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61 – Teaching Cross-Cultural Care

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The need for cross-cultural care and cultural competence

The need for cross-cultural care derives from the fact that modern societies are increasingly becoming multi-cultural and the observation that many cultural groups are not satisfied with health care, while medical practitioners say that some cultural groups are difficult to work with (Waxler-Morrison et al., 2005). On this note, Waxler-Morrison et al. (2005, p.6) argued that we need to adopt a cross-cultural care approach in order to deal with such "problems with health care". These problems with health care relate to the different philosophies and knowledge that medical practitioners and lay people have with regard to health, illness and the management of diseases. Waxler-Morrison et al. (2005) explained that when a medical practitioner and a patient do not share the same culture they may not understand each other and lead to what they authors called "clash of cultures" (p.2). Such a clash should be avoided when medical practitioners communicate with and treat their patients. But how can they avoid it? To answer this question, we should first look into the main source of the different understanding between medical practitioners and lay people. This difference is attributable to the distance between the biomedical model and social knowledge.

The biomedical model, which medical practitioners are trained to adopt, makes a distinction between the body and mind, and focuses on measurable characteristics of the body and identifiable symptoms, which represent distinct medical conditions (Helman, 2007). Furthermore, the biomedical model is concerned with causes of health conditions which can be observed in the physical world or inside the body, while it tends to attribute the development of certain diseases (i.e. heart diseases) to human behaviour, such as diet and lifestyle choices (Helman, 2007). Interestingly, biomedicine tends to underplay influential social forces, such as socio-economic status, occupation, migration and so forth. On the other hand, lay people rely heavily on socio-cultural knowledge to understand the causes and management of diseases. Such socio-cultural knowledge can result from cultural and religious values, such as the belief in the spiritual world or the evil eye. Moreover, lay people pay particular attention to the importance of social relations and the stress they experience in daily life (Helman, 2007). In other words, while medical practitioners are looking into the individual to find out the causes of diseases, lay people look at the outside world. To reduce the distance between these two regimes of knowledge we should not expect patients to acquire medical knowledge but medical practitioners should become "culturally competent" (Betancourt et al., 2005).

Cultural competence is increasingly considered an important skill for medical practitioners. Betancourt et al. (2003, p.297) explained that cultural competence

refers to “understanding the importance of social and cultural influences on patients’ health beliefs and behaviours”. These social and cultural influences may relate to services, language barriers, belief systems, habits and so forth. If medical practitioners manage to understand the rationale of their patients’ beliefs and behaviour they can then develop their skills in how to work with their patients more effectively. But how can we make medical practitioners culturally competent? A multi-layered long-standing training may be very effective.

Methodology of teaching cross-cultural care

The *Cultural Competence Train-the-Trainer* Manual (2011) outlines a series of teaching methodologies in cultural competence. Drawing from this manual we propose a more simplified teaching methodology of cross-cultural care and cultural competence which should rely on situated learning and constructivism. Situated learning refers to contextualising learning by using examples or cases (Kaufman and Mann, 2010). Constructivism refers to the role the learners play in their own learning and to the process of constructing their learning by being active participants (Davis and Forrest, 2008). Both situated learning and constructivism have been used in modern medical education through adopting Problem-Based Learning (PBL) as the main method of teaching.

Based on situated learning and constructivism, we propose a pyramid of building competence in cross-cultural care (figure 1), which is a modification of Mehay’s (2012, p.358) pyramid of clinical assessment. The proposed pyramid consists of three layers in order to train medical practitioners and students more effectively. The first layer is called “acquiring knowledge” and focuses on transferring knowledge to the learners through lectures. The second layer, “applying knowledge” could be enhanced by making the lectures case-based. Therefore, the learners learn the basic information in the social and cultural background of specific cultural groups and then they apply their knowledge to real life cases. The third layer, “practising knowledge” would train learners in how to perform their knowledge. In other words, the learners would be trained in the ways that they could use their knowledge in medical practice. To achieve this, teachers of cross-cultural care could construct cases and tasks for the learners to undertake based on these cases. For example, a scenario could describe a female migrant who cannot accept the medical diagnosis by her doctor and prefers attributing her condition to the act of the evil eye. The learners should then be taught how they should handle this patient. This third layer of practising knowledge could take the form of small-group role play sessions and reflection on work-based experience. Through the pyramid of building competence in cross-cultural care, medical practitioners can acquire knowledge, skills and attitudes to communicate with and treat their patients more effectively.

Conclusion

The need for cross-cultural care has increasingly been acknowledged as an important element in medical practice. Based on situated learning and constructivism, a three-layered pyramid of building competence in cross-cultural care can be implemented to help medical practitioners acquire knowledge, skills and attitudes to become more competent and effective in communicating with and treating their patients. Better cross-cultural care would thus mean better health care in general and improved medical practice.

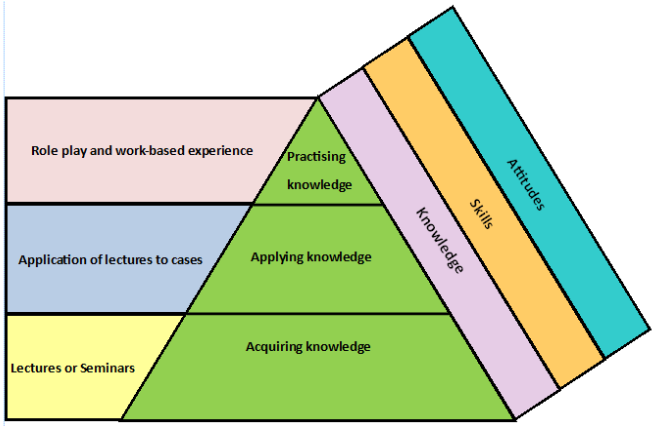

Figure 1: Pyramid of building competence in cross-cultural care. Modified from Mehay’s (2012, p. 358) pyramid of clinical competence. Mehay based his approach on Miller’s prism of clinical competence published in 1990 at *Academic Medicine*, 65(9): 63-67.

Take-home messages

- Medical practitioners need to be trained in how to become competent in cross cultural care.
- To improve their communication with and treatment of patients, medical practitioners should be trained on the basis of the pyramid of building competence in cross-cultural care in order to acquire, apply and practise their knowledge.
- Better cross-cultural care means better medical practice.

Original abstract

http://www.woncaeurope.org/content/1014-wo-teaching-cross-cultural-care

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