STUDENT ESSAY

The Critical Components and Ethical Nature of the Concept of Cultural Competence

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In the United States more than five minority ethnic groups comprise a total of nearly 23 percent of the entire American population. This makes it imperative to have a multicultural perspective when it comes to dealing with policies, concepts, and institutions that affect more than one group. This is even more important due to the fact that religion, culture, and ethnicity can all affect one's ethical perspective on a matter.

In areas such as health and medicine, these differing ethical perspectives can have practical and tangible effects on the practice of health in a given population, so individuals must be prepared to understand and deal with differing cultural and ethical perspectives when working in the clinical setting. This type of multicultural perspective is known as cultural competence. Many differing models of cultural competence have been proposed and developed for the clinical setting. Although there are many differing models of culturally-competent health care, this paper highlights how a review of recent literature suggests that there are three main, critical components that are necessary in virtually every viable model of culturally-competent health care: a commitment to pluralism, an awareness and commitment to cultural/ethnosensitivity, and the necessary skills to implement this sensitivity into the health care organization's practices. Further, this paper delineates why culturally-competent health care is an ethical obligation rather than merely an optional preference, and it argues that this ethical obligation is even stronger in Catholic health care due to its consistency with the overall mission and goals of the Catholic ministry of

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health care, i.e., continuing Jesus' mission of healing and love ("Catholic Health Care in the United States" 2013).

History and Critical Components of Cultural Competence

Though the notion of cross-cultural medicine has been around for several decades, as a practical component for health care, the concept of cultural competence has only existed as a definable term for a little over 25 years. In the late 1980s, new research and statistical evidence emerged that demonstrated that minorities regularly received lesser health care than the majority population of white Americans, and it became apparent that cross-cultural medicine was not sufficient in its scope and methods. The discipline of cross-cultural medicine needed to expand its focus in three distinct ways: from a focus on only new immigrants to all minority groups; from a focus on only cultural differences to issues of prejudice/bias, stereotyping, and the social determinants of health; and from a focus on individual patient care to a larger focus on communities and the organizational approach to health care (Saha, Beach, and Cooper 2008).

Thus, in 1989 Cross et al. gave us the first standard definition and model of this newly formed focus for cultural competence in their monograph, "Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children who are Severely Emotionally Disturbed." This document was meant to create a philosophical and conceptual framework to more effectively serve all minorities and culturally diverse individuals, specifically children and adolescents. Cross et al. ultimately defined cultural competence as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al. 1989). This definition has largely served as the baseline, standard definition of cultural competence throughout its existence (Stewart 2006).

However, numerous other conceptions of cultural competence have been derived from this original philosophical and conceptual framework, most giving their own definitions, such as Campinha-Bacote's definition that defines cultural competence as "a process for effectively working within the cultural context of an individual or community from a diverse cultural or ethnic background" (Campinha-Bacote 1994, 1-2). Culturally-competent health care even has

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various different unique definitions, such as the following definition that includes differing interventions at the organizational, structural, and clinical levels:

> "'Cultural competence' in health care entails: understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g., at the level of structural processes of care or clinical decision-making); and, finally, devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations. Given the evidence of sociocultural barriers to care and the levels of health care delivery in which they occur, a new framework for cultural competence would include organizational, structural, and clinical interventions…" (Betancourt et al. 2003, 297).

In health care, then, cultural competence specifically "describes the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs" (Betancourt, Green, and Carrillo 2002). Thus, cultural competence in health care can generally be described as a skill, process, and mindset that allows professionals in the dominant culture to effectively communicate and serve the health care needs of a variety of individuals that come from various different cultures and backgrounds.

In addition to the numerous differing conceptions and definitions of cultural competence, there are also numerous differing models for culturally-competent health care. However, virtually every model is based on three critical components that form the basis and foundation for every practical model. The first and most important essential component is the *desire* and *will* to ethically and effectively treat various different populations with vastly different backgrounds, beliefs, and values. As seen in America's tumultuous past with race relations, this *desire* and *will* to be inclusive, tolerant, and accepting has not always been present. Thus, the first and most important component of cultural

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competence is an acceptance of pluralism within the clinical setting. Pluralism can come in many forms, e.g., religious, cultural, moral, etc. With the presence of so many differing backgrounds and cultures in American society, it is unrealistic to expect a social consensus on ethical issues, especially those issues involving health (Charlesworth 2005). However, this does not necessarily mean that pluralism entails a relativistic outlook on all of these concepts either (Durante 2009). Rather, it is a process of dialogue that seeks to embrace and engage diversity and promote understanding across many lines of ideological differences (Eck 2006).

Pluralism in the clinical setting then entails a perspective that seeks to understand and value individuals from differing backgrounds, cultures, and ethnicities as equal to oneself and worthy of respect and ethical and effective health care. Coincidentally, this is the final construct of Campinha-Bacote's model of culturally-competent clinical care, and she labels the construct as "cultural desire." She describes this acceptance of pluralism in the health care setting as:

> "…the motivation of the health care provider **to want to, rather than have to,** engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters… What is of grave importance is the health care provider's real motivation or desire to provide care that is culturally responsive. Cultural desire includes a genuine passion to be open and flexible with others, to accept differences and build on similarities, and to be willing to learn from others as cultural informants" (Campinha-Bacote 2002, 182-183).

This "cultural desire" and acceptance of pluralism in the health care setting is then the basic foundational component of any practical model of cultural competence in health care, because without this will and desire to change, there is no catalyst to change.

The second essential component of any practical model of cultural competence in health care is a commitment to

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cultural/ethnosensitivity. This concept is defined as "having an awareness of a client's cultural beliefs and practices… [that] enables the practitioner to respect and value the client's perspectives and to be nonjudgmental and inoffensive when working with the client" (Huff, Kline, and Peterson 2015, 49). It further involves "the process of becoming more sensitive and respectful of cross-cultural differences" (Huff, Kline, and Peterson 2015, 13). Thus, this concept is both a commitment to being sensitive to potential cultural differences and having the requisite education and knowledge for that very cultural sensitivity, because without the education and knowledge of potential cultural differences, it would be virtually impossible to be culturally sensitive in any substantial way.

This component is widely present in practical models of cultural competence in health care. For instance, Mary Curry Narayan incorporates learning about patients' cultural backgrounds and understanding how culture affects health care decision-making into the second and third steps of her six-step process towards cultural competence. She also associates this component with empathy, and argues that culturally-competent physicians are "sensitive to how it feels to be an outsider in a different culture" and able to "walk in another's moccasins" (Narayan 2001, 41-42). Additionally, Brach and Fraserirector's cultural competency techniques include two techniques that employ the tactic of cultural education, experience, and sensitivity: the technique of cultural competency training programs and the technique of immersing oneself into other cultures for cultural experience, education, and sensitivity (Brach and Fraserirector 2000).

The final essential component of practical models of cultural competence in health care involves the practical skills and mechanisms necessary to implement this cultural sensitivity and education into the health care organization's practices. Essentially, this is the skill and ability to combine the commitment to pluralism with the commitment to cultural/ethnosensitivity to effectively implement culturally-competent medical interventions and health plans. As with the second component, many authors already directly employ this ability and skill in their model's framework. Perhaps the best illustration of this component, Berlin and Fowkes' guidelines for health practitioners rely heavily on this skill in their steps of *recommend* and *negotiate*. These guidelines suggest that health professionals should *recommend* culturally appropriate health

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plans and treatments to their patients, and the final determination should be a *negotiation* between the doctor and patient working to find the best health plan possible given the cultural context of the patient. These guidelines best demonstrate this component, because they detail how to implement these commitments to pluralism and cultural/ethnosensitivity into ethical treatment decisions and health plans within the clinic (Berlin and Fowkes 1983). Carrillo, Green, and Betancourt also devised a similar approach based on negotiating across cultures, which is basically another way of discussing this cultural skill of implementation, and both Narayan and Campinha-Bacote use the terminology of "assessments" to define this skill of devising and implementing culturally-competent health plans in their model's steps and constructs, respectively (Carrillo, Green, and Betancourt 1999; Narayan 2001; Campinha-Bacote 2002).

The fact that these three critical components form the basis of virtually every practical model of cultural competence in health care is no surprise, because the original model from Cross et al. essentially created this foundation for these models. For example, Cross et al. states:

> "Five essential elements contribute to a system's, institution's, or agency's ability to become more culturally competent. The culturally competent system would: 1) value diversity; 2) have the capacity for cultural self-assessment; 3) be conscious of the dynamics inherent when cultures interact; 4) have institutionalized cultural knowledge; and 5) have developed adaptations to diversity" (Cross et al. 1989).

Valuing diversity comes from an acceptance of pluralism. The development of cultural/ethnosensitivity allows individuals to have the capacity for cultural self-assessment, be conscious of the dynamics inherent when cultures interact, and have institutionalized cultural knowledge. Finally, the development of adaptations to diversity is a direct consequence of having the practical skills and mechanisms necessary to implement the commitments to pluralism and cultural/ethnosensitivity into clinical practice. Thus, these three components have formed the foundation of practical models of cultural competence from the very

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beginning, and they are necessary components of any effective practical model of culturally- competent health care.

The Ethical Nature of Cultural Competency

It still might be asked – why is cultural competency needed in health care in the first place, and why is it a necessary component of Catholic health care? The answer to this question is twofold – poor health care outcomes and ethical obligations. And not coincidentally, cultural competency in health care primarily focuses on two distinct outcomes-based ethical areas of concern: language barriers and differing values, preferences, and interpretations of health and health care. For example, certain studies have found that hospital communication issues resulted in up to 65 percent of all sentinel events within the hospital (Keehan 2013). And communication only gets more difficult when language barriers exist between individuals. For example, certain subsets of American minorities, such as Mexican-Americans and other Hispanic-Americans from Central America, still have significant sections of their population who cannot speak fluent English. Further, studies show that communication with and material from the doctor is even more difficult for patients to understand when English is not their first language. This impacts everything from the doctor's communication directly with the patient to reading prescriptions and take-home directions from the doctor, and these issues significantly compromise health care quality even more for these patients with poor English fluency or patients whose primary language is not English (Collins et al. 2002).

On the other hand, differing values, preferences, and interpretations of health also can cause problems with the efficacy and quality of health care. For example, studies suggest that ethnicity contributes to decisions about the use of life support in end-of-life situations, and most minority American groups, specifically Korean-, Mexican-, and African-Americans, have a more positive view on life support at the end of life compared to the majority population of white, European-Americans. One Korean-American even stated that the health care team and family were obliged "to lengthen the life even one second or one minute longer." And 78 percent of the Mexican-American participants agreed with the statement "life-sustaining machines should never be stopped even if the patients appear to be dying because there is always the chance of a miracle," which is significant

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compared to only 29 percent of European-Americans agreeing with this statement (Blackhall et al. 1999). Further, many non-Western cultures are not as individualistic as Western culture tends to be, and certain cultures interpret the concept of autonomy more in a familial sense than an individual sense. That is to say that these cultures generally expect the family unit, rather than individual patients themselves, to jointly deliberate and decide upon even routine medical decisions. This obviously has tremendous implications for clinical decision-making in our society's health care system that is so focused and reliant upon individual patient autonomy. (Fagan 2004). One Korean-American from the study stated the following regarding their own decision-making in keeping themselves on life support: "I would be the one who was dying, so it wouldn't be my decision to make" (Blackhall et al. 1999).

Thus, it's clear to see how these two areas establish cultural competency as a clinical ethics issue, because they can greatly impact the efficacy, delivery, and quality of health care in these populations, leading to poor health outcomes. If we assume that each individual, regardless of race, ethnicity, creed, or religion, is of equal value, worth, and dignity, which is an ethics thesis that is virtually unanimously accepted in Western culture, then we must also assume that each person we treat is entitled to the same quality of treatment and standard of care. However, since it has been empirically proven that cultural and linguistic contextual factors do affect values and the conception, process, and quality outcomes of health care in culturally-diverse populations, it is absolutely unethical to not take these factors into consideration and be culturally competent in this way. In the Aristotelian sense, this would be "treating equals unequally" due to a non-moral property of race, ethnicity, or language, and it ultimately amounts to a type of professional negligence, especially if you practice medicine in a multicultural area.

This ethical obligation is doubly important for Catholic health organizations, because it is inherently tied to the mission of Catholic health care. According to the Catholic Health Association of the United States (CHA), "Catholic health care is a ministry of the Catholic Church continuing Jesus' mission of love and healing in the world today" ("Catholic Health Care in the United States" 2013). CHA President and Chief Executive Officer Sister Carol Keehan, DC said, "The mission of Catholic health care is profound but simple: to treat with dignity

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and compassion every person who is in our care" (Keehan 2013). Within the hospital context, though, treating each person with dignity and compassion is a complicated task due to the inherent differences within each patient's sociocultural and linguistic context. Treating patients with dignity and compassion means to provide effective and empathetic health care to all within one's care. However, one's culture has a significant influence on one's worldview and health care decision-making, which means a "one size fits all" approach is not appropriate for the utilization of health care in multicultural societies. Thus, an obligation to "treat with dignity and compassion every person who is in our care" requires a multifaceted approach that takes culture and language into context when caring for diverse multicultural populations.

But the connection is deeper than that. For example, Directive 3 of the *Ethical and Religious Directives for Catholic Health Care Services* states:

> "In accord with its mission, Catholic health care should distinguish itself by service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination: the poor; the uninsured and the underinsured; children and the unborn; single parents; the elderly; those with incurable diseases and chemical dependencies; **racial minorities; immigrants and refugees**. In particular, the person with mental or physical disabilities, regardless of the cause or severity, must be treated as a unique person of incomparable worth, with the same right to life and to adequate health care as all other persons" (*Ethical and Religious Directives for Catholic Health Care Services*, Fifth Edition, USCCB 2009, 5).

Just as with Jesus' mission, the marginalized and vulnerable of society are of utmost importance to Catholic health care, and the same is true of the culturally and ethnically diverse, who are significantly marginalized and vulnerable in many areas of health care, as these statistics (and many more) highlight. Just as serving society's vulnerable

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and marginalized populations is a central tenet of Christian philosophy, serving the health care needs of society's vulnerable and marginalized, including the culturally and ethnically diverse, is a central tenet of the mission and philosophy of Catholic health care. Thus, cultural competence and education are ethical obligations that are manifest throughout the very mission and goals of Catholic health care and its ministry of the continuation of Jesus' mission of love and healing for all. Jeff Thies states it best: "The very mission of Catholic healthcare 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" (Thies 2010, 11-12).

Conclusion

To conclude, Catholic health care has an ethical obligation to provide culturally competent care to all of its patients. Although there are many differing practical models of cultural competence in health care available today, they are all essentially expanded models of the basic three components that were analyzed within this paper. These commitments, skills, and abilities within these components are essential to any practical model of cultural competence in health care, and they provide the basic framework for more expansive and elaborate models to be developed. Essentially, these three components provide the logical sequence needed to address and overcome clinical ethics issues that are derived from cultural, ethnic, and linguistic differences in patients. If these components are not utilized, effective and ethical Catholic health care in a multicultural society may not be possible.

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