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# Cultural Competency — The Caregiver Connection

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*Healthcare that is respectful and ethical must also be culturally competent, and a variety of tools are available to empower caregivers to provide culturally competent care. This article reviews the tools that the University of Michigan Health Care System's Program for Multicultural Health provides to caregivers throughout its many services. Cultural competency begins with self-awareness and knowledge, but it is also to embark upon a lifelong journey. Progress is cumulative, and assessment is an important part of the process.*

Cultural competency is inextricably connected to caregiving because healthcare that is respectful and ethical is culturally competent. At the University of Michigan Health Care System, the Program for Multicultural Health's Cultural Competency division strives to empower all caregivers to provide culturally competent, ethical healthcare.

Our goal is to enhance patient and family-to-staff relationships from a cultural perspective; our mission is to share with all University of Michigan Health Care System staff, faculty, and students *what* cultural competency is, *why* it is important to caregiving, *how* it can be implemented in the services caregivers provide, and how we assess our progress on this lifelong journey.

## Defining Cultural Competency

Cultural Competency is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals to enable that system, agency, or those professionals to work effectively in cross-cultural situations (Cross et al. 1989; Isaacs and Benjamin

1991). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes that can be used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes (Davis 1997).

In general, "cultural competency is really about respecting cultural autonomy" (Baumgarten 2001). In other words, caregivers work more effectively in cross-cultural situations when the system and agency in which they work, the caregivers among whom they work, and their own behaviors and attitudes are congruent with integrating and providing culturally competent, ethical healthcare.

## Understanding Cultural Competency

Clinicians have long acknowledged that a patient's health beliefs, practices, and communication style play a critical role in care and caregiving. Issues of cross-cultural communication and variations in health beliefs and practices affect both patient satisfaction and clinical outcomes. To be leaders in healthcare, caregivers must remain at the cut-

ting-edge of developments in culturally competent medicine. By so doing, they will

- make more effective use of time with patients,
- increase the patient's comfort in disclosing information,
- be better able to negotiate differences,
- increase patient compliance in treatment protocols,
- create more positive clinical outcomes,
- experience improved communication with patients,
- have less stress,
- build more trusting relationships,
- increase patient satisfaction, and
- find it easier to meet increasingly stringent government regulations and medical accreditation requirements.

### **Providing Cultural Competency**

Caregivers provide culturally competent health care by learning how each patient and family would like to be treated in all aspects of their care. At the University of Michigan, we stress "each" patient and family because no culture is homogeneous. Cultures have subcultures, and subcultures have subcultures. Further, it is not necessarily the case that any two families or family members will hold identical healthcare beliefs or practices. Therefore, caregivers must learn how each patient and family wants to be treated.

We stress "all" aspects of care because a variety of patient-caregiver interactions occur, each of which has the potential to change one's treatment preference. Whether caregivers are scheduling an appointment, prescribing medications, addressing symptoms management, or discussing end-of-life issues, they must learn how each patient would like to be treated in these aspects of care.

To progress toward cultural competency and ethical healthcare, caregivers must become aware of their own preconceived notions, cultural biases, and beliefs. Second, they must have a desire to learn more about various cultural health beliefs and practices. Third, they must become informed through various resources, whether by dialoguing with fellow caregivers, asking questions of patients and families, or reading creditable materials.

Finally, as caregivers apply these newly gained skills, they accrue additional encounters of caregiving among different cultures, which inevitably gives them new knowledge and enhances their understanding. If caregivers become self-aware, desire to gain more knowledge, and apply their skills during cultural encounters, they will become intrinsically connected with cultural competency.

### **Implementing Cultural Competency**

The University of Michigan Health System's Program for Multicultural Health offers a variety of tools to connect caregivers to cultural competency. For example, every other Monday morning we email a multicultural health generalization to those who request it. These generalizations are bulleted paragraphs of information on a specific health topic from the perspective of one culture (see, e.g., the Iraqi Practices on p. 19). We select the health topics and cultures by paying attention to requests, hot-buttons, frequent encounters, and patient population statistics.

Other tools include bringing in speakers, posting materials on our website, preparing printed pocket guides for providers who prefer not to use the website, publishing a multicultural calendar, providing consulting services and strategic planning, and serving as a liaison to other departments that are seeking expertise in culturally competent care. I will discuss some of these tools in detail.

● **Speakers.** We host a multicultural health series on a monthly basis. That is, we sponsor a presenter, usually a University of Michigan Health System affiliate, who speaks about a health topic

## Iraqi Traditional Medicine Practices

Although the peoples of Iraq have a long tradition of complementary and alternative medical practices, much variation between tribes and across geographical areas exists. The following describes some common, but by no means universal, traditional medicine beliefs and practices:

- Cumin powder dissolved in water is given for stomach ache, as is green tea.
- Lemon juice or plain rice given for diarrhea.
- A heated brick, covered with a cloth and sat upon, is also used for diarrhea.
- The Karawya herb, boiled in water, is given for stomach ache, diarrhea, or constipation. This herb is also believed to ease abdominal pain, especially in children.
- To treat a cough, Iraqi patients may drink a mixture of honey and lemon juice or lemon juice and orange juice.
- To treat a cold, a steam tent is constructed where the patient can be kept covered for up to twenty-four hours.
- Boiled in water, the anise seed is used for a sore throat or laryngitis.
- Ground cumin, ninia seed, shabak seed, are all ground and mixed together as a powder and placed on the gum for toothaches.
- For a dislocated shoulder, ninia and churned butter are mixed together as an ointment and applied to the shoulder.
- To treat burns, barley is burned, mixed with butter, and applied as a poultice on the burn for 48 hours.
- For a splinter, a paste of flour and sugar is placed over the splinter or over an infected pimple or cyst.
- An infected eye with pus drainage is treated by placing a cloth, boiled in tea, over the eye.
- To treat fever, a cloth is dipped in a mixture of cumin and egg yolk heated in water, and then placed over the forehead.

(Source: [www3.baylor.edu/~Charles\\_Kemp/iraqi\\_refugees.htm](http://www3.baylor.edu/~Charles_Kemp/iraqi_refugees.htm). Retrieved 4/2/03.)

from a specific cultural perspective. Although these presentations are open to the public, our target audience is University of Michigan Health System employees. From our presenting site at the main hospital, these presentations are simultaneously teleconferenced to three off-site clinics; and since each presentation is videotaped, our video lending library is available to all. Nurses who attend the presentation in person can earn continuing education units. Examples of these presentations include the following:

- Christian Science in the Healthcare Setting
- Cultural Beliefs and Health among Puerto Rican Families
- Diet in Islam: An Overview
- Factors Associated with Cancer Screening among Asian American Women
- The Impact of Chronic Pain in African-Americans
- The Japanese Birthing Experience

- Issues in Migrant Farm Worker Health Care
- How Jewish Traditions Impact Health Care Relationships

● **Worldwide Web.** Our website strives to empower all caregivers to provide culturally competent healthcare. It offers a variety of resources – from definitions and reading lists to communication approaches and assessments. Visitors can find this site at [www.med.umich.edu/multicultural/ccp/](http://www.med.umich.edu/multicultural/ccp/).

● **Pocket Guides.** Because some caregivers need or prefer hardcopy versus online material, we have consolidated some key content into twelve-page double-sided pocket guides. These color-coded pages are a quick reference tool and provide direction for additional resources.

Sample content includes the platinum rule (do unto others as you would like it done unto you),

#### Anticipating Cultural Encounters

Caregiver: I have a patient and family from the Middle East coming in tomorrow. What can I do to prepare for their being Muslim?

Consultant: Have you confirmed that they are Muslim?

Caregiver: Well, no, what do you mean?

Consultant: Not everyone from the Middle East is Muslim. It's such a large region with many countries — and so many subcultures in each country. Your new patient may be Muslim, Jewish, Christian, or something other than all of these! If you can find out more about your patient's background, we will be better able to help you. Each subculture has its own way of approaching healthcare; the more we know the better we can prepare you to provide culturally competent care.

Caregiver: Great! Thank you. I'll be back in touch as soon as I know more.

the definitions of, and differences between, a generalization (a starting point) and a stereotype (an ending point), and exercises that teach similarities and differences.

● **Calendar.** Our multicultural calendar features a different multicultural photo each month. The back cover is a reproduction of the Chinese zodiac symbol representing the year. We post many, but not all, holidays and special observances on this calendar. Each monthly page contains notes that describe the meaning of each holiday and names the cultures or countries that observe it. This tool is not only educational; it can also be used as a communication starter with patients, families, and fellow caregivers.

● **Consultation.** Immediate cultural consultations take place when a caregiver realizes that cultural issues are involved in his or her interaction with patients and families, but the caregiver is not sure how best to handle the situation. The cultural competency division helps the caregiver create culturally competent action plans and provides additional resources. In other cases, the caregiver may anticipate cultural encounters during future patient interactions and comes to us for help in building action plans. We provide tools and resources, and remain on-call to ensure that new patients and families receive respectful, ethical, culturally competent healthcare.

● **Strategic Planning.** At the request of a clinic, nursing group, or other department, we are available to help various University of Michigan Health System teams create cultural strategic plans. Overall, a cultural strategic plan involves a three-step process. First, we help them identify the various cultures that may present a challenge to the team.

Second, we explore the specific challenges that these cultures present, including differences in communication style, trust-building issues in the patient-caregiver relationship, or difficulties understanding their familial decision-making process.

## Muslim Patient Care Committee

The Muslim Patient Care Committee was established after our local Muslim Health Association approached the University of Michigan Health System for support with projects that could enable these two organizations to collaborate in providing quality culturally competent health care that addresses the unique needs of Muslims in our increasingly diverse community. With the Cultural Competency division leading this committee during its three years of operation, the following is a list of established top priority projects.

### Completed but ongoing:

- Friday Prayer Room established and services offered
- Implementation of “entering room door signs” with OB/GYN
- Development and implementation of the formal Islamic Volunteer Service Program
- Development and distribution of Muslim patient brochures
- Providing Islamic in-service trainings for staff

### In Progress:

- Addressing dietary needs of patients and staff
- Documenting end-of-life care issues and procedures
- Writing of same “Gender Care Policy” with OB-GYN (not operative at this time).

Caregivers at the University of Michigan healthcare system can become better at providing respectful, ethical care to Muslim patients by familiarizing themselves with the work of this committee.

Third, we consider what educational methods will work best for the team – how can the team most efficiently gain and retain the knowledge to work toward more positive cultural encounters. Perhaps the team meets on a weekly basis, but some team members need more time to develop self-awareness and are therefore not ready to share their thoughts and concerns. Or perhaps an electronic communication board will work best for this team, at least initially. Delving into this step often leads to revisiting steps one and two. Hence, providing culturally competent healthcare is a lifelong journey.

● **Standards.** While our immediate cultural consultations focus primarily on assisting individual caregivers and our cultural strategic plans center on teams of caregivers, we also observe the National Standards for Culturally and Linguistically Appropriate Services in Health Care (CLAS). These standards were issued by the U.S. Department of Health and Human Services’

Office of Minority Health to eliminate racial and ethnic health disparities and improve the health of all Americans. They provide institutional guidance in providing respectful and ethical care. For information and guidance on CLAS, visit [www.omhrc.gov/clas/index.htm](http://www.omhrc.gov/clas/index.htm).

● **Intramural Events.** Other University of Michigan departments can also share their expertise in connecting cultural competency to caregivers. Adult and Pediatric Ethics Committees, Medical Anthropology, Pastoral Care, Interpreter Services, Human Resources, culture specific clinics, are just a few examples of departments that can be called on to engage in or spearhead additional cultural competency forums or collaborations. For example, the Muslim Patient Care Committee (highlighted on this page), resulted from a collaboration between the university and the Muslim Health Association.

## Assessing Cultural Competency

Our fourth and final guiding principle is to assess our progress on this lifelong cultural competency journey. We use assessment measures that are both formal and informal, internal and external.

Informally and internally, caregivers are asked two specific questions during our presentations and during other appropriate opportunities:

1. What cultural challenges do you encounter?
2. What would help you with your cultural encounters?

Responses to these questions allow us to create relevant tools for caregivers that enhance their understanding and help them provide more culturally competent, respectful, ethical health care during each cultural challenge. Over the years, an increased number of caregivers have requested our services while fewer caregivers are returning with requests for help related to their earlier concerns.

Formally, we are managing two internal assessments. The first is electronically administered on a biannual basis to elicit caregivers' cultural competency needs. Results have confirmed our progress and provided us with additional direction. This assessment not only continues to connect caregivers with cultural competency but also directly links us to critical and revealing data.

For example, the top two cultures about which caregivers asked for more information were Muslim and Chinese; and the top five topics within these cultures were communication styles, health practices, illness beliefs, family relationships, and relationships with healthcare providers. In fact, one outcome that we found surprising was that although caregivers use cultural consultants when available and as needed, they do not identify this consultant role as a frequent or separate need.

The second formal internal assessment has yet to be administered. We are currently in the process of seeking funding to assess our patients' and families' degree of satisfaction with receive-

ing culturally competent care from our caregivers. This assessment would allow us to measure our effectiveness from two sides of care: patients and families and caregivers.

The formal, external assessment of our progress is a benchmarking report that is currently in production. This report, "Cultural Competency Efforts of the Top 10 Hospitals" (*U.S. News & World Report*, 2000-2003), will outline the major cultural competency initiatives of the hospitals ranked as top ten *U.S. News and World Report* honorees in 2000, 2001, 2002, or 2003. While these institutions may not have the best cultural competency programs in the nation, their stories are a starting point for inquiries, comparisons, and standards to effectively sustain the caregiver-cultural competency connection.

Each chapter of the report focuses on a specific hospital. To keep organization consistent and facilitate referral to the material, each chapter is organized by hospital-wide programs, collaborative efforts between different entities, and departmental programs. Various methods were used to provide an intensive investigation of the initiatives of these hospitals. As a result, five major program types were identified:

1. Incorporation of cultural competency into an atmosphere of respect for all cultures,
2. Incorporation of cultural competency into core values and operating principles of the institution,
3. Education of health profession students and continuing education for current practitioners,
4. Diversity recruitment, and
4. Cross-cultural health research.

Every hospital highlighted in this benchmarking report strives to incorporate a culturally competent and ethical environment in which patients, families and caregivers feel respected and supported. This environment results in improved patient outcomes, increased patient satisfaction,

increased caregiver satisfaction, and an overall healthier environment.

## Conclusion

Even though documented evidence of significant health disparities in access and status among ethnic populations in the United States continues to mount, we must continue to have a national commitment to conduct and support research that will result in good health for all people. The mission and vision of the Cultural Competency division of the University of Michigan's Program for Multicultural Health are directly linked to this national commitment. By successfully following our guiding principles, we are committed to developing best practices that reduce health disparities and provide respectful and ethical healthcare, thereby sustaining the caregiver-cultural competency connection.

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