americans in Arizona gave a culturally competent disaster preparedness training session a rating of 4.2 out of a possible five. To make the training sensitive to Native American customs, each training session included prayers led by tribal members.

To ensure that a younger generation of doctors can provide optimal care for all their patients, residency programs at the University of California (UC), Davis Health System and University of California, Irvine Healthcare have been incorporating cultural competency education into their curricula. With 26 percent of Californians being born in a foreign country, and 40 percent speaking a language other than English at home, cultural competence has particular relevance in the Golden State. Cultural competency education is gaining traction in other parts of the country as well; the Medical University of South Carolina, for example, is scheduled to unveil a graduate medical education curriculum on this topic next year.

Psychiatry residents at UC Davis participate in a longitudinal cultural competency curriculum, which has been running for about five years. Russell Lim, M.D., an associate clinical psychiatry professor at UC Davis who coordinates the program, said that being culturally aware is an important part of providing quality mental health care.

"Psychiatry is more dependent on how the patient describes their situation," Lim said. "Patients say things like 'I've been feeling sad' or 'I hear voices.' But what exactly do they mean? We often would give a patient who hears voices antipsychotic medication, but in some Native American cultures, communication with a deceased grandmother is encouraged and is not pathologic."

In the psychotherapy component of the UC Davis curriculum, residents learn to be aware of any tension between them and their patients resulting from different cultural identities. While psychiatrists are traditionally taught to be neutral and not to divulge anything during psychotherapy, this blank slate approach might not always work.

"Some Hispanic patients may want to know if you are warm and friendly," Lim said. "We advise residents to reveal something to build a stronger rapport with patients."

In discussions at rounds, residents hear examples of different cultures' interplay with mental health, such as suicide among Hispanics and psychiatric trauma in refugees. According to a 2005 *Journal of the American Medical Association* article, half of Cambodian refugees suffered from major depression, and 62 percent had posttraumatic stress disorder 20 years after resettling in the United States. At the end of residency training, trainees present one patient case to a "cultural consultant," a person from the same demographic group as the patient. The consultant then provides insights into where the doctor took account of the patient's background, and where he or she missed some important cultural cues.

"The community expert is able to tell the doctor what is 'normal' when factoring in the patient's background, and what isn't," Lim said. "We emphasize that individual differences between people are more important than cultural generalities, but not knowing the general leaves you in no-man's land," Lim said.

Farther down the California coast, UC Irvine family medicine residents are learning to collaborate effectively with translators. Ensuring that patients who do not speak English understand their medical condition and treatment plan is a big part of cultural competence, said Charles Vega, M.D., UC Irvine's family medicine residency director. For this reason, UC Irvine uses language interpreters in the patient care arena.

But to strengthen their relationship with their non-English-speaking patients, UC Irvine residents have been learning body language techniques to use when an interpreter is in the room. The young doctors are instructed to address the patient, not the translator, and sit in a place where the patient can see them, Vega said. Residents practice these techniques on standardized patients and then view their performance on videotape.

Next year, the program is introducing a mandatory medical Spanish class for all family medicine residents so that they can better understand their Spanish-speaking patients. This weekly 45-minute class will cover basic vocabulary pertaining to illnesses, symptoms, medication, and other medical terminology.

Vega said that the translator curriculum will not be phased out.

"English does not share a lot of similarities with a language like Vietnamese," Vega said. "We see patients from all over the world, and learning to work effectively with interpreters needs to continue."