CULTURAL COMPETENCE
An Ongoing Quest

BY JEFF THIES, M.A., M.Div., D. Min.

In the ministry of Catholic health care, we are called to engage and respond to the whole person, an experience potentially rich and inevitably diverse. The 2010 U.S. Census will validate a trend long underway: that the communities we serve are growing ever more culturally complex. As a result, developing cultural competence and delivering culturally responsive services will continue to be our organizational, structural and clinical responsibility. This charge is important to providing appropriate patient care and ensuring quality care. It is important to enabling health care organizations to appropriately respond to market needs. And, it is important as a response to our call to bring people together in the service of our diverse communities.

For health care leaders, it will also be a personal responsibility, enriching the life and service of each of us as we reach out to people of other cultures, working to "answer God's call to foster healing, act with compassion, and promote wellness for all persons and communities ..."[1]

As has been increasingly evident over the last two decades, the United States is becoming more diverse, with minorities numbering more than 100 million people or 34 percent of the total population — a percentage likely to grow after the U.S. Census Bureau tabulates the 2010 data.[2] This diversity is rapidly expanding beyond the traditional metropolitan areas to suburbs and other communities throughout the country.[3] In four states — Hawaii, Texas, New Mexico and California — and the District of Columbia, Caucasians are in the minority, and six additional states are less than 60 percent white.

Minorities comprise 30 per cent of the residents in half of the nation's congressional districts (compared to 25 percent in 1992), and minority populations are growing throughout the country. A recent estimate stated that in 2008, 44 percent of children under age 18 were minorities. The percentage grows to 47 per cent for the nation's children younger than the age of 5.[4]

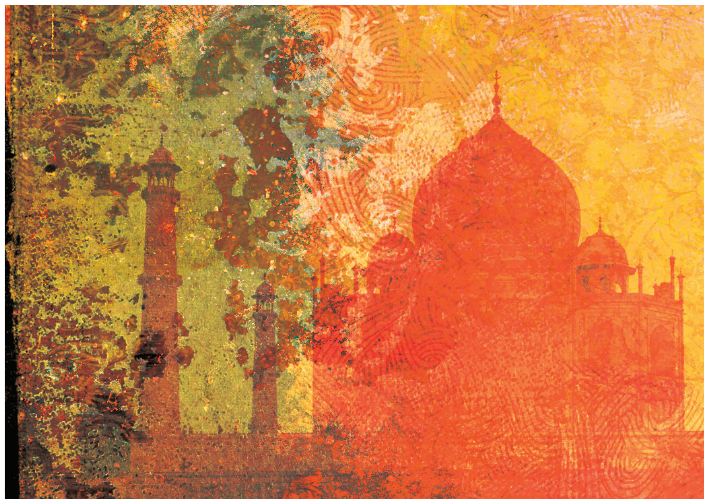
Census data also quantifies "Limited English Proficient Persons," that is, people who do not speak English as their primary language and who have a limited ability to read, write, speak or understand English. Information about this group is especially relevant to the question of communication and language access and provides a tool for understanding the question of cultural identification within a community.[5] The American Community Survey, which contains data collected every year to supplement the decennial census program, gives communities a fresh look at how they are changing. The 2008 community survey identifies 14 states where more than 6.5 per cent of the population speaks English "less than very well," again a number likely to grow once the 2010 Census results are compiled.[6]

WHAT IS CULTURAL COMPETENCE?

Cultural competence is the personal and organizational capability to effectively engage and provide health care services for peoples of the diverse cultures within our communities. Culture is foundational to beliefs and behaviors and is multidimensional in its application to health and health care. The very mission of Catholic health care draws us to emphasize the importance of culturally competent and linguistically appropriate care as we bring together

people of diverse backgrounds and answer God's call.

We know health disparities exist, by condition and treatment, among racial and ethnic groups. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, a study published



in 2004 by the Institute of Medicine, identified root causes that include health system factors, care process variables and patient level variables. Culturally competent care can assist in improving "the capacity of health care providers to make accurate diagnoses; prevent patients from exposure to unnecessary risks from diagnostic procedures (especially where language barriers play a role); enable providers to obtain truly informed consent; and allow patients to participate in clinical decision-making."[7]

A BUSINESS AND LEADERSHIP FOCUS

The business case for culturally appropriate care is a developing area of focus. Health care organizations have potentially four interrelated incentives that together "constitute a business case for cultural competence":[8]

- Appealing to the minority consumer
- Competing for private purchaser business
- Responding to public purchaser demands
- Improving cost-effectiveness in treatment

Organizational and operational applications of cultural competence are worth noting, as well. One such framework links cultural competence to health care delivery outcomes in this way:[9]

- **Organizational application:** The organization ensures that services are accessible, acceptable and effective to the cultural communities it serves and are appropriately used.
- **Structural application:** Language and communication barriers are removed and effective communication enables the target population to understand the health care process, the messenger and the message.
- **Clinical application:** At the clinical level, sociocultural differences are understood, valued and integrated into clinical care.

PERSONAL COMPETENCE

In addition to the organizational and operational applications of cultural competence, the ministry of Catholic health care calls each leader to develop personal competence in order to fulfill the mission. Transcultural health care and mental health nursing specialist Josepha Campinha-Bacote, Ph.D., describes this as a process of *becoming* culturally competent, not *being* culturally competent. She identifies five constructs:[10]

- **Cultural awareness:** Conducting self-examination of one's own biases towards other cultures and the in-depth exploration of one's cultural and professional background.
- **Cultural knowledge:** The process in which health care professionals seek and obtain a sound information base regarding the worldviews of different cultural groups as well as biological variations, diseases and health conditions and variations in drug metabolism found among ethnic groups.
- **Cultural skill:** The ability to conduct a cultural assessment to collect relevant cultural data and conduct a culturally based physical assessment.
- **Cultural encounter:** A process which encourages the health care professional to directly engage in face-to-face cultural interactions in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.

- **Cultural desire:** Being motivated — *wanting to*, rather than *having to*, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters.

TOOLS FOR CULTURAL ENGAGEMENT

For over 15 years, I have taught the course *Managing a Multi-Cultural Workforce* for the M.B.A. program of Loyola Marymount University, Los Angeles. Through those years, students have used ethnographic techniques and tools in their studies of other cultures. These tools have provided an effective process for engaging in the cultural encounters Campinha-Bacote described, and they have proven to be effective techniques for leaders to develop personal competence.

In the course, each student is required to select a culture different from her or his own as the focus of study. Each student starts with a conscious attitude of almost complete ignorance about the other culture. This starting point is critical because it presumes the humility to acknowledge the need for understanding and the recognition that one must look beyond personal biases and assumptions to be able to engage the dignity of the other person and his or her culture.

The second step is a field experience. Each student selects a specific topic to study based on a question or a challenge in a cultural interaction. The point is to be specific about what needs to be understood or learned.

The third step is to meet with members of the other culture to seek insight and knowledge about the cultural behaviors being studied. The ethnographic technique is to study behavior and practices, with the student becoming a "participant-observer" in order to understand the beliefs and values of the other culture through the lens of that culture's behavior. This enables the student to seek understanding and meaning in the practices of that culture, rather than projecting his or her own cultural framework and presumptions.

The fourth step is academic research relevant to the cultural issues being studied. The learning is grounded in academic research, but is defined within the context of the behaviors, cultural orientations and values of a particular culture.

Finally, students participate in an international immersion experience in order to view management within another culture and link their field experience and research to that culture's management practices.

Students routinely report that these ethnographic techniques and the cultural encounters they facilitate enable them to switch off cultural cruise control and develop cross-cultural mindfulness. This means simultaneously:

- Being aware of one's own assumptions, ideas and emotions
- Noticing what is apparent about the other person and tuning in to their assumptions, words and behaviors
- Using all of the senses in perceiving situations
- Viewing the situation from several perspectives, that is, with an open mind
- Attending to the context to help interpret what is happening
- Creating new mental maps of other people's personalities and cultural backgrounds
- Creating new categories and recategorizing

MINORITIES BY THE NUMBERS

In the U.S. population of just over 300 million, about 1 in 3 residents is a minority.

The breakdown:

34% **(over 100 million)**
Total minority population in the U.S.

44.3 **million Hispanics**
The country's largest and fastest-growing minority group

40.2 **million African-Americans**

14.9 **million Asians**
Includes many groups that differ in language and culture. Of them, the three largest groups are Chinese, 2.8 million; Asian Indians, 2.2 million; and Filipinos, 2.1 million.

4.5 **million American Indians and Alaskan Natives**

1 **million Native Hawaiians and other Pacific Islanders**

— Source: U.S. Census Bureau

others into a more sophisticated category system

■ Seeking out fresh information to confirm or disprove the mental maps

■ Using empathy or the ability to mentally put oneself in other persons' shoes as a means of understanding their situations from the perspectives of their cultural backgrounds rather than one's own.[11]

The graduate students report on ways their management abilities have been enhanced through the competence they have gained. They learn in ways that are both experiential and academic, and they gain knowledge that is both personal and intellectual. Opening their eyes and hearts to the richness and goodness of other cultures helps them develop strategic and operational thinking and more effectively engage employees and the markets their organizations serve. That's a lesson in cultural competence that Catholic health care organizations and leaders should recognize and embrace as a personal and organizational calling to "answer God's call to foster healing, act with compassion, and promote wellness for all persons and communities."

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NOTES

1. Catholic Health Association, *A Shared Statement of Identity for the Catholic Health Care Ministry*.
2. U. S. Census Bureau, *Minority Population Tops 100 Million*, Press Release, May 17, 2007, www.census.gov/Press-Release/www/releases/archives/population/010048.html.
3. William H. Frey, "Five Myths about the 2010 Census and the U.S. Population," *The Washington Post*, Feb. 14, 2010, www.washingtonpost.com/wp-dyn/content/article/2010/02/11/AR2010021103898.html.
4. U S. Census Bureau, *Census Bureau Estimates Nearly Half of Children under Age 5 Are Minorities*, Press Release, May 14, 2009, www.census.gov/press-release/www/releases/archives/population/013733.html.
5. Census data reports racial and ethnic data and language proficiency data, based on survey participant self-reporting. A related question relevant to cultural competence is that of cultural identity and assimilation. See Felipe and Betty Ann Korzenny, *Hispanic Marketing: A Cultural Perspective* (Burlington, Mass.: Elsevier, Butterworth-Heinemann Press, 2005), Chapter 5, "The Processes of Enculturation, Acculturation, and Assimilation."
6. U.S. Census Bureau, M160: *"Per Cent of People 5 Years and Over Who Speak English Less Than 'Very Well': 2008,"* American Factfinder interactive map, www.census.gov.
7. Joseph R. Betancourt, "Improving Quality and Achieving Equity: The Role of Cultural Competence in Reducing Racial and Ethnic Disparities in Health Care," The Commonwealth Fund, October 2006, v. Available online at www.commonwealthfund.org.
8. Cindy Brach and Irene Fraser, "Reducing Disparities through Culturally Competent Health Care: An Analysis of the Business Case," *Quality Management in Health Care* 10, no. 4 (2002): 15-28.
9. Joseph R. Betancourt et al, "Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care," *Public Health Reports* 118, no. 4 (July-August 2003): 293-302. Also, Miguel A. Perez and Raffy R. Luquis, ed., *Cultural Competence in Health Education and Health Promotion*, (San Francisco: Jossey-Bass, 2008), 48-50.
10. Josepha Campinha-Bacote, *The Process of Cultural Competence in the Delivery of Health Care Services*, www.transculturalcare.net.
11. David C. Thomas and Kerr Inkson, *Cultural Intelligence: Living and Working Globally*, (San Francisco: Berrett-Koehler Publishers, 2003), 51-52.