AN ABSTRACT OF THE THESIS OF

Pamela A. Racansky for the degree of Master of Arts in Applied Anthropology presented on December 4, 2002. Title: Oregon Health & Science University's Understanding of Cultural Competency.

Abstract Approved: ________________________________

Sunil Khanna

The United States population continues to increase and diversify. The cultural composition within the United States embodies a multitude of people from a variety of belief systems, religious backgrounds, and ethnicities. Within current biomedical practice, many of these differences are often marginalized, leaving populations with unsatisfactory experiences in seeking health care. Cultural competency attempts to address those differences in health care delivery. Many health care institutions are striving to become more culturally competent yet there is not a common understanding of what cultural competency means. In addition, there are many obstacles that limit the implementation of cultural competency in health care delivery.

This thesis examines the need for cultural competency in health care, addressing the lack of understanding between institutions regarding cultural competency and assessing its understanding at one particular institution. Recent research at Oregon Health & Science University in Portland, Oregon has provided new insight to the discussion of cultural competency and how uniquely it can be defined in a single institution. Qualitative interviews were conducted with medical students, physicians/physicians-in-training, administrators and nurses/CMA in order to uncover how cultural competency
is defined as well as the issues that are involved when delivering culturally competent health care. By being aware of an institution's cultural composition and understanding of cultural competency can help that institution enact health programs and policies that have a better chance of representing and respecting the populations they serve.
OREGON HEALTH & SCIENCE UNIVERSITY'S UNDERSTANDING of
CULTURAL COMPETENCY

by

Pamela A. Racansky

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I understand that my thesis will become part of the permanent collection of Oregon State University libraries. My signature below authorizes release of my thesis to any reader upon request.

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Pamela A. Racansky, Author
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>INTRODUCTION</td>
<td>1</td>
</tr>
<tr>
<td>BACKGROUND</td>
<td>4</td>
</tr>
<tr>
<td>Discussing Cultural Competency</td>
<td>4</td>
</tr>
<tr>
<td>Continuum of Cultural Competence</td>
<td>4</td>
</tr>
<tr>
<td>The Need for Cultural Competence</td>
<td>7</td>
</tr>
<tr>
<td>Cultural Composition</td>
<td>8</td>
</tr>
<tr>
<td>The Internship</td>
<td>9</td>
</tr>
<tr>
<td>Oregon Health &amp; Science University</td>
<td>12</td>
</tr>
<tr>
<td>OHSU’s Mission</td>
<td>12</td>
</tr>
<tr>
<td>OHSU’s Patient Population</td>
<td>13</td>
</tr>
<tr>
<td>THEORETICAL BACKGROUND AND LITERATURE REVIEW</td>
<td>15</td>
</tr>
<tr>
<td>Cultural Competency</td>
<td>15</td>
</tr>
<tr>
<td>Defining Cultural Competency</td>
<td>17</td>
</tr>
<tr>
<td>Limits to Adoption</td>
<td>19</td>
</tr>
<tr>
<td>Worldview</td>
<td>21</td>
</tr>
<tr>
<td>Illness vs. Disease</td>
<td>22</td>
</tr>
<tr>
<td>Explanatory Model (Kleinman)</td>
<td>23</td>
</tr>
<tr>
<td>Exploring Medical Anthropology</td>
<td>25</td>
</tr>
<tr>
<td>Critical Medical Anthropology Perspective</td>
<td>27</td>
</tr>
<tr>
<td>Critique of the Levels of Health Care Systems</td>
<td>28</td>
</tr>
</tbody>
</table>
Appendix A  Research Questions Medical Students, Physicians/
Physicians-in-training, & Administrators_______ 108

Appendix B  Research Questions for Nurses/CMA _________ 109
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Continuum of Cultural Competence</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>United States Physician Demographics 1998 (%)</td>
<td>47</td>
</tr>
<tr>
<td>3.</td>
<td>Oregon Physician Demographics 1998 (%)</td>
<td>47</td>
</tr>
<tr>
<td>4.</td>
<td>United States Population 1990 (%)</td>
<td>49</td>
</tr>
<tr>
<td>5.</td>
<td>United States Population 2000 (%)</td>
<td>49</td>
</tr>
<tr>
<td>6.</td>
<td>Oregon Population 1990 (%)</td>
<td>50</td>
</tr>
<tr>
<td>7.</td>
<td>Oregon Population 2000 (%)</td>
<td>50</td>
</tr>
</tbody>
</table>
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Expected/Projected and Actual Sample Size</td>
<td>39</td>
</tr>
<tr>
<td>2. Compilation of Data</td>
<td>90</td>
</tr>
</tbody>
</table>
# LIST OF APPENDICES

<table>
<thead>
<tr>
<th>Appendix</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Research Questions for Medical Students, Physicians/Physicians-in-Training, &amp; Administrators</td>
<td>108</td>
</tr>
<tr>
<td>B. Research Questions for Nurses/CMA</td>
<td>109</td>
</tr>
</tbody>
</table>
LIST OF ABBREVIATIONS USED

CLAS  Culturally and Linguistically Appropriate Services
CMA  Credited Medical Assistant
CMA  Critical Medical Anthropology
EM  Explanatory Model
HRSA  Health Resources and Services Administration
IRB  Internal Review Board
LPN  Licensed Practical Nurse
OHSU  Oregon Health & Science University
OSU  Oregon State University
RN  Registered Nurse
This thesis is dedicated to my parents, Carole and Charles Racansky,
to my sister Karen,
and to my brother Allan (Bud).
For all your love and support,
but most of all, for always believing in me.
OREGON HEALTH & SCIENCE UNIVERSITY'S UNDERSTANDING of CULTURAL COMPETENCY

INTRODUCTION

"Ib tug pas ua tsis tau ib pluag mov los yog ua tsis tau ib tug laj kab".
One stick cannot cook a meal or build a fence.
(Fadiman 1997: 327)

In the year 1914, a baby boy was born to a Czechoslovakian immigrant and his Czechoslovakian, yet American born wife. He was named Charles and was raised in the city of Chicago. During his childhood, if he became ill, it was his mother who would take care of him. If, at times, an illness of Charles' was too much for his mother to manage, the neighborhood doctor would be called to the house. This is the type of health care Charles received as a Bohemian child: personal, individualized health care by a person who he knew well and was comfortable around, and in a warm environment, which was his home.

Entering adulthood, Charles received health care through the United States Army, where he was involved with communication for American planes during World War II. After returning from the war, the next time he would see a doctor would be fifty years later largely because his Bohemian heritage stressed the predominance of home remedies as opposed to visits to the doctor.

In 1996, cataracts led Charles to seek medical attention. The ophthalmologist agreed to conduct cataract surgery under the condition that
Charles first underwent a physical. He agreed, found a doctor, had a routine physical, and then received surgery to correct his cataracts. The surgery was a simple "same-day" procedure, which made him happy since he was not used to doctors or hospitals, and did not want to stay there any longer than he had to. The surgery went well, and Charles went home healthy and recovered fine.

Four years later, Charles went to the doctor for a flu shot. After receiving his shot, he informed his doctor of a lump he had noticed on his chest. Charles was eventually diagnosed with an early stage of breast cancer, a rarity among men. The lump was drained to no avail. Charles was left with two options: remove the cancer through chemotherapy or by way of a mastectomy. He chose the mastectomy and was admitted to the hospital a short while later, in hopes of eradicating the cancer. After a successful mastectomy, Charles was moved back to his room to begin his recovery. A nurse placed a device on his legs to help increase circulation throughout the night. With the device aiding in his recovery, he fell asleep, cancer free.

At about 3:30am, Charles awoke in pain. He felt burning sensations on his legs where the device to help his circulation was located. He called the nurse in to have it removed. The nurse arrived and told him that the device looked fine as it was and asked him to go back to sleep. Charles was not used to this impersonal type of health care, and felt insulted that his pains and concerns were not being addressed. He felt ignored and did not like the impersonal treatment. Instead of going back to sleep, he took out his IV, unplugged the other devices attached to him, put on his clothes and shoes and left the hospital.

There was great concern when Charles was found missing as he had just had major surgery and still had a drain in his chest. A phone call was
made to his wife, waking her out of her sleep. The hospital told her that her husband was missing. Charles' wife was in disbelief, angry, and worried, and was asked to remain at home in case her husband arrived. Two hours later, at 5:40am, Charles showed up at his home. He had walked over a mile from the hospital to his home in the middle of the night, only hours after receiving a mastectomy. The hospital was called and Charles received a police escort back to the hospital, all the while explaining what had happened and the reason why he left. He stated that he felt fine after surgery, and desired to return home. He didn't want to stay overnight in a hospital where they were not listening to or understanding his concerns. He had never once stayed the night in a hospital in his eighty-eight years, let alone had to listen to doctors telling him what to do. He was not used to this modern, impersonal type of health care, and was not going to be a part of it. Charles' distrust of biomedicine, stemming from his Bohemian background, influenced the miscommunications that sparked his flight from the hospital. I can identify with Charles because he is my grandfather. Luckily my grandfather healed quickly, despite leaving the hospital so soon after such an elaborate surgery which had disrupted his health and recovery.

The miscommunications and misunderstandings that occurred in my grandfather's medical experience gave me a personal connection as well as a first hand look at how easily an incident like this may occur. It is imperative for those who come into contact with patients, whether they are doctors, nurses, or others, to be culturally competent, and to be aware of differences between cultures, and how to address those differences. This is the only way to receive adequate health care in today's society, and it is the thesis of my findings.
Discussing Cultural Competency

In the United States, biomedicine is the leading type of health care delivery system. However, this does not mean that everyone desires or accepts biomedicine. The relationship between a patient and his/her health care provider is unique because the qualitative value of the care is dependant upon innumerable variables that can come into play. There can be differences in ethnicity, cultural beliefs and values, religious beliefs, sexual orientation, age, socioeconomic levels, perceived abuse histories or health care world views between the health care provider and the patient that can lead to miscommunications and misunderstandings if the differences are not recognized. The foundation of cultural competency attempts to address those very issues.

Continuum of Cultural Competence

The path to cultural competence progresses through many different levels of understanding and awareness. Adapted from Cross (1989) and Lecca et al. (1998), Figure 1 shows this by illustrating the continuum of cultural competence and attempts to provide some basic understanding of the term. The first level is described as “cultural destructiveness.” This is where differences among individuals or groups are seen as a hindrance. One superior culture is recognized and minority individuals are dehumanized or
Cultural Destructiveness
Differences seen as a hindrance; one superior culture

Cultural Competence
Respects & values difference; minority groups involved

Cultural Blindness
All people are the same; differences aren't recognized

Cultural Awareness
Recognizes differences; realizes weaknesses

Cultural Incapacity
Maintains stereotypes; lack of awareness & respect

Advanced Cultural Competence
Research, hire specialists

Figure 1. Continuum of Cultural Competence
subhumanized in the process. Two examples of acts at this level would be
the Tuskegee Syphilis Experiment, where experiments were conducted on
African Americans without their consent or knowledge of having the disease
(Freimuth et al. 2001), and the Indian Child Welfare Act, where Native
American children were taken from their families and environment to live
with non-Native American families (Lecca et al. 1998: 52).

The next level, "cultural incapacity," illustrates the lack of awareness
of differences and deficiency of skills with which to address those
differences. This ignorance enables stereotypes to be maintained due to the
focus on the dominant culture as being "the best" culture. "Cultural
blindness" is the subsequent level in which all people are seen as the same.
Differences between peoples on this level are still not recognized and
dominant culture programs or plans are seen as being able to serve any group
of people regardless of what differences are prevalent. There is an extreme
lack of information about minority groups as well at this level.

The next stage represents the move toward the positive end of the
continuum with "cultural awareness." At this point, differences are
recognized and weaknesses are realized within an institution in regards to
how it deals with the people for which the institution exists. The institution
desires to change in regards to its weaknesses. Hiring minority staff
members, training in cultural sensitivity and/or holding assemblies that
recognize cultural or ethnic specific groups are examples within this stage.

Cultural awareness is a precondition for "cultural competence," the
next level. It is not until cultural awareness is applied to programs such as
health care, that a cultural competence level is realized. Here, differences
are respected, valued and accepted. Minority communities are asked to
become involved in planning and their ideas are used to create more culturally cognizant programs and policies.

The final level, "advanced cultural competence", focuses on taking cultural competence one step further in conducting research concerning the issue, educating those that are less informed and publishing literature dealing with cultural competence. In this stage, institutions strive to build cultural knowledge and retain programs that recognize and respect cultural differences and practices. Specialists in cultural competence practice are hired to inspire programs and policies to become more culturally proficient and competent.

The Need for Cultural Competency

As communities are becoming increasingly diverse, the need for culturally competent health care has become increasingly important. The diversity of treatment preferences is as broad as the diversity of the patients needing treatment. The way in which patients' opinions are approached and incorporated into their treatment affects the relationships these patients have with their health care providers and the health care system. The level of respect and attention health care providers give to patients from differing backgrounds may determine whether the patients follow the prescribed treatment and establish trust in the decision whether to seek medical attention for their ailments in the future.

Within the medical literature, documented case studies have demonstrated the existence of misunderstandings between the patient and health care providers (Fadiman 1997), misperceptions of the risks of chronic
diseases (Lawson 1998), the change in culturally based behaviors influenced by social and political contexts and gender (Arcia et al. 2001), lack of providers' awareness of different issues that play a role in the provision of health care (Schilder et al. 2001) and racial and ethnic disparities in health care and health outcomes (Baquet and Commisky 1999; Mayberry et al. 1999; Sheifer et al. 2000; U.S. DHHS 1999a). In response to these concerns and many others, a "call" for culturally competent health care has been proposed by such organizations as the American Medical Association (American Student Medical Association: 2001), the American College of Obstetricians and Gynecologists (ACOG), the U.S. Department of Health and Human Services (2000; 2001), Oregon's Developmental Disabilities Council (McCarthy 1999) and Surgeon General David Satcher (CPEHN 2001: 9). The imperative is to address the differences between the cultural beliefs and values of the health care provider and the patient that impede optimal care delivery. However, the existing literature suggests that there is no common understanding of cultural competency that has been uniformly agreed upon among these organizations.

Cultural Composition

As the issue of cultural competency becomes more significant the need for accurately defining and understanding the term becomes more urgent. Defining the term in such a way that health care administrators can more easily understand what the term entails and how it can be incorporated into their health care practice can lead to great improvements in the perceived quality of health care for people of all ethnicities and cultures.
In defining cultural competency, an institution must take inventory of their “cultural composition” or, in other words, prevalent backgrounds, cultures and ethnicities of healthcare providers and patients involved in the institution, in order to optimize its capacity to provide culturally competent healthcare. Analysis is incorporated at the institution level because policies and programs are enacted at this level that will influence and impact providers and patients. Identifying the areas of the patient population that require the greatest need for understanding in health care delivery will allow an institution to see which populations, large or small, warrant the most time and energy in research and attention. In addition, health care providers must be able to properly identify the differences they may have with the patient to determine the most effective method of health care delivery.

The next issue in achieving culturally competent health care involves not only defining what it means to be “culturally competent”, but recognizing the obstacles present within the medical community in delaying its adoption. Throughout my research, through interviews and presentations, I have come in contact with healthcare providers who have had negative, value-laden preconceptions of the idea of cultural competency. Identifying those preconceptions and misunderstandings is vital in inspiring health care providers to be proponents rather than opponents to the implementation of culturally competent health care.

**The Internship**

In the summer of 2000, I participated in an internship at Oregon Health & Science University (OHSU) in Portland, Oregon, with the intention
of observing the cultural issues present in the delivery of healthcare while also formulating a research topic for my thesis. The internship consisted of four distinct parts: observation of physicians-in-training meetings with their Attending Physician, observation in the International Psychiatric Clinic, development of cultural-specific literature for medical students, and leading a discussion with physicians-in-training about cultural competency. Each of these parts contributed to my view that there is a lack of understanding, need, and desire for culturally competent healthcare delivery.

The main component of the internship focused on the outpatient teaching clinic and its daily operations. I regularly sat in on discussions between physicians-in-training and the daily Attending Physician who discussed each individual physician-in-trainings' patient issues for that day. I noted the vocabulary used in these discussions, as well as how the physician-in-training described dealing with difficult, or "non-compliant", patients. Remaining in the background during these sessions, my presence was often forgotten. Many of the interactions lacked cultural sensitivity, as the physicians-in-training expressed condescending attitudes about some patients' desires to include non-biomedical practices.

For the second area of the internship, I observed desire on the part of a health care provider for help in becoming more culturally cognizant in his interactions with patients. A psychiatrist asked me to sit in on his patients' appointments, as he wanted my help in understanding why his patients weren't taking their prescribed medications. I observed interactions between the psychiatrist, the translator, and patients who were Hmong, Vietnamese and Cambodian, all of whom were diagnosed with schizophrenia. Afterwards, I suggested ways in which he could communicate better with his patients.
The third component displayed the recognition of a need for cultural awareness at OHSU. It involved taking part in a committee charged with reviewing and revising the readings selected for first and second year medical students. The goal was to make the literature choices more culturally sensitive in an effort to extinguish the assumption that all patients' ethnic or cultural backgrounds were white and American.

The last part of my internship provided me insight into the misunderstanding and lack of agreement of the meaning of cultural competency apparent at the university. I was asked to conduct a four-hour presentation on cultural competency for a teaching seminar held each Friday for internal medicine physicians-in-training. We reviewed articles and passages from medical anthropology literature I had selected, one of which was a passage from *The Spirit Catches You and You Fall Down*, by Anne Fadiman (1997). It discusses eight questions a doctor could ask the patient that would probe to the root of any cultural or ethnic differences (Fadiman 1997: 261-262). At this point, the discussion began to center around the lack of time physicians-in-training and physicians have for cultural competency in order to stay on schedule with other patients. The discussion addressed what cultural competence means to the medical community. There were many different understandings of cultural competence and each of us brought a different perspective. After the discussion, I realized that a large obstacle to medical institutions becoming culturally competent was the medical community's lack of agreement on a common understanding of the term.
**Oregon Health & Science University (OHSU)**

Portland, Oregon is home to Oregon Health & Science University (OHSU), an academic medical center whose 100+ acre campus sits upon Marquam Hill, overlooking the city. Four schools (nursing, dentistry, medicine, and engineering) and two hospitals make up OHSU including numerous primary care and specialty clinics, community service programs, research institutes and centers, and interdisciplinary centers. OHSU is Portland’s largest corporate employer and ranks fourth largest employer in the state. Of the currently licensed physicians in Oregon, more than 40 percent received their undergraduate or graduate medical education at OHSU. OHSU educates around 3,500 students and trainees annually. Of those 3,500 students and trainees, 900 are from the School of Medicine and 957 are interns, residents, fellows and clinical trainees. Overall, OHSU treats, trains and influences a large proportion of people in the Oregon population (OHSU 2001a, OHSU 2002a).

**OHSU’s Mission**

U.S. News & World Report, in 2001, ranked the Oregon Health & Science University School of Medicine second among American medical schools in primary care education programs, up from third the year before, in its "Best Graduate Schools 2002" edition. Its Family Medicine education program earned fourth place and rural medicine at OHSU tied for eighth in the national ranking. OHSU’s School of Nursing master’s program was ranked in the top two percent by U.S. News & World Report and has been a top rank
each year since the advent of the surveys in the magazine 12 years ago (OHSU 2001b).

OHSU's mission statement dictates its efforts for compassion, integrity and leadership. Its website states,

OHSU's fundamental purpose is to improve the well-being of people in Oregon and beyond. As part of its multifaceted public mission, OHSU strives for excellence in education, research, clinical practice, scholarship and community service. OHSU stimulates a spirit of inquiry, initiative and cooperation among its students, faculty and staff, through its dynamic interdisciplinary environment (2002a).

**OHSU's Patient Population**

OHSU has a diverse patient population that differs from other hospitals in the state. A large percentage of OHSU's patient population is low-income on Medicaid or is uninsured. It provides health care to more low-income patients, which includes a large proportion of ethnic minorities, than any other health care institution in the state of Oregon. "OHSU cares for the state's most vulnerable citizens. It serves individuals with cultural and language barriers, the poor and the most seriously ill" (OHSU 2001a).

OHSU serves patients from all over the state of Oregon in the OHSU hospital, as well as in Doernbecher Children's Hospital, the Child Development and Rehabilitation Center, and dozens of primary care and specialty clinics. With more than a billion dollar annual operating budget, OHSU is a major contributor to Oregon's economy. OHSU receives its funding from a variety of sources. They are:
- State support-less than 5%
- Gifts, grants, contracts- 28%
- Patient Revenues- 57%
- Other 10%

(OHSU 2002a)

This issue will also be revisited in the Discussion and Conclusions chapter.
THEORETICAL BACKGROUND AND LITERATURE REVIEW

Cultural Competency

In recent years there has been a surge in improvements in Western medicine, medical research and technology. However, health care delivery has not been able to keep up with these improvements. Examining health care at the macrolevel, the delivery of health care services has not kept pace with medical research (Ma 1999: 5). The most neglected are the low-income communities where a large number of ethnic minority people are living. For these populations the quality of health care has not proportionally improved with the rest of the country. There have been many different theories developed to help explain this lack of health care delivery and understanding for diverse populations.

The United States has seen an increase in the diversity of its population, generating greater differences among its peoples. Many scholars have discussed the importance of cultural competency because of this increase in diversity and deem it essential in the delivery of health care. More and more health care providers are striving to provide culturally competent health care and attempting to improve health care because of their own diversity of patients (Meadows 2000: 1). Ma and Henderson refer to Asian American populations in the United States and insist that, "Health care professionals are mostly unaware and/or unprepared to deal with the cultural and linguistic barriers that further compound the problem of inadequate access and use of appropriate health care by many Asian
American groups especially those who are recent immigrants from cultures that are highly dissimilar from their adopted home in the U.S." (1999: 90). Arthur Kleinman, a medical anthropologist and psychiatrist, has discussed the importance of cross-cultural healthcare and healing in the many different books and articles he has written (1980; 1988; 1995). Kleinman stresses the importance of examining the total health care system in a holistic manner. He notes the importance of giving voice to all sides, especially to that of the family and patient (Kleinman 1995: 8).

When there is a lack of communication between the patient and the health care provider, which might lead to failure to follow treatment recommendations prescribed by the practitioner, the blame falls upon the patient who is seen as lacking understanding and motivation, and who is labeled as non-compliant (Hunt et al. 2001:350-355). The perception that the patient is non-compliant contributes to a breakdown in communication, leading to ineffective healthcare for the affected groups. A study conducted to identify factors that influence compliance with prescribed treatment in chronic heart failure indicated that the patient/health care provider interaction and relationship is an important factor in that compliance (Strömberg et al. 1999). The study concludes, "Health care professionals can support the inward factors through paying attention to personal resources, self-concept, beliefs, attitudes, and how the patient is affected by the disease and treatment" (Strömberg et al. 1999: 340). Understanding the beliefs and values of the patient population being served as well as exhibiting cultural sensitivity in the delivery of health care may help to ameliorate the label of non-compliance.
Defining Cultural Competency

The definition of cultural competency differs among institutions as the definition of the term is dependant upon an individual institution’s cultural composition. The Working Groups on Cultural Competence in Managed Mental Health Care Services asserts that “Cultural competence includes attaining the knowledge, skills, and attitudes to enable administrators and practitioners within systems of care to provide effective care for diverse populations, i.e., to work within the people’s values and reality conditions” (2000: p.19). This includes the awareness of the differences between the patient’s worldview and that of the health care provider. The National Maternal and Child Health Resource Center on Cultural Competency defines cultural competency as “A set of behaviors, attitudes and policies of a system, agency or individual in transcultural interactions” (McCarthy 1999: 11).

Within the same institution, differences in the meaning of cultural competency can be detected. The U.S. Department of Health and Human Services and the Office of Minority Health states that “Cultural competency means the ability of health care practitioners to recognize the cultural beliefs and health practices of diverse populations and to use that knowledge and evidence to prescribe the best possible treatment or intervention” (2001). The culturally and linguistically appropriate services (CLAS) project, which is part of the U.S. Department of Health and Human Services and the Office of Minority Health, states, “Cultural and linguistic competence is 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" (Meadows 2000:1).

Ira SenGupta, cultural competency training program manager at the Cross Cultural Health Care Program in Seattle, acknowledges that there are no health care policies that state they will discriminate against patients: “Policies don’t provide disparate care, people do” (Healthcare Benchmarks 2001: 52). Policies and programs are very important and an important first step is to know the makeup of the patient population. “...If you don’t know what groups you serve,” she asks, “how can you know how to treat them respectfully?” (Healthcare Benchmarks 2001:52). The executive director of the Center for Cross-Cultural Health in Minneapolis, Okodon O. Udo, states, “To be culturally competent doesn’t mean you are an authority in the values and beliefs of every culture. What it means is that you hold a deep respect for cultural difference and are eager to learn, and willing to accept, that there are ways of viewing the world” (Healthcare Benchmarks 2001: 56).

Ana E. Nunez acknowledges the fact that one study by AL Kroeber found 150 different definitions of culture (2000: 1071). Her approach to defining cultural competence states that in order to understand cultural competence we must define culture itself (Nunez 2000). In the case of health care, the culture in focus is the individual health care institution. Each institution has its own unique composition of prevalent cultures and ethnicities of health care providers and patients and its own values and traditions of care delivery. Therefore, the definition of cultural competency, to be most effective and useful, must be modified by each institution to meet the needs of that particular institution.
Limits to Adoption

When discussing the cultural differences that exist among peoples, stereotyping and generalization of particular groups is an issue that must be carefully addressed before new programs are adopted. In the book, *Multicultural Clients: a Professional Handbook for Health Care Providers and Social Workers*, Sybil M. Lassiter states that some have attempted to avoid stereotyping a patient by ignoring cultural differences altogether. Lassiter argues that ignoring cultural differences is unacceptable and states that many others agree that it is. However, Lassiter suggests that using stereotypes can help to understand a patient. In each of the next 15 chapters of the handbook, devoted to a different United States ethnic group, Lassiter gives the reader, aimed at health care providers and social workers, common characteristics of the ethnic groups mentioned. However, Native American groups are not mentioned in the handbook (Lassiter 1995). Characteristics are given for fifteen ethnic groups Lassiter mentions in order to better understand the patient. Throughout my literature review, I have encountered other literature that follows along these very lines. Using stereotypes of an ethnic group may help at first to elicit some issues, beliefs and/or values, however, stereotyping should be carefully used, if used at all. While knowing common characteristics of particular groups is helpful in health care delivery, it is not the only aspect that is important about patients.

In the United States, health care providers train for years studying biomedicine in preparation for their roles as health care providers.
"Biomedicine constitutes the predominant ethnomedical system of European and North American societies and has become widely disseminated throughout the world," Hahn affirms (as cited in Baer et al., 1997). That training undoubtedly places the provider in a largely scientific mind frame when dealing with patients. Further, Hahn argues,

Biomedicine focuses primarily upon human physiology and even more specifically on human pathophysiology. Perhaps the most glaring example of this tendency to reduce disease to biology is the common practice among hospital physicians of referring to patients by the name of their malfunctioning organ. The central concern of biomedicine is not general well-being nor individual persons per se but rather simply diseased bodies (Baer et al. 1997: 11).

While biomedicine boils human ailments down to the common denominators of anatomy, physiology, and disease, narrowing health care delivery to the organs of the patient's body obviously does not recognize the social and cultural systems involved, thus limiting cultural competency. Although this may be a hindrance, I did not find patients being referred to by their "malfunctioning organ" to be the norm in my internship at OHSU. I observed many positive and sensitive interactions between the physician and the patient where the patient's well being was taken into consideration.

Arthur Kleinman (1988) proposes that health care systems are social and cultural systems regardless of how they are constructed. He further argues that health care research must be performed in a holistic manner because the health care system is a cultural system that is a socially organized reaction to disease and illness (Kleinman 1980). Leclere (1994) asserts that the individual perception of how to treat illness, as well as the
interpretation of what an illness is and is caused by, varies from culture to culture. Therefore, the interpretation of the cause of a disease in one culture may be completely different in another. Grace Xueguin Ma and George Henderson (1999) state that, for this reason, the health of a third world patient cannot be improved by simply applying Western medicine and expecting the patient to adhere to Western treatment practices, while pushing aside the patient's own cultural beliefs and values if need be (1999:9). Ma and Henderson (1999) attribute the socioeconomic status of a patient as a variable largely responsible for discrepancies in multicultural health care and health status (1999:15). While Ma and Henderson (1999) argue that a lower socioeconomic status may lead to lower culturally competent health care, the opposite case might also be true. A lower degree of culturally competent health care and subsequent misunderstandings and "non-compliance" could lead to a greater proportion of income spent on recurring health conditions and therefore to a lower socioeconomic status level.

Worldview

Each person's worldview is unique to that individual. Aspects such as gender, religion and cultural influences help to mold an individual's worldview. People can be stereotyped due to common characteristics of their worldview and even common health beliefs, yet each worldview is unique and stereotypes trivialize the beliefs of the individuals seeking treatment. Differences in worldviews contribute to the discrepancies between the health care provider and patient because these differences are often not recognized and
addressed. Even failing to differentiate between "disease" and "illness" can lead to further misunderstandings.

**Illness vs. Disease**

There are numerous terms used to define the symptoms, feelings and emotions present when one is unhealthy. The term "sickness" is used to describe all aspects involved in the varying responses to core human problems which are shaped by biological processes (Guarnaccia 2001: 425). Underneath sickness fall two terms, illness and disease, whose relationship and dichotomy from an essential concept in the field of medical anthropology. Confusing the terms can play a large role in the cultural misunderstandings in health care delivery. Illness is the patient’s perception of what ails him/her, while disease is the health care provider’s perception of the patient’s ailment. Examining the terms more closely, illness is the shaping of a disease around the cultural characteristics present in behavior and experience. Arthur Kleinman states, "it (illness) is created by personal, social and cultural reactions to disease" (1980: 72). Illness acts as a coping function and response to disease that attempts to explain the disease. Therefore, illness can differ across cultures. Two patients with the same type of disease may not have the same illness. Illnesses are individual and unique (Basch 1999: 144).

Whereas illness is seen from the perspective of the patient, disease is seen from the perspective of the doctor, defined through biomedicine (McElroy & Townsend 1996: 44). While illness affects not only the individual as well others, such as family and community, disease affects the individual
because of its reference to malfunctioning biological or/or psychological processes (Kleinman 1980: 72-73). In situations of cross-cultural health care, the patient may come from an ethnic or cultural background of beliefs and values that differ from that of the health care provider's beliefs and values, as well as biomedical background. The lack of understanding and attention to a patient's health belief system, how an individual views his/her illness, or how they want to be treated, can result in misunderstandings. This reflects on an institution's ability to deliver culturally competent health care. Illness and disease are explanatory concepts that represent a clinical reality. Each interpretation of a sickness and the response to it, whether it is oriented more toward disease or illness, can be defined as one's explanatory model (Kleinman 1980:73).

Explanatory Model-Kleinman

The cultural issues involved in health care delivery have been tackled by many, across a variety of backgrounds and experiences. Throughout his studies, Kleinman has suggested that by addressing and understanding the explanatory models (EM's) held by patients and their health care providers, a clear and precise analysis of that relationship can be exposed. Kleinman defines explanatory models as "the notions about an episode of sickness and its treatment that are employed by all those engaged in the clinical process" (1980: 104-105). In dealing with cultural competency, the patient's perception and the health care provider's perception of the illness must be recognized and understood.
Kleinman suggests that demonstrating genuine, non-judgmental attitudes about patients' beliefs and views regarding their illness improves communication about the health care delivery process. Providers can use open-ended questions to discover the patient's explanatory model (EM). Encouraging the patient to share their understanding of their illness is crucial to appropriate treatment (Kleinman 1995: 8-9). Kleinman recommends eight questions to help elicit patient explanatory models that have been cited in various literature and used by many different institutions such as the Center for Health Professions at the University of California, San Francisco (2002:100), The American Medical Student Association (2001a) and in the book *The Spirit Catches You and You Fall Down*, by Anne Fadiman (1997:261-262). They are:

1. What do you call your problem? What name does it have?
2. What do you think has caused your problem?
3. Why do you think it started when it did?
4. What does your sickness do to you? How does it work?
5. How severe is it? Will it have a long or short course?
6. What do you fear most about your sickness?
7. What are the chief problems your sickness has caused for you?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

(Kleinman 1980: 106)

While some of these questions may seem obvious and the response would be easy to predict, it is important to note that, with so many different
backgrounds, values, interpretations, religious beliefs, and cultural histories among people in the world, one cannot assume that all answers would be similar. Through the use of open-ended questions, clinicians can strive to overcome cultural biases and ethnic and lifestyle stereotypes, thereby treating the patient as an individual with his or her own particular perspective (Kleinman 1995:53). Kleinman (1980: 1988: 1995) emphasizes that health care providers can not assume and must attempt to uncover the values of all the parties involved in order to avoid future misunderstandings and miscommunications that would complicate the health care delivery process.

Exploring Medical Anthropology

Medical Anthropology is a sub-division of Anthropology, the study of humans, which applies anthropological concepts to the inquiry of health, disease, illness and sickness in individuals as well as populations. Holistic and cross-cultural approaches are taken in order to better understand the biological, cultural, linguistic and historical background of the subject being examined. Medical anthropology, one of the youngest sub-disciplines of anthropology, uses an anthropological approach to understand, among other things, the patient-provider relationship. This subfield of anthropology is multidisciplinary, often borrowing theories and ideas from other disciplines such as sociology, biomedicine, history, and so forth.

Many theoretical perspectives and approaches have influenced medical anthropology and how illness can be explained throughout a wide range of cultures and societies. McElroy and Townsend (1996) have identified four types of theories that have had the most influence on medical anthropology.
Interpretative theories, political economy or critical theories, ecological or biocultural theories, and political ecology are groups of theories or approaches that help to understand people by listening and learning from them (McElroy & Townsend 1996: 63-69). However, McElroy and Townsend (1996) concentrate more on ecological perspectives, emphasizing that only through the holistic examination of a culture's environment can a culture be understood concerning the health and disease issues surrounding it.

Three perspectives are categorized by Robert Hahn (1999) as having an influence upon medical anthropology as well as with public health. Ecological/evolutionary theory, cultural theory, and political/economic theory are all theoretical positions that can be used to reaffirm one's view or bring change to an existing one (Hahn 1999:10).

Baer, Singer and Susser identify three theoretical perspectives: Medical Ecology Theory, Cultural Interpretive Theory and Critical Medical Anthropology. However, throughout their book, the Critical Medical Anthropology (CMA) perspective is more abundantly used. CMA seeks to understand the influence of biomedicine and the power relations that are involved in the delivery of health care (Baer et al. 1997: 27). While my qualitative and ethnographic study draws upon many of the theoretical perspectives associated with medical anthropology, I will be focused mostly on the Critical Medical Anthropology (CMA) perspective. I will discuss the ways in which illness and disease are shaped by larger political, historical, and economic determinants (Keshavjee 1996: 1096).
Critical Medical Anthropology Perspective

The term “critical medical anthropology” (CMA) was first used in a paper presented to the American Anthropology Association in 1982. It is a term Hans A. Baer and Merrill Singer use to help illustrate the notion of critically examining health issues in their historical and social-political contexts as well as the many different power relations that are involved in the delivery of health care (Baer et al. 1997:26-27). The critical perspective takes root in the works of three German critical theorists, Karl Marx, Friedrich Engels, and Rudolf Virchow, and has been applied to medical anthropology. Baer and Singer examine and argue that a person's social environment and daily activities are factors that contribute to their disease and illness (Baer et al. 1997: 35-36). CMA began as a challenge to medical anthropology at the time; a way to critique the ideas, scope, and perceptions of medical anthropology and open up discussion regarding those findings (Singer 1995). Over time, CMA evolved into a more critical analysis of health care systems and the human body as well as the relationship between the patient and the doctor. Merrill Singer (1995) suggests that the time has come to move “beyond the Ivory Tower” and seek application of critical medical anthropology concepts within the health care field.

An appropriate starting point for understanding CMA is biomedicine as it is the dominant health care system in the United States. Not only is it used in nearly every hospital, emergency room, doctor's office, pregnancy and birth, but it is also the predominant training received in medical schools across the country. Biomedicine is unable to have complete hegemony because some patients do request the services of alternative treatments and healers
(Baer et al. 1997: 215). However, our country’s health care system is built around the principles of biomedicine. But who controls biomedicine? Who decides what should be included in biomedical training when becoming doctors or nurses? What are the areas of resistance within biomedicine that affect the functioning of the medical system and how do those areas of resistance affect people’s relationship to the medical system? Where do heterodoxic, naturopathic or chiropractic medical systems fit in, for example? These are types of questions that CMA attempts to uncover and address (Baer et al. 1997:27-29).

Critique of the Levels of Health Care Systems

Baer, Singer and Susser (1997) suggest that there are four levels of analysis regarding health care systems: macro-social, intermediate social, micro-social, and individual. At each of these levels of analysis, different social and biopsychological relations can be found. The macro-social level includes the global world system consisting of the capitalist world system, corporate and state sectors and plural medical systems. Health institution policy and decision making is what is examined at the intermediate level as well as administration and health personnel interactions. The micro-social level includes interactions between health personnel, the physician-patient relationship and/or the healer-patient relationship. At the individual level, the analysis hones in on the patient’s personal support network, the patient’s experiential response to illness and the human psychobiological system (Baer et al. 1997:27-33).
While the focus of CMA is more concentrated on the macro-social level of analysis, this study will be directed toward the intermediate level and micro-social level. The notion of cultural competency must first be understood at the micro-social level, analyzing what the health care provider deems important regarding the relationship with the patient. Only by first interpreting the issue at the micro-level can policies be addressed and amended in hope of bringing change through administrative decisions and administrator’s interactions with health personnel. However, in order to generate any changes, the intermediate level must be critiqued in order to determine what is possible regarding change.

Oregon Health & Science University Literature

The issues of cultural competency and diversity are relatively new concerns at Oregon Health & Science University (OHSU). In 1987, Barbara Glidewell, who worked in the Patient Relations office at OHSU at the time, needed a tool she could use to educate new staff members about these very issues. She wrote *Penetrating the Cultural Fog* and *Deciphering the Cultural Code* as the foundation material she would use in the in-service training on cultural awareness she conducted. She states,

> When working with culturally diverse populations, and when working with a medial interpreter, the doctor needs to learn how to proceed. This includes using language that is appropriate to the patient’s level of education, speaking in short sentences, using the active voice, charts and pictures, determining how the patient perceives illness and avoiding worst of all sins, stereotyping care. When assessing a patient, issues
such as family migration and relocation history, culture shock, stress, and concept of illness are essential sources of information (Glidewell 1987: 1).

She also includes information about prevalent cultural differences, common cultural characteristics, the influences of traditional healers, the importance of cultural competence, and the Explanatory Model based on the work of Arthur Kleinman (Kleinman et al. 1978). This training is required for new staff members at OHSU, but, unfortunately, it does not include physicians, medical students, nurses and administrators.

The Spirit Catches You

An important piece of literature was written by Anne Fadiman, about a Hmong little girl with severe epilepsy, The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures (1997). Fadiman became involved with the little girl, Lia Lee, attempting to encourage communication between the Lees (Lia’s family) and her biomedical doctors in California. The importance of this book has been its recent influence in the medical culture. Many of the literary sources mentioned and interviews conducted in my research have cited this book, therefore, a summary of this book is necessary to enhance comprehension of my thesis.

The Lees had fled from Laos to the United States and it was in a small California hospital that Lia was born. Lia Lee was diagnosed with severe epilepsy at eight months. However, this diagnosis occurred during Lia’s third encounter at the Emergency Room, following two previous misdiagnoses. According to Lia’s parents, Lia’s epileptic episodes first began when Lia was
three months old when her sister had slammed the front door. Fadiman describes the Lees interpretation of Lia’s illness, by the symptoms she had experienced, as “quag dab peg,” which means, “the spirit catches you and you fall down” (Fadiman 1997: 20). In other words, Lia’s spirit had been scared out of her body by the door slamming and became lost (illness construct).

Conversely, by biomedical standards, Lia was diagnosed with epilepsy (disease construct).

Fadiman’s book provides the reader with great examples of miscommunications that had occurred between Lia’s parents and doctors, many of which stemmed from cultural barriers that were not understood by either party. The Lees’ version of what was going on was essentially ignored until Jenny Hilt, Lia’s social worker, became involved. Both Hilt and Fadiman were able to address the cultural barriers that inhibited Lia’s treatment and needed to be broken down to more effectively treat Lia. Throughout Lia’s tragic story, there are many miscommunications and issues that are ignored and must be uncovered in order for Lia to receive the health care she deserves.
RESEARCH APPROACH AND METHODOLOGY

Preliminary Information Gathering

As mentioned in the background section, research for my thesis began in the summer of 2000 when I took part in an internship at OHSU where I spent three months observing the internal medicine clinic operations. During this time, I integrated myself in a variety of different contexts with the intention of observing the culture of OHSU. I sat in the waiting room to observe patients interacting with other patients discussing their health, observed the doctor/patient relationship in the Psychiatric Clinic, and observed the residents (physicians-in-training) discussing their patients with the Attending Physician. In addition, I took part in a committee examining the medical teaching material for first and second year students, seeking new material that would be more culturally relative. On July 28, 2000, I led the Ambulatory Skills Block Seminar, which is a weekly seminar for residents from the Internal Medicine Department. The discussion centered upon cultural competency and its importance in the delivery of health care.

Holistic Study

The nature of this study involves obtaining information from many different perspectives and approaches. As an anthropologist, I approached this as a holistic study. The anthropological term, "holistic" is defined as, "viewing culture as an interconnected whole" (Feder 1993: 127). If I were an
anthropologist studying a remote tribe in the middle of Africa, I would approach that study similar to the way I approached this study at OHSU.

Anthropology assumes that all facets of the organism's anatomy, physiology, behavior, environment, and evolution are interrelated and can only be fully understood in terms of those interrelationships. (Feder 1993: 127)

Taking this into account, in order to thoroughly understand what the term cultural competence represents at OHSU, for the institution and the participants involved, it needs to be holistically studied. My study used participant observation, a literature and demographic review, and qualitative interviews with four different groups of OHSU participants (involved members in the institution).

**Participant Observation**

I conducted participant observation in three different areas of the project. The first took place during the internship, as stated at the beginning of the Methodology Section. Next, while IRB approval was being considered by Oregon State University (OSU) and OHSU, I worked as a volunteer at OHSU in the Surgery Waiting Room, one day a week for four hours, to better understand the culture of the institution. I logged over fifty hours volunteering and observing interactions between health care providers and patients' family members. Outside the doctors' presence, family members would speak to me about the issues they were having as they waited for their loved one(s) to return from surgery. I would help answer
questions regarding the status of the surgery, where the patient was moved after surgery, and the services OHSU offered in the family's time of need and understanding. Finally, I devoted time specifically in clinic waiting rooms, where I would observe patients waiting to be seen by their health care provider, who were discussing their visits to the clinic and health issues with family members or other patients. This provided insight into the relationships and interactions involved at the institution and included observations of the provider/patient relationship from the patient perspective.

**Literature Review & Changing Demographics**

Over the course of the literature review, I examined material regarding cultural competency in a variety of contexts. Most of the literature was taken from the medical and anthropological community. Existing programs promoting the need for and importance of cultural competence were investigated as well.

Research on the changing demographics of the patient population of the United States and Oregon was examined as well as the enrollment statistics for U.S. medical schools. Physician racial/ethnic diversity percentages were gathered from the U.S. Department of Health and Human Services for the U.S. and Oregon from the most recent year, 1998 (1999b). This was compared with the patient demographics. The term "physician" is defined by HRSA, Health Resources and Services Administration, as "Primary Care Physicians as a percentage of total physicians in the year cited."

Primary Care is defined as, "all Federal and Non-Federal patient care /family
practice, general internal medicine, general pediatrics, and general OB/GYN MDs” (U.S. Department of Health and Human Services 1999b). Demographic information, for national populations as well as Oregon populations, was taken from the U.S. Census for both 1990 and 2000 and used to indicate the demographic changes in those populations (2002). In some cases regarding census information, Hispanic racial/ethnic categories were not listed with the main racial/ethnic choices. Therefore, to arrive at the percentages used, the population of those reporting Hispanic origin was added onto the total population which equaled the number \(x\) and then the Hispanic population was divided by that number \(x\). The Asian and Pacific Islander racial/ethnic categories were combined into one category, Asian/P.I. This is because the 1990 census data included them in one category, however, the 2000 census data, listed them as two separate categories. For this study, they were kept combined as one category for comparison purposes.

**Internal Review Board (IRB)**

I gained Internal Review Board (IRB) approval from Oregon State University and Oregon Health & Science University in the fall of 2001. The IRB at Oregon Health & Science University was the most difficult due to the lack of procedures in evaluating qualitative studies. As an outside member of the OHSU medical community, a more in depth review of the study was taken before approval of my study. IRB approval was required from both OSU and OHSU before the study began. For selected forms, such as the Informed Consent form, OHSU’s approved version was used since those signing it were members of that institution.
Informed Consent

Before the interview session, each participant (medical student, physician/physician-in-training, administrator or nurse/Credited Medical Assistant (CMA)) was given an OHSU IRB approved informed consent form to read and then sign. Because the interview sessions were audiotaped, the form functioned to inform the participant that confidentiality would be maintained. The form also maintained the participant's right to discontinue the study at any time.

Confidentiality

Participation in an interview or focus-group session was audiorecorded to ensure that the subjects' words were not misunderstood or misrepresented. Identities were concealed through a code letter and number assigned to each subject throughout the data collection and analysis process. The code identifiers for the medical students are M1-M16, the physicians/physicians-in-training were identified with P1-P5, the administrators are marked with A1-A5 and the nurses/CMA subjects were identified with N1-N5. These codes were used to label information gathered about the subject during the study. Audiotapes were transcribed and subsequently erased. All material from the taped interview sessions was kept secured at all times, until the tapes were erased.
Snowball Sampling

Once IRB approval was gained, I began to locate participants for the study. Snowball sampling was used to find participants representing those most educated about cultural competency or cultural issues at OHSU. This type of sampling is used in difficult-to-find populations (Bernard 2000:179-180). Those interested in cultural competency are difficult to find because there is no discipline or interest group targeting the issue. Therefore, snowball sampling is used to locate a few informants who can flush out other informants who have knowledge of cultural competency. Members from the OHSU medical community who were asked to participate were also asked to recommend other medical colleagues at OHSU to participate who had some knowledge of cultural competency or who had minority cultural backgrounds. This was a non-random convenience sample and not representative of the medical community at OHSU as a whole. However, this study is not after a representative understanding of cultural competency at OHSU, but rather strives to comprehend what level of understanding there is of cultural competency in the medical community among those who are most educated about the topic.

Projected Sample Size

The sample size used was to be limited to forty participants. Of these participants, it was planned that 10 would be medical students at different years in their training, 15 physicians at varying levels of practice, 5
administrators and 10 nurses. This non-random sample of participants was to be selected for comparative measures.

Nurses Strike

On December 17, 2001 the nurses at OHSU began a strike that would last until February 13th, 2002 (Rojas-Burke 2001: OHSU News Release 2002). The loss of OHSU nurses for those 59 days affected my nurse sample size. I could not conduct interviews with the replacement nurses because those nurses would not have had the same understanding of cultural competency as the OHSU nurses. Therefore, nurse interviews were postponed until after the strike. After the strike ended, the backlog of work limited the time OHSU nurses, administrators, physicians and physicians-in-training had to be interviewed.

Actual Sample Size

The actual sample size consisted of 16 medical students, 5 physicians at different levels of practice, 5 administrators and 5 nurses/CMA. Colleagues of those interviewed were asked who else they thought would like to participate. Two physicians and one nurse interviewed were also in administrative positions and thus were counted in both categories.
### Table 1. Expected/Projected and Actual Sample Size

<table>
<thead>
<tr>
<th>Interviewed Group</th>
<th>Expected/Projected</th>
<th>Actual Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical students</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td>Physicians/physicians-in-training</td>
<td>15</td>
<td>5</td>
</tr>
<tr>
<td>Administrators</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Nurses/CMA</td>
<td>10</td>
<td>5</td>
</tr>
</tbody>
</table>

#### Qualitative Interview Sessions

Qualitative research was conducted to gain a deeper understanding of the perceptions, attitudes and ideas medical students, physicians & physicians-in-training, administrators and nurses/CMA had regarding cultural competency. Individual interviews and focus groups were conducted to enhance this understanding and elicit the issues involved in the delivery of health care. Interview sessions varied in the length of time. Each interview session was conducted in a site chosen by the respondents, whether in their office, a coffee shop, a classroom, my apartment, or their own home.

Quantitative research was not conducted because the study is not seeking a representative sample, or answers to a particular question. The main goal of these interview sessions was to reveal the level of understanding of cultural competency held by the most informed and interested OHSU health care professionals.
Individual Interviews

I began interviews in January 2002 with administrators, physicians and physicians-in-training, nurses/CMA, and medical students. Individual interviews were conducted with participants in each of these four groups. A list of questions, included in the appendices, was used to keep the discussion centered on cultural competency and to further discussion about the topic. These interviews were semi-structured, meaning that the interview had the possibility to move in the direction the respondent wished to take it. Given that the conversation kept centered around the issues associated with cultural competency, this leeway was permitted. Each individual interview lasted between twenty minutes to more than one hour.

Focus Groups

Focus groups were arranged to evoke an extensive discussion of the ideals, views, and criticisms surrounding cultural competency and the medical curriculum's incorporation of the topic. The focus groups were important for the medical students and nursing/CMA groups because early interviews with each group demonstrated a limited understanding of cultural competency when compared to the administrators and physicians/physicians-in-training. It was an opportunity for colleagues to share and discuss their understanding and views of cultural competency as well as to debate those ideals which helped avoid superficial discussions of the topic. Two focus groups were conducted with the medical students and one with nurses/CMA. The first focus group consisted of only two medical students while the second group
consisted of twelve students. The nursing/CMA focus group consisted of one Registered Nurse (RN), a Licensed Practical Nurse (LPN) and a Certified Medical Assistant (CMA). Each focus group session lasted between forty-five minutes and an hour and a half.

**Coding & Analysis**

Every interview was given an identifier so that confidentiality would be maintained. For most interviews, the interview was coded by the researcher and one other party to improve reliability and avoid any biases that could have been present. In a few cases, some of the interviews fit into two categories, such as a participant being both a nurse and an administrator. In those instances, the interview was analyzed with one group and then the other.

Individual interviews were examined and coded into general topics. Select segments of text that exemplified important concepts and thoughts about cultural competency were extracted and arranged into categories. Interviews that shared common concepts and thoughts were put into the same category. If the categories shared common characteristics, they were grouped to form a theme that represented the group. These themes were illustrated with selected quotes from the respondents (Bernard 2000: 450-456).

How cultural competency was defined was the first level of analysis for each of the four groups: medical students, physicians and physicians-in-training, administrators, and nurses/CMA. Next, the rest of the interview was coded to decipher the understanding of cultural competency and the
issues and concerns that were involved. When the participant(s) defined cultural competence their academic definition and understanding was used in the coding process, however, their practical and instinctive knowledge and understanding of the term was also valuable and coded.

Research Limitations

In some ways, the fact that I was an outside anthropologist involved with OHSU benefited my research and, in other respects, limited it. As an outside party, respondents could speak freely about the institution and not fear being reported. However, getting the interviews was more difficult as I lacked the connections enjoyed by affiliation with OHSU. For this reason, involvement in my study was limited to those who either had a connection to a party already interviewed, or were genuinely interested in the project.

The nurses' strike that began on December 17, 2001 limited the availability of nurses to be interviewed as well as those administrators and health care providers who were needed to cover for the striking nurses. Over the following months it became increasingly difficult to obtain the time for interview sessions due to full schedules and limited resources.

Most researchers desire to have more time and resources to be able to gather more data. It would have been beneficial to have collected more data from more subjects; nevertheless, because this was a qualitative study, having more in depth interview sessions was more desirable than simply more interviews. Quantitative studies are typically the form of research conducted in the medical community. Therefore, demonstrating the
importance of a qualitative study was difficult and limited the number of participants interviewed.

My selection of participants to be interviewed was biased given that my study was not after a representative sample of how the institution defines cultural competence, but how those who are most knowledgeable of the term define it. This was done to determine what is possible at OHSU regarding cultural competence. The four groups chosen, medical students, physicians/physicians-in-training, administrators and nurses/CMA, were chosen because these groups work the closest with patients, thereby, dealing with the issue of cultural competence. Therefore, I sought out someone with experience and/or knowledge with cultural competency issues to be interviewed, and then asked for others they knew with similar experience and/or knowledge, the snowball sampling. This was biased, however, it was deliberate.
RESULTS AND ANALYSIS

Participant Observation

The participant observation conducted in this study was used to better understand the medical institution and the players involved from an outsider's (internship observations) and from an insider's perspective (volunteer employee at OHSU). No formal data was extracted from these observations as the purpose was to gain a deeper understanding of the daily operations, personal interactions and everyday topics of conversations that transpire at OHSU. These observations fell into two categories: observations from the internship and observations from the surgery waiting room.

Internship

During the summer of my internship at OHSU, as stated earlier in my thesis, I was involved with many projects and interacted with many groups of people. I determined that there were groups at OHSU interested in the issues of cultural competency; however, there is no formal program or expertise that addresses those issues at OHSU. The aspect of time, and how limits to time in health care delivery causes a hindrance to cultural competence, is a significant issue in the discussion of cultural competency and I used that information as source of inquiry in my interview sessions. There was a number of health care staff interested in cultural competency
who desired to learn more about how to better recognize miscommunications and misunderstandings.

Surgery Waiting Room

Volunteering in the surgery waiting room differed from my internship in that in this instance, I was an insider. I worked for the hospital and was part of the system, rather than a passive observer. The hospital staff trained me and set their expectations of me. In the morning, I picked up a copy of the scheduled surgeries for the day, headed up to the waiting room where I checked in and began work at the volunteers' desk. During my morning shift, I would keep track of which visitors were waiting for which patient, answer the phone, check for surgery updates on the computer, and attempt to answer questions asked by the patient's family and friends regarding what was taking place with the patient's surgery. Typically, I was kept up to date on the status of the patient through phone calls by the surgeons, nurses or hospital staff. I would relay this information to those waiting for that patient.

It was in these situations that I was able to observe the interactions between all members involved. In some instances, I was a confidant to the family of the patient, a source with whom they could share their concerns regarding the surgery and the patient. They would occasionally voice their frustrations to me, in which case I would have to balance the interests of the hospital while empathizing with their issues and concerns. In a few instances, language barriers were apparent. With no interpreter present, I would do the best I could to communicate what was going on. In those situations, I
made an attempt to find a family member or friend, who could speak at least a little English. In some instances, I would notice discrepancies between what they were telling me and the information I had about the patient. In other scenarios, the family and friends of the patient would simply discuss what was going on that they didn't understand. As a surgery volunteer, I would try to clarify misunderstandings, however, I could not see myself as a true resource because I could not speak to their concerns with absolute authority.

**Demographics**

The demographics of physicians and patients in Oregon are imperative in determining the cultural composition at OHSU. To best depict the physician and patient populations, a number of graphs are used to represent the data. The demographics of physician populations for the United States and Oregon for 1999 (Figures 2 and 3), as well as the patient population of the United States and Oregon for the year 1990 and 2000 (Figures 4-7) are depicted in these graphs to visually compare these populations.

**U.S./Oregon Physician Demographics 1998**

Comparing the demographics of physicians taken from the U.S. Department of Health and Human Services for the United States and those taken for Oregon in 1998 show drastic differences between what is found as a nationwide average and what is found in Oregon (1999b). Figures two and three demonstrate how these populations differ in the amount of ethnic
Figure 2. United States Physician Demographics 1998 (%)

Figure 3. Oregon Physician Demographics 1998 (%)
diversity found among physicians. In Oregon, 90.9% of the physician population is White (Non-Hispanic) while the national average is 75.5%. For the Black (Non-Hispanic) population, the nation records 3.5% of physicians identified in this category, while Oregon records 0.8%. The Asian/Pacific Islander physician population also demonstrates stark differences between nationwide statistics and Oregon. The United States has 12.5% of its physician population identified as Asian/Pacific Islander, while Oregon has only 5.9% of its physician population identifying themselves in the same category. The Hispanic physician population for the United States resides at 4.9%, while Oregon holds 1.1% of its physician population in the same category. The American Indian/Alaskan Native physician populations for both the United States and for Oregon are found at 1.1%.

These statistics demonstrate the stark differences between nationwide physician demographics and Oregon physician demographics. Examining and comparing the statistics for both populations, Oregon has a distinctly lower amount of diversity among its physicians than the national average. This issue will become more significant when compared to the patient population.


There is an abundance of information one could attain from figures four-seven. The focus of this section rests in examining how populations for the United States and Oregon have changed from the 1990 census to the 2000 census and how each compare to the physician demographics in figures two and three. This data was taken from the U. S. Census Bureau (2002).
Figure 4. United States Population 1990 (%)

Figure 5. United States Population 2000 (%)
Figure 6. Oregon Population 1990 (%)

Figure 7. Oregon Population 2000 (%)
Between the 1990 census and the 2000 census, two of the racial/ethnic categories changed. In the 1990 census, the category Asian/Pacific Islander existed, however by the 2000 census, this category was split into two separate categories. For the comparison purposes in this study, the two categories were kept together.

An increase in the diversity of the populations of the United States and Oregon from 1990 to 2000 can be detected in figures four-seven. The United States had increases in population diversity in all categories except White (Non-Hispanic) which included the following categories: Black, Hispanic, Asian/Pacific Islander, and Native American. Oregon increased in diversity in only two categories, Hispanic and Asian/Pacific Islander, while staying at the same percent as in 1990 in the Black and Native American categories. Oregon's White (Non-Hispanic) category decreased as the United States' had as well. However the increase in the Hispanic population from 2.1% in 1990 to 8.0% in 2000 was a large increase for the state of Oregon. While on the surface this may not seem to be a significant statistic, when compared to the percentage of Hispanic physicians in Oregon from figure two, which was 1.1% of total Oregon physicians, its importance becomes more apparent.

**Semi-Structured Interview Results**

As mentioned in the previous chapter, to maintain the confidentiality of the health care professionals and administration personnel interviewed, each respondent is recognized with an identifier and then a number. These identifiers are 'M' for the medical students, 'P' for the physicians and
physicians-in-training, 'A' for the administrators and 'N' for the nurses/CMA. For a few of the interviews, some of the respondents fit into two categories. In these instances, two separate identifiers were used.

Medical Students

In medical school, students take four years of classes before earning a medical degree and becoming physicians-in-training. Another three to four years is spent completing their residency (physician training) program before becoming certified physicians. Overall, medical students spend seven to eight years in formal education before becoming practicing physicians.

In all, sixteen medical students were interviewed with reference to cultural competency. Two focus groups and two individual interviews were conducted. The focus groups involved first and second year medical students and the individual interviews were with first to third year medical students. Fourth year medical students were not included because their schedules didn't allow for the time necessary to be interviewed. In order to differentiate between the medical students, each was given an identifier of M1-M16.

The medical students' understanding of cultural competency was the simplest of the four groups interviewed. They had literary and academic knowledge of the term, but not practical knowledge of cultural competence. Most of the respondents, when asked to define cultural competence, stated that it was to be aware of different cultures. Another common response was to define it as knowledge of other cultures and having the ability to see from the patient's point of view. Medical student (M1) maintained that,
in terms of competency it is having some type of knowledge of how other cultures fit into your frame of reference and having some kind of ability to look at it through their point of view. And specifically, how it applies to health care, since we are all physicians to be, we’ve had some amount of education on having to think about where everyone else is coming from. Oh, your patient, especially ones who have been born abroad with their beliefs on health and medicine, social norms and taboos, and their society; we have to have not only sensitivity but knowledge of those different cultures. And, you know, changing your attitudes and behaviors appropriately.

Medical student (M4) mentioned that it is important for her to match up her ideas with her patients.

For myself, I guess it’s realizing that there are a lot of cultures out there and a lot of those people aren’t going to see things, necessarily, the same way as I do. I think it’s important, as far as with my dealings with them, to understand that they’re probably coming at things from a different aspect than I am and to work that into whatever treatment plan or into whatever kind of relationship that we have so that my ideas for them kind of match what they have as their own ideas of what’s going on.

Overall, the medical students viewed cultural competence as an abundance of knowledge and awareness of many cultures rather than understanding the individual patient. Medical student (M12) asserted:

I think it’s a level of cultural cognizance to me. Being aware of the different cultures, whether they be ethnic or racial or other demographics, like gender or
something like that, actually play quite a role in one's perspective of the world at large and their role of themselves.

Another medical student (M7) continued the thought:

I think that knowledge of other cultures, regardless of what it is, not necessarily ethnicity or race but I think that's huge in medicine culture. People's views and values, all those things effect the way they view themselves.

Two strong themes emerged from the interviews with the medical students concerning their understanding of cultural competence. The first one concerned the attainability of cultural competence. The second theme concerned changes to the curriculum and training with senior physicians.

In one of the individual interviews the subject (M3) has had considerable experience with cultural issues before her choice to become a doctor. Her belief is that cultural competency is unattainable because she sees it as a process or skill, rather than something that is mastered. However, she is open to the life long process of developing that skill:

There are some areas where competency is like a skill you can master, you're done. I don't know, like playing a certain song on the piano. You just reach a certain level and you're finished and I don't think cultural competency is like that. I mean I guess I think it might have to do with recognizing, kind of like we were talking about earlier, like how huge the field is and being able to be really open and reflective and to recognize that you are never going to get there no matter at what stage in the
process you are, you are always keeping track of yourself. And looking for ways that you can become more aware or more sensitive. That's not really a defined state but that's how I think it is. I don't think you ever get there.

In another individual interview, the respondent (M4) described the importance of realizing that there are different cultures and that not everybody is going to see things the same way and that there is always going to be that inevitable cultural blind spot.

I think it's really hard to achieve. I think everyone should keep it in mind and try their best, but I think at times there's so much to it, that I don't think you can be totally culturally competent. I think you can try and I think that you can work with people, but I don't know if you ever really see into each other's own culture as much as you'd like to.

In a focus group composed of two first year medical students, their perception of the attainability of cultural competency concerned the issue of the time it might take to be culturally competent. M2 expressed her idea of the achievability of cultural competence:

I think that it's extremely important and it depends on what type of practice you have. I mean if you are a surgeon and you are seeing thirty patients in your afternoon, you're not going to have time to do a cultural or social history with all your patients. But I think it's something that in primary care it's extremely important. Because in the long run I think you save time by knowing how to interact with a patient and knowing what that patient is looking for. I mean you could treat this patient with this and this and this and the patient may
not take any credit for what you said because that's completely outside of what they believe in. Or that's something that because of the way you approached them, it offended them. I think it's a huge barrier and if you don't get past that, you are kind of treading backwards in a lot of ways with your patients. I mean I think that it's a huge time commitment to do that and that most physicians don't have the time to do that. To really get to know their patients culturally, as well as socially, as well as physically as well as they need to.

The second respondent (M1) continued along the same lines as her colleague and asserted:

We learn to take all these spiritual histories and cultural histories and family histories and you just don't have the time. I think probably when it becomes an issue is when... I mean I'd say a majority of the people we see now aren't necessarily the migrant population. Or aren't people who don't know any English at all and haven't been here before like the whole Lia Lee family thing (Fadiman 1998). That was a very extreme kind of example and it's extraordinarily important there. But say in daily practice, it doesn't become an issue as it would in a more critical type of environment where there is total breakdown of communication because there of that: due to language barrier but also due to the "cultural barriers". But I think that it is very difficult.

The second focus group, which consisted of twelve medical students, touched on many of the important issues in treating patients and how to respect their worldview. One of the six males in the session (M6) answered a colleague regarding cultural awareness:
I agree with M7, just in that it's the diversity of experience, relationships as far as how culturally competent you are. There is no end point. There's too much unknown at this point. I don't think you can ever be completely culturally competent. It's more of you start to see patterns of themes that increase cultural competence, depending on how many times you've see them and how much time you've had to be with different cultures or groups of people.

The second theme for the medical students revolved around possible changes to the curriculum and how to change the minds of senior physicians and administrators regarding the importance of cultural competence. M7 disclosed:

I don't see cultural competency as an extra. I think it's part the consultancy thing and it's part parcel with medicine. The bottom line is that we want to heal our patients and that's done through patient compliance. And the only way we can enhance compliance is through understanding their culture. I don't want to learn about the Hmong just for fun, if I want to do that I'll go to it during the summer. We can learn about regulating blood pressure through the 25 mechanisms, but if our patients don't take those tablets, what's the point? I think it's huge. I think somehow they have to find a way to include it.

Types of constraints in maintaining cultural competency was a topic brought up by M3 as well as factors she saw that would limit it. Humility within the medical community is an issue that she indicates is not addressed by its members:
Yeah, medicine in itself is definitely a culture. And medical school is at least as much as a paradigm of culture as it is teaching of facts because we're even told that most of the facts, like two-thirds of them, will be updated by the time we're five years out, or something. So if that's the case, then what is it that they're teaching us of culture? And a big part of that culture is to be knowledgeable, to know your stuff and even if you don't, act like you do, and to take charge and to be assertive and all those qualities are very incompatible. If you nurtured those in yourself, then it's pretty difficult for you to be culturally aware.

This medical student has a Native American background and was put in charge of instructing some experimental and pilot courses for the first year medical students. In these teaching sessions, she critiqued the biomedical system and shared her personal experiences with other medical students. In her interview, she disclosed her feeling that other students are biased against learning aspects of medicine that are not physiologically based.

I did some trainings here, I did some trainings of the entire first year class. My entire class and the class before me I spent a lot of time preparing and they gave me about eight hours with each class and the whole idea of I started at real basic stuff because I know that around here, here being Oregon, people probably need that. I mean I've done a lot of it, so it's not just my guess, I know that you have to start at the very beginning because people were real resentful, based on the evaluations and they said things that were negative and this is so ignorant, so ignorant and just goes to show that they're wrong, "I've been accepted to medical school, I don't need to be trained in these things." Look, doctors now do things like amputate your legs more often if your black than if you're white if you've got diabetes. It's documented and that's just out, that's
new research. The same thing about bi-passes, it's quite clear that doctors are prejudiced. I mean it's just a numbers thing, it's not an opinion thing, it's a numbers thing, and so to say, "I've been accepted to medical school, I have this under control" just goes to show how little they understand. It's just amazing. And, of course, I demand of people, in my teachings, that you wrestle with ideas that might put you in a place to confront stuff like that. I'm trained as a teacher, so I know how to engage people. I don't lecture; you've got to deal with people. People were really, really uncomfortable. Even people that were pleased that I was doing it were uncomfortable because there's such high tension.

In the twelve person focus group, a conversation arose concerning how to deal with health care professionals who dismiss the need for cultural awareness. The conversation continued:

M12: So what do we do with them? Do we beat them up with sticks until they are culturally competent?
M10: I think we wait for all their patients to get pissed at them and then come to us.
M12: Or do we take the passive approach and say well this is our agenda and we respect their agenda? And we'll just clean up if we need to.
M13: Cultural competence is not something you can just learn from a book. I can be like, "Damn it! Be culturally competent" but you are not going to get it. There is no substitute for hands on real life experience. And that changes your world perspective so much in such a way that you cannot just drill it into someone's head. It's like kids learning English overseas; they can learn perfect textbook English but cannot say anything. They have no experience with it. So do we need to take physicians and say "come with me and look at my patient
and watch me interact with someone who's different from me. Are we active or passive?

M16: I think it's something to just get people thinking about it. So many people are not even aware that it's an issue. And I think that if most people thought that it was an issue, most people would sincerely make an effort to do something about it. To take that first step, which I think is the hard part. I don't think that everyone needs to spend a summer in Malawi to learn how to be culturally competent. You just need to be aware. Although that would clearly be great that everyone could do that and have that cultural experience.

The medical students in this focus group seemed to struggle with the issue of how to make senior members more culturally aware so that more can be learned from them. In addressing the effects that could arise if measures are not taken to become more culturally aware and competent, another medical student (M7) forecasted the future for physicians:

I think it's an individual thing too. It's just natural selection. As far as physicians, we are all going to be 21st century physicians, if we don't learn cultural competency, we won't survive. Not matter where we practice, L.A., Portland, wherever, if we don't become aware of diversity in whatever way, we're not going to get any patients. If we can't understand our patients then we fail.

Physicians and Physicians-in-training

After graduation from medical school and obtaining their medical degree, students must complete a residency program lasting three to four
years. During this time the physician-in-training is called a resident. Once they complete the residency program they become full time practicing physicians. This group of five individuals included four physicians and one physician-in-training, or resident. Physicians and physicians-in-training are identified with the codes P1-P5.

Overall, the physicians and physicians-in-training defined cultural competency as the way to take the patient's cultural background and incorporate it into the evaluation, diagnosis, and treatment program in a way that would benefit the patient. When asked what each believed cultural competency to mean, three out of the five respondents gave a definition that they thought represented the institution's understanding of it. Each then gave a personal interpretation of how cultural competency is defined. Physician (P5), who is also an administrator, gave this example:

If I were to describe myself as being a culturally competent physician that would be different than an institution’s notion of cultural competency although very tightly related. Perhaps an institution’s cultural competency is best manifested in the individual behaviors of the collected group at that institution. And so it’s really dependent upon everybody’s notion and knowledge and action as a culturally competent health care worker at a place like OHSU. For me personally, it’s practicing medicine and perhaps even education and teaching with an awareness that other people have different sets of values and backgrounds that influence the way they perceive circumstances and instances. So with regard to patients in particular, the patients are coming to our clinics with their own background, values and belief systems that may not match up with mine. So to be culturally competent in those circumstances, the first step is to be aware that we may not mean the same
thing when we are talking about their health problems; how they prioritize the problems; how I wish they would prioritize their problems; how it is they understand my recommendations. Do we speak the same language essentially with regards to the health problems? Do they use the health care system in the same way that I think the health care system is designed to help them in very complex ways? It's not just patients who don't speak my language who may or may not have English as a second language, who clearly come from another country where I might expect them to have a different notion of health or illness or disease or suffering. Because I've really grown to the notion that people who may be English speaking who have different backgrounds or different socioeconomic backgrounds or different family backgrounds have different beliefs. And even though I might share background and language with a person and they look more familiar to me I might be very much missing the mark. So cultural competency is knowing whether or not you are meeting someone where they are in terms of their health needs and beliefs about why they are seeking your advice and missing it. A lot of the time I don't think that we are even aware.

A physician-in-training (P3), when asked what she believed cultural competency means in the medical community, declared she didn't think it meant anything to her colleagues.

I don't think that anybody thinks about it in the medical community. I don't think that it's a term that means much to anybody. I don't think that even when you get a little "cultural training" in medical school, and even working on the wards, anybody really thinks about culture. Or what it means or if you are competent or not. So on one hand I think it means nothing. On the other hand, I think that ideally it means just being aware that cultures matter. I don't think that it means
anything about... because it is impossible to that... that any culture is this way. I think that it just means, yea, that culture matters. It changes the way we think about things, it changes the way we act.

Two general themes emerged in the interview sessions with the physicians and physicians-in-training. The first one differed from the medical students' theme that cultural competency is unattainable. The second theme referred to the limitations of hospital resources, time and energy that hamper health care delivery.

This group of respondents believed that cultural competence is attainable, yet certain programs are necessary to improve the knowledge needed. One of the physicians was born in another country, but went to an American school before moving to the United States to finish her orthodontist training at Dental school. The hospital refers Hispanic patients to her because she can speak the Spanish language and has a Hispanic cultural background. She discussed how she deals with her patients and how she believes more programs are needed to better understand the hospital's patients:

For me just dealing with Hispanic patients it's very easy, obviously, and maybe American patients too, because I have those backgrounds. But for somebody that's maybe let's say, if I was born here in the states and I'm a physician, a dentist and I've never ever been to South America and I've just been in the states or well up to Canada, but have never really explored any other cultures and I think it's just very hard to try to have a Hispanic patient or Russian patient and not knowing exactly what their culture is like and how to deal with how you can talk to them, how you can approach them,
you know, can I look into their eyes or should I not, is that going to be respected in their culture. So I think if you have not had that opportunity like me it's harder. But I think that if you could put programs together and have discussion panels where people like me can explain to Americans or whomever about how best to deal with Hispanic patients. So if you have some type of programs maybe people can get the information that they need. So I think it's possible if there were certain programs.

When asked a question regarding the degree of miscommunication that can occur in the delivery of healthcare, one of her colleagues, (P2), responded:

What is probably more haunting is that we don't know. I suspect we are far less aware of the problem than we think we are. We certainly find issues coming up, but I'm humbled to think I suspect that they are far more evident or their far more prevalent than we recognize. I think when we uncover problems related to cultural differences, I prescribe a therapy that the patient might disagree with or feel like it's not in line with what they want to do. I think it's a minority of patients who really tell me that they are, that they disagree with something. So I think we uncover it, but I think it's the tip of the iceberg and I suspect it crosses into the term of kind of medical literacy. It kind of overlaps into medical literacy. I think there's a huge difference in what we expect patients will do after we leave. So I think it's underrecognized, undertapped, and I suspect it's an area we can improve care and impact it.

An interview conducted with resident (P3), who has a Ph.D. in medical anthropology, addressed the medical students' theme regarding the attainability of cultural competency and how it is so unattainable because it
would require one to know everything about everything. She asserted the following:

My fear is that most people think that cultural competency, who knows about everyone, but I don’t think cultural competency means that you know everything about a culture. There are a lot out there. I’m afraid that that’s what most people probably think it is like. Well, I know that Hispanics tend to me X. Or tend to believe Y. Unless I know that, I’m not culturally competent. Because what’s the point, first of all, because not every Hispanic is the same. And second of all you think, well I can’t be culturally competent in every culture so why be competent at all? So my theory is that people think that. That you have to sort of study the belief systems of other ethnic groups in order to be competent and in order to work. And I really just don’t buy that, I think culture matters. And to be truly effective in the true medical world, to really be competent, then you have to be able to probe that. And be open to that, and to open to the fact that you, yourself are coming from a background.

She continued her discussion about people from the medical community who believe that cultural competency is unattainable because it would require one to know everything about all cultures.

If you think that competent is knowing everything about that culture, of course it’s not attainable. It’s just impossible. I spent a year and a half in Brazil, I’m not competent culturally, if it means that I understand all that there is to understand about Brazil. Or even about my own community. But if it really just means that understanding and that openness then I think it’s completely attainable. But I don’t think people look at it
that way. But yea I think it's very attainable, although most people aren't interested in it.

A physician and administrator (P5), who works in primary care, addressed that changes need to happen in order for OHSU to recognize cultural competency. She stated,

I actually think that we do have a pretty diverse patient population. The people that we see in the hospital and this particular clinic here are quite diverse. Lots of languages spoken here, and lots of socioeconomic diversity which again I think is a different way of being incompetent and not appreciating the perspective. The example that comes to mind in that respect is that are the white, American, poor, single-parent families whose health care system has been the emergency room because their mom is at work all day and when mom gets home at 5:30 or 6pm as the only pay check to the family, if she finds sick kids they go to the emergency room. And that's a type of health care system for a family that has been passed down from generation to generation because you have all of these single women. Sometimes you have four generations of children who have received their health care in the emergency room. We aren't going to turn around and say, “You are not going to the Emergency Room for that, you are going to go to the clinic”, when that doesn't make any sense to them. It just seems like we fight and impose system issues on them without really thinking about what those issues are. I don't know what the barrier is.

This physician continued to express this need and most of the other physicians interviewed also touched upon the need for additional education about the concepts surrounding cultural competency. She took it one step
further and stated that expertise is needed to effectively examine and assess OHSU's policies and plans.

Certainly with the curriculum we have more things to teach than we have time to teach, which is no excuse. I think probably also it is not having expertise. If we had people who are experts in understanding cultural competency and the notion of that in health care systems here and available to continually monitor and mentor and respond to, they become change agents for our university. Every time we have had changes occur it's been because we have had expertise in one or two people who were able to add and transform the culture by who they were, how they spoke, the kinds of issues they brought up, and the position that they held within the university. So as long as we have a lot of really bright and amazing individuals here but none who hold expertise in and prioritize the notion of cultural competency, it isn't going to transform the place. And I think we can have celebrations of other cultures all the time but they seem to be outside of the working dynamic and until we figure how to bring in the celebration of the health tradition of X, Y or Z, caring for African patients, or Vietnamese patients or Chinese patients, we are not going to really change anything because it is seen as something outside of the usual routine. And I worry that the institution thinks that it's culturally competent if it has enough of those visible activities. That that's enough. But I don't think that that's transforming the way we practice.

This physician's (P5) statements lead into the second theme that arose from the interview sessions with the physicians and physicians-in-training. This theme concerned the limited time and resources available to health care providers that would help with understanding their patients. Every one of these five interviewees discussed the aspect of time and how
there are only 15 minutes to be spent with a patient in which the physiological screening must take place. The physician-in-training (P3) who has a background in medical anthropology and cultural issues addressed this issue head on. She insisted that only when the subculture of medicine begins to recognize the need for culturally competent health care, and makes the time and resources available for it, will institutions be able to have culturally competent programs.

I don't think that people understand that they are part of the culture. I mean they do but they don't. It shapes what they do, they way they act. I don't think they get what it means and that it matters. And then I think that even if they do, like let's pretend me, I have training in anthropology. You get into medicine and you get the job done and you want to get done as fast as possible and you are really tired and you are in your own medical subculture. And the whole world within the medical subculture is telling you that it is the most important subculture there is. And you buy it. You're tired and you want to get done and everyone is saying that really the only thing that matters is what you're doing and so it becomes very easy to ignore what others think and believe. Tragically. But I think that is why. Even when we say that we don't think this, we've become very convinced of our own...omnipotence is a little too strong but...just that our way is really the right way. And so what everyone else thinks is sort of interesting but not very important. So I think that people who have been trained in this and immersed in this need to take a step back for a second and let's become culturally competent. They just don't want to. I just don't think they are convinced it matters. Until the subculture of biomedicine believes it matters, it's not going to happen.
This physician then disclosed some of her feelings and concerns regarding her patients and their needs. She recognized that she needs to spend more time with some of her patients and desires to, but in order to keep close to being on time with her schedule, she must confine her patient's visit and limit particular conversations.

I have these incredible Vietnamese patients who don't speak English and who are coming in for medication. And I've got 20 minutes and I'm already running late, and they have 30 different medical problems. I'll ask them what's going on with a problem, but that's not going to happen usually. It's frustrating because I have to stop sometimes. So I guess logistically it's hard. I guess the one benefit I have which might make me culturally competent to an extent when I am acting, as a physician is that I do really get that. That their belief system matters. And that what's going on isn't just someone being annoying. Or somebody who just doesn't care about their health. And I guess that's good but the downside is that I know it but I don't feel like I have much power to act on it with more compassion.

Administrators

On the whole, the administrators had a comprehensive understanding of cultural competency. Their definitions were more complex and carefully thought about when defined. In general, the group of administrators believed that there were many levels to cultural knowledge which can found on a continuum, constantly in motion. They also believed that in the health care delivery process, the patient's background needs to be taken into consideration and respected in order to benefit the patient. One
administrator (A4), though not familiar with the term itself but with the idea behind cultural competency, defined it as follows:

Being sure that the patient's cultural background is incorporated into our evaluation, diagnosis, and treatment program in a way that will most appropriately benefit the patient. And I guess that would include everything including patient scheduling. So all of the interactions between the clinical organization and the patients, taking into consideration the patient's cultural and physician's background.

Another administrator (A1), when asked about his notion of cultural competence, stated:

I wish I knew. I wish I knew what cultural competency is and how to measure cultural competency because of the different levels of cultural knowledge that a person has. You can be, culturally aware or aware of the behaviors of beliefs and values of a given culture. And you can be aware of a number of them. And you can be culturally knowledgeable and culturally sensitive and then you can be culturally competent. I would say that cultural competence deals with a concept that has to do with how a person is able to understand, communicate, and discern the meaning of actions and their beliefs in specific cultures or other cultures. And I would say that, for example, I would consider a person is likely to be competent, have what we would say as a level of knowledge of competency or competent in the knowledge of the culture of which they belong. And you can acquire knowledge and you may reach a level of "competency" to the point that even on a known scale that this person is competent. If this person has lived for a number of years and kind of understands the behaviors and meaning of behaviors, can understand the
language, the values of that particular culture. From that standpoint I think that an individual can be culturally competent as it relates to a culture or perhaps even several cultures. To be broadly competent or worldly competent I find that improbable. That a human being could have the time in a life cycle to be competent, can be knowledgeable, sensitive to cultural characteristics and cultural inputs in as much to recognize that I understand or I do not understand. But I do not think that that person can be called a worldly and have the quality to be competent for all cultures.

All of the administrators interviewed concurred with his thoughts and acknowledged, in one way or another, that while one can strive to become culturally competent, one cannot attain a point of total competence with regards to culture.

Two themes emerged from the administration interviews. The first involved the limit of time that takes place in the delivery of health care. This theme had a second underlying aspect which was comprised of financial and economic concerns that are prevalent for the institution. The second theme addressed the need for program restructuring at OHSU and medical training reform so that cultural competency can be discussed.

A few of the administrators mentioned that there just isn't enough time to address all of a patient's concerns. This is reflected in one administrator's (A2) statement:

Health care providers that are working in an outpatient setting, and this is in great respect to them, are pushed to get people in and out in a 15 minute appointment. And when the patient comes in, essentially one major medical
problem may be addressed during that time. And there isn't a lot of time available to the provider to become more involved in the patient's perception of health care or the cultural standards of receiving health care. So, not even in a perfect world, but I think in a better world, where access to care wasn't so finite and so difficult and the timing of getting appointments and getting so many in, if we didn't have that as sort of a barrier, then more time could be spent understanding where the patient is coming from. But I feel all care comes from the hub, which is primary care. You spin out to a specialist or to a surgery but you spin back in. That's where the development of the patient's standards and values should become documented and appreciated and not used as a label that would be derogatory.

This administrator suggested that more time is needed to be spent with a patient to tackle the emotional and personal beliefs in order to deliver adequate health care. She continued her thoughts:

Okay, if I ruled the world here's what I would do if I were a primary care provider. In primary care now, we take a history and physical, we take domestic violence histories, we take sexual histories, and I believe we take values histories. And in the values histories you can have your getting to know you appointment and you can do your history and physical. This patient came in for a cold, I think the patient should be able to come back to discuss values and expectations and how they really want to receive health care. And that can include their issues on death and dying, withholding or withdrawing care, what's the meaning of being sick, is there redemption in suffering, where are they coming from spiritually and emotionally. This is so their family physician has an understanding of and can look back on that and rely on that when needed. I have an example
of a values history that is used when discussing advanced directives and end of life issues and there are some components to that values history that I think could be expanded on and used in and included in the inventory assessment that the physician is making. It would only take one appointment and you could give it to the patient in advance and then meet to discuss it. And then the provider could use that as a basis from which over the continuum of years they are involved, or months or weeks, to reflect on say... if the patient wants to take medicine or not, are there herbal remedies or not, but where are they at. I think that it's as essential as the history and the physical to be able to understand the emotional and cultural beliefs of the patient. So many people really don't have a primary care provider, they just go to specialists, and they just bat from post to post. I think that the community needs to understand the necessity of having a primary care provider and trusting in that relationship. So that creates a confidence between the patient and provider and working as a team.

Other aspects of the limitation of time theme are the financial and economic issues involved. The costs of health care are extremely important to a health care institution and are continuously monitored. An administrator/physician (A4), who works in a specialized surgery and research program, sees patients from all around the world. The first session he has with his patients lasts four hours and if an interpreter is needed, the session will last up to eight hours.

It's interesting for us from a patient care standpoint because a lot of the people that need care that come in that require the most intervention, the most cultural, for example, translation, are the most expensive. It takes us twice as long to provide the service and many
of the ones that we see here have the least reimbursement from a health care standpoint. So we may get twenty percent of what it costs to provide the normal service, but yet it costs us twice as much for that individual. So instead of spending four hours it requires eight hours because of the translator. And yet we get almost nothing for it. So it's huge stress from a business standpoint.

This statement flows into the second theme which is the larger of the two themes. The theme revolves around restructuring the present system, whether OHSU or the medical system in general, so that the strong Western medicine influences can more easily be recognized. It also incorporates the ideas about how to better train health care providers and staff on how to embrace the cultural issues of themselves and their patients that they feel are lacking.

The administrator and physician (A5) that works in primary care recognizes the conflict that takes place between health care providers and their training in Western medicine and how it affects their practice. She refers to a Chinese man she had treated who had come from China to visit his daughter. The daughter and her husband brought her father to the clinic because he was experiencing some health problems. While at the clinic, it was diagnosed that he had lung cancer. His son-in-law, who acted as translator because his wife's father did not speak English, told the physician (A5) that she could not tell the patient that he had the disease. The daughter explained that if her father was told that he had lung cancer, it would harm his spirit and his transition to the afterlife. The residents under A5's supervision had a hard time keeping a secret like that from the patient.
She discussed this experience and how Western medical training had influenced her residents' reactions.

The conflict for Western trained medical students and residents is that we teach them to respect the patient's autonomy and seek the patient's advice about treatment or no treatment decisions and to go only through family members to make decisions for this gentleman was very troubling and problematic. So it gave us a great opportunity to discuss the principle of autonomy and the way it's viewed from Western culture may not be the way to practice and be respectful of Eastern culture. We shouldn't impose upon them our ethics and our belief in terms of our trump value of our autonomy. In the clinic, it's much more common for me to hear the residents be frustrated with their patients because they don't follow the directions so they will frequently refer to them as "non-compliant". And whenever I heard that word "this patient is non-compliant with their diabetic regimen", "this patient is non-compliant with their blood pressure medications", it always make me think "what do we not understand about this patient's home life, background, belief system, ability to buy their medications?" The success with that we are able to communicate the importance of taking this medication, the clarity in which we did that, as opposed to this is something wrong with this patient who is just being defiant. So what I try to do with the residents is say what do you think is behind the non-compliance? "That's an interesting word that you used". From the patient's point of view they may in fact be doing what they were supposed to be doing. And how well did we communicate with them and bring that in as a teaching point. The problem with an outpatient teaching setting is that it is really time pressured and it's difficult to cover all those things. While the residents may be referring to non-compliance the time we have to teach about that case is limited to the issues we have to take
care of as opposed to exploring the issue of what do we mean by non-compliant. So I think there are so many missed teaching opportunities.

She (A5) continued and addressed how this type of medical teaching can be seen as “soft” science. This is because it requires the recognition as well as the analysis of particular emotions, thoughts and beliefs.

No, I don’t think that there is any formal curriculum. Which is not to say that I don’t think there are faculty that believe we should be addressing these issues or that there isn’t interest on the part of the residents, but like with so many things with medical education, it’s seen as the soft part of medical education and until we can make it a stronger priority and perhaps illustrate with cases that could have gone better had we had a more culturally competent group of health care providers, it’s hard to make it a priority. So I’ve chosen to teach it on a case by case basis with the students and residents under my influence at any one time. But there isn’t any systemic way in which we are addressing the issues of cultural competence here that I know of. Certainly not in the medical residency program and I’m quite familiar with their program.

She (A5) stressed that in order to initiate any change at OHSU, it has to come from multiple levels:

We can’t just say that we are going to teach the medical students or teach the residents. We have to say and transform the way we teach and the way we practice and implement the notion of being culturally competent in the way we provide health care. And I say that because I know that learners look for role models and if we tell them one thing in a lecture and turn around and role model the opposite the role modeling tends to be
more powerful around these types of issues. They are trying to figure out how to be doctors and they tend to model their behavior to the people who are modeling for them. A greater sense of the power of role modeling on the part of our faculty I think is going to be necessary in order to be able to make headway here.

Tailoring the system to the patient is suggested by one administrator (A3), who is also a nurse and focused most of her career in cancer patients and research.

It's important to me that there is not a cookie cutter approach to health care. There has to be some system efficiencies, and the system has to be flexible enough to provide culturally competent health care. To tailor it. Just like we believe that all breast cancers aren't alike and thus all treatments for breast cancer. There is variation even within two women with the same breast cancer, not from a physiological standpoint, but from an experience standpoint of their culture etc. Different coping mechanisms, however you want to define it. What causes uncertainty in one may not cause uncertainty in another. Where another value that comes from the 'white' culture is autonomy, and 'it's my body, my choice'. Well, in fact the Russians, if you want to use that, the Ukrainians. It isn't her body, her body is a vehicle and it belongs to her husband, the man. Yea, it's flabbergasting, in that respect. I'm not going to make that decision. And if I think it's important that they use my service, we have to adjust the system to make it useful to them.

Another administrator (A2) works in the patient advocate office. When there is a problem, complaint or misunderstanding between the health care provider and his/her patient, the case is sent to the patient advocate office.
The office then addresses all parties and attempts to determine where the misunderstandings or miscommunications are coming from by working with the health care provider and the patient.

In this office our whole purpose is to try and understand it (cultural competency) and try to demonstrate it to the providers who are caring for the patient and their family. Social work also is exquisite at that and in recognizing it and promoting it in the provider relationship. So when you think about that also in pediatrics, child life is very good at that. That is part of their skills and their training. So there are resources for the providers: social work, patient advocate, child life. And I really think the medical interpreters are incredible resources.

However, she does admit that not everyone knows about the service or uses it. In reality, the cases that get reported to the patient advocate office are often reported by the patient him/herself, as a complaint after the health service. Other than that, it is a nurse or health care aid that brings a concern they have about a patient. More often than not, the health care provider is either unaware or does not realize the importance of the concern until the concern reaches the patient advocate office.

Nurses/CMA

Individual interviews were held with the two nurses interviewed, N1 and N2. And a focus group was held with three of the respondents, N3, N4 and N5. The focus group consisted of a nurse, a Certified Medical Assistant (CMA) and a Licensed Practical Nurse (LPN). The five nurses/CMA
participants interviewed did not have an academic definition of cultural competency before the interview, however worked out a definition during their interview or focus group session. The focus group idea of cultural competency dealt with understanding and having knowledge about diverse cultures in order to meet their patient's health care needs. N1, a nurse for over eleven years at OHSU stated that she first thought of cultural competency as:

How competent we are at dealing with diverse cultures and I guess that's sort of it. I'm not really sure. It's sort of understanding and appreciating diverse cultures and being able to meet the needs of the whole community that we need to deal with and all cultures it entails.

When asked how often she came across situations that exemplified needing to be culturally competent she replied, "Oh probably everyday or close to everyday. I have to deal with patients of different cultures everyday." The focus group of nurses/nursing staff also agreed that they deal with cultural issues and the need to be more aware and understanding on an everyday basis. A registered nurse (N5), with almost twenty years of experience half of which has been at OHSU, stated that respecting her patients and attempting to understand them is an important part of health care delivery. She continued:

Certainly we get an interpreter so that the communication is open. I mean that is number one because usually the interpreter is of the same ethnic origin and certainly, like with a Spanish interpreter. And rely on the interpreter to help us try and understand
what cultural differences there are and understand what the barriers are. Whether it be that they don’t want to take any medications because they want natural supplements or herbs because that is a cultural thing with them so they aren’t going to be compliant with this. That helps us to understand why they might not be compliant. And having an open mind towards other people, that’s key. And I think that we do a pretty good job with that. Not stereotyping and that’s part of the deal, to have open arms. And I know that I feel that way.

N2, an oncology nurse of twenty-seven years, conveyed that cultural competency has many layers and that even the term “culture” is defined in countless different ways.

Competency has a specific meaning of sort of a benchmark of knowledge, skill application and demonstration of behavior, because I can think of competencies in terms of delivering chemotherapy. I’ve gotta have the knowledge, I’ve gotta demonstrate the psychomotor skills and I’ve got to put that all in context of the person, so competency is all of those things: knowledge, skills and application. Culture, you get much more difficult concept to define because I think of different culture in terms of: there’s the physician culture, nurse culture, there’s many cultures within this health care organization. There’s the academic culture, the clinical services culture… but in general it’s a set of norms, a set of values, it’s a way of behaving that permeates sort of daily living. So, cultural competency… I don’t know whether that means that you live those values, I guess. And it means you have the knowledge and skills to deliver those values. That’s pretty good; I’ll leave it at that. But I think that the confusing part to me is how you define culture. Are differences based
on where I was born, what color my skin is, the neighborhood I'm from, the profession that I've become there's all sorts of ways to dice it up and that's the part that is not often addressed, it's assumed inside an organization and that's difficult.

There were two strong themes that developed through the interview sessions. The first theme relates to the physicians with whom the nurses/CMA works and how there is a lack of collaboration between the two groups. The second theme calls for a program restructuring and more training in cultural competency. Overall, this group did not have a strong academic understanding of cultural competency and therefore could not address the attainability of the concept when asked. While they were not informed about the term, they did understand and recognize differences they have with their patients and the misunderstandings that can sometimes develop in the delivery of health care.

The nurses/CMA described how some of the physicians they work with or come into contact with stereotype their patients or simply don't understand the background of the patient. This group recognized that some of the stereotyping is derived from the differing perspectives and backgrounds nurses/CMA hold from that of the physicians. N1 mentioned after the interview, how ethnocentric some of the doctors are with whom she works and how frustrating it is because she feels they don't want to understand their patients. When asked how she deals with colleagues stereotyping patients, she responded:

Well, I try to keep an open mind, myself, but I certainly don't know everything about every culture, and I find
myself sort of fighting against the stereotypes like other people refer to and try to present alternative... I hear and I see my colleagues sort of having these stereotypes in their minds that I sort of try to dispel, sometimes, I guess. Not like I'm some kind of saint (ha-ha), but I try to point out, maybe you're thinking that this is happening because of this, but what if it's because of this. You're just looking at it the wrong way.

N2 describes her frustrations working with physicians who didn't really understand her patients. She explained:

If you are living, you interact with someone who is living. They may not be using the communication and what we're used to. They can't give you data, they can't say, "oh Dr., I'm so glad that you are here". I'm really exaggerating the point. But they still have needs, they still have unfinished business, and symptoms that need to be managed. I remember being accused of practicing euthanasia by a physician. And I was dumbfounded. It was so out of context from what we did, which was manage people's pain, but the amount of drug didn't matter. How the patient describes their pain and the level of pain was what we focused on. I was the manager of the Inpatient Oncology Unit and not only would we meet with the physicians but we would meet with ourselves and we would talk about what was difficult. You know these cultural conflicts really. And we came up with ways to deal with it. So when the house staff said, "this person they rate their pain at like a 5, that's good enough". The nurse said, "Not on this floor it's not". And he was kind of arrogant anyway, but he went "huh". But she had a beautiful, respectful response because that's what we always said. They can't help themselves sometimes. And how do you treat anybody who is ignorant, or unaware. You don't yell at them, that is not going to teach them anything.
A Licensed Practical Nurse (LPN), originally from Sweden, described how she (N4) is able to understand the patients more than the physician because she talks with the patient over the phone before the visit and during the visit; she tries to understand where the patient is coming from.

I used to be on the phone a lot, did phone triage and such, and there were people I talked to a lot so I felt like I knew what was going on. And then they might come in and see the doctor and only tell half the story and not relay it all and I know that there is more behind it. Which I think that the doctor needs to know but the patient hasn't told it because they are embarrassed or they forgot it... I try to ask patients what countries they are from, what language they speak and during the conversation say where I am from. I try to find out how to say thank you in their language or hello or something like that.

A Certified Medical Assistant (CMA), who moved with his family from Laos when he was younger, uses his family's experiences when they have sought medical assistance, in his patient interactions. When there are differences in backgrounds, he (N3) tries to understand where the patient is coming from.

I let them talk as much as they want because I want them to explain clearly to me through an interpreter, so that the patient will know what is going on. Because when my dad goes in as a patient and I go with him, I want to let him know what is actually going on. So he won't be surprised. So I say, 'Dad they are going to give you this type of shot because it will help you, it's going
to be sore, there's going to be pain. So it's not, 'what did they give me a shot for? Are they going to kill me?'

N2 explained that, at the prior health institution where she worked, there would be weekly joint practice meetings where nurses and physicians would convene to discuss a posted question. She recalled a particular session where she saw that she came from a different perspective than the physicians she was working with.

The one I remember the most was, it was so enlightening, why did you choose oncology? And the nurses would say... I've sort of already said it: it's an opportunity to use your intellect, to use your compassion. Back then, this was the '80s, we didn't have all these supportive care drugs, so a lot more of care was done in-patient and we would make these people so sick, it was just sad. And chemotherapy was the great alleviator in that respect. And people needed our support, our education, our caring, to not walk away when they're puking, to celebrate when they finally have a bowel movement. I mean, life got pretty basic. The physicians' response was none of that, and in fact, the physicians chose oncology because, and we were all about the same age, it was an opportunity for breaking ground and it was a new frontier in terms of research. And we just looked dumbfounded at each other. Well, what's our common ground here? No wonder we don't understand each other.

A second theme emerged from the focus group discussion and it referred to the differences they saw in the patient population at OHSU with other area institutions they at which had worked at. They were very aware of the importance in recognizing those differences. When asked if trying to
understand patients with different backgrounds than the
physician/physician-in-training was an everyday occurrence, N5 responded:

I think probably more so up here (at OHSU) in a university setting because of the history of it being a county hospital way back when. I think all of that definitely comes into play on what our patient population is versus what St. Vincent's patient population is. It's a very different patient population at the university.

Her colleague (N4) added that the patient population at OHSU is definitely more diverse than other area institutions.

I worked at the clinic downtown before I came here and everybody had jobs, everybody had a home everybody had insurance. Hardly ever did anybody come in who didn't speak English.

The particular makeup of the patient population is important when attempting to understand the motivations behind patients' actions. N5 acknowledged that some patients who don't show up for their appointments are labeled as "non-compliant" even though there are many reasons why they might not show up. When N4 stressed that transportation is a large barrier for some patients receiving health care, N5 added:

That's a lot of the reason why they weren't keeping their appointments. It was because they didn't have transportation. For some it's a cognitive thing. They either have to write everything down or we call with reminders. So of it is that they just need to be
checked every week with a weekly phone call from a nurse saying, 'How are you doing?' 'How can I help?' 'Do you have transportation?' And that helps them with their compliance. Some of it is to go and see what their living situation is like.

Even though the nurses/CMA did not have an academic training knowledge of the term "cultural competency", their expressed ideals encompassing the term and practical knowledge was enhanced compared to the other three groups interviewed. The attainability of cultural competence did not develop as a theme, as it had in the other three groups of interviews. This was probably because the nurses/CMA had practical and intuitive knowledge of the concept of cultural competence, yet lacked the academic knowledge of the term. Much of their concern was concentrated on their relationship with the physicians they work with while attending to patients and the differences they have with those physicians. There seemed to be a gap in communication between nurses/CMA and physicians, a gap not addressed in the physician interviews. The nurses/CMA appeared to be aware of the differences between them and their patients and the importance of recognizing those differences.
DISCUSSION AND CONCLUSIONS

Challenges for the Culture of OHSU

Many challenges face an institution like the Oregon Health & Science University in providing culturally competent health care. The importance of cultural competence has to be addressed first and foremost along with providing the necessary resources and programs that will enhance further education relating to the concept. Biases must be uncovered and acknowledged so that studies can be more readily accepted that address the misunderstandings and miscommunications present as well as the dominance of cultures, such as the biomedical culture. Examining the political economy of the institution, in addition to the short term and long term goals, is important for policy changes to occur. Changes in the roles of health care providers, understanding and acceptance of policy changes, and acceptance of support from fellow health care providers are crucial elements in program and policy implementation. All of these points are challenges that OHSU needs to address and examine.

Why Cultural Competence?

The understanding of the term "cultural competence" varied greatly from group to group, although common themes, such as respect for patients and understanding of the differing backgrounds of the health care provider and the patient, were present in the majority of the interviews. In order to
determine what cultural competence signifies to OHSU, these definitions must be taken into consideration as well as the cultural composition of the institution. The background of the patient population and physician population should be compared because of the differences that are present, as shown in Figures 2-7. Yet the backgrounds of those mentioned do not include simply cultural or ethnic differences. They include differences such as socioeconomic, transportation, livelihood, residence, religious, and sexual orientation differences. These dissimilarities must be acknowledged as well when identifying the cultural composition of OHSU.

The possibility of the attainability of cultural competence fluctuated among all four groups interviewed. The medical students thought cultural competence was unattainable, the physicians-in-training and physicians believed it was attainable with certain programs, the administrators thought it was attainable but total competence was not, and the nurses/CMA didn't have enough academic information about the subject to make any clear judgment. The nurse/CMA group had better practical knowledge of cultural competence than the other three groups, yet lacked the academic training and knowledge of the term. This demonstrates that there is a large variance even about culturally competent health care not to mention the understanding of the concept itself. Each of the groups insisted that the restructuring of programs and policies is necessary so that cultural competence can be better communicated, understood, addressed and used in the health care practice at OHSU.

Efforts must be taken at the intermediate-social level, where interactions between administration and health personnel are present, to address and restructure institution policy and decision making. Beginning at
this level, change can occur that will affect subsequent levels, the micro-social and individual level, and possibly the macro-social level, which would influence state, federal and global world systems. By developing changes in education, policy and programs regarding cultural competence at the intermediate-social level, the trickle down effect can occur. Training changes such as the inclusion of Kleinman's Explanatory Model (Kleinman 1978) and eight questions, listed in the theoretical background section, are examples of training modifications that can be made. Senior health care providers who are extensively trained in the importance and application of cultural competence can then not only instruct physicians-in-training and medical students on its concepts but effectively model its principles.

Going Back to the Continuum

The themes that developed through the data collection and analysis process help to illustrate where the institution might appear on the Continuum of Cultural Competence from Figure 1. However, each of the four groups interviewed appear to be at a different point along the continuum depending on whether cultural competence is viewed from an academic or practical viewpoint. If the understanding of cultural competence is viewed more academically, the administrators seemed to have a better academic understanding of cultural competence than the nurse/CMA group, therefore, would be further along on the continuum. However, the nurse/CMA group had a better practical and intuitive knowledge of the term; hence if the term was viewed from a practical perspective, that group would be further along the continuum than the administrators.
<table>
<thead>
<tr>
<th>Interviewed Group</th>
<th>Attainability of C.C.</th>
<th>Barriers That Exist</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Students</td>
<td>Unattainable, a very long and difficult process</td>
<td>Senior physicians who don't role model cultural competence; Changes must occur to curriculum</td>
<td>Include cultural competency training in role modeling; Increase C.C. training for senior physicians</td>
</tr>
<tr>
<td>Physicians &amp; Physicians-in-Training</td>
<td>Attainable, but proper programs are needed for it to happen</td>
<td>Lack of time and resources available to be C.C.; New programs and policies are needed to improve knowledge of C.C.</td>
<td>Increase collaboration with nurses/nursing staff; Include physician input in program restructure</td>
</tr>
<tr>
<td>Administrators</td>
<td>Attainable, but total competence is not</td>
<td>Lack of time, money to be C.C; Need for better program and medical training reform</td>
<td>Encourage informed administrators to create programs aimed at cultural competence</td>
</tr>
<tr>
<td>Nurses/CMA</td>
<td>Not informed enough to make an academic judgment; yet practiced daily</td>
<td>Physician attitudes; Need to understand patient population</td>
<td>Involve nurses &amp; nursing staff in cultural competency training; Increase collaboration with physicians</td>
</tr>
</tbody>
</table>

Table 2. Compilation of Data
One of the hypotheses that developed as my research progressed was that each institution has its own understanding of cultural competence and its own cultural composition that needs to be recognized before successful programs and policies can emerge. While I still believe this to be true, what I realized after conducting my interviews is that even within a single institution there are different understandings and perceptions of cultural competence. Table two illustrates what each group believes the attainability of cultural competence to be and the barriers that exist for the group. If a training program was initiated, targeted at the OHSU medical community as a whole, it would have to be targeted at those who are the least informed, the nurses/CMA in this case. The administrators, who are quite educated and aware of cultural competence, might become bored with material they already know. There are also different barriers to the integration of cultural competence in health care delivery that each group experiences. Therefore, the level of training in cultural competence would need to be matched with the knowledge level of the group targeted as well as addressing the barriers that exist for that group. In this case, one size does not fit all.

"Soft Science"

It would be safe to assume that biomedicine is seen as "hard science," that is tangible data, information and fact, by a majority of the medical community. Quantitative studies are conducted to determine the effectiveness of particular tests used on the body, body reactions, the effects of medication, etc, in order to provide concrete data that either supports or disproves claims made. Qualitative studies are often seen as
**soft science** because they investigate people's stories, beliefs and values. Qualitative studies also focus upon enriched smaller collections of data, whereas quantitative studies strive to collect larger, statistically significant sources of data.

Along the same lines, the integration of culturally competent health care into the medical system has also been identified as **soft science** because it takes into account the emotional side of the patient when trying to achieve adequate health care. It also considers the beliefs and values of the patient, in addition to the physical ailments of the patient, although not focusing exclusively on the former. These biases must be identified, acknowledged and overcome before important discoveries using **soft science** methods can be fully integrated into our knowledge of health care systems.

Relating Cultural Competence with the Political Economy

There is no doubt that Oregon Health & Science University has a strong influence in Oregon with the number of people it employs, health care providers it trains, patients it treats, and programs it manages. It has been discussed through literature and by respondents interviewed that OHSU receives a very diverse patient population and that a large proportion of the total patient population is low-income and uninsured. Satisfying the needs of its diverse patient population from the first hospital or clinic visit in a cost effective manner is a major challenge. Implementing culturally competent health care practices may help ensure optimal care and help maintain its annual billion dollar operating budget.
A theme continuously brought up by medical students and physicians-in-training when interviewed involved a perceived constraint on the time available when treating a patient in clinic settings. The common concern was that only fifteen minutes are allocated to be spent with a patient. What if the patient's concerns are not addressed in those fifteen minutes? What if the patient has to return for another visit because those needs were not met? Money for returning visits has to be paid by someone whether it is the patient, the hospital, the insurance company, or the government. What if the time was taken to probe a little deeper in addressing the needs of the patient, or developing a more comprehensive understanding of the patient and how his/her background may differ from that of the health care providers involved? Maybe those return visits wouldn't be as frequent because the patient could be helped in the first visit.

What about the fifteen minutes? Is this a standard or merely an average? If it is only an average then why are medical students and physicians-in-training so concerned about maintaining those fifteen minutes per visit? There are a number of patients assigned to health care providers to be seen during their shift. Maybe the number of patients seen per shift should be amended so that physicians do not feel like they have to rush to maintain the fifteen minute limit, and have the opportunity to take the time to better understand their patients. When one of the medical faculty professors was asked about this issue, she stated that the average time for residents to see a patient is actually about thirty minutes, not fifteen. This issue needs to be researched and better understood because medical students and residents really stress the fifteen minutes and see it as a barrier in their health care delivery.
Changing the Roles

Perhaps what needs to occur in regards to the perceived constraint of time in a patient visit is a shift in the roles of the physician and nurse. While the nurses/CMA interviewed did not have an academic understanding of the term "cultural competency," they understood and practiced the concept. The physicians and medical students interviewed, while they could give a useful definition of cultural competency, did not believe they had the time to practice cultural competency in their delivery of health care. The nurses interviewed expressed how they spend more time with the patient and try to understand the patient but that the information gained by the nurses is not easily conveyed to the attending physician. Nurses work with patients in scheduling of appointments, follow up on care and treatment, and are present before, during and after the physician's examination of that patient. Nurses are able to speak with the patient more frequently than the physician, therefore, what if the information from nurses was taken more readily by attending physicians? If medical students and physicians believe that there is not enough time to thoroughly address the concerns of their patient and ask more comprehensive questions, why not use the nurses as a resource to obtain that information? Nurses interviewed affirm that they are already attempting to understand their patients and respect their backgrounds, hence training nurses in academic cultural competency, comparable to the physicians' training on the same matter, might remove the constraint of time issues brought forth by medical students and physicians, and transfer the time needed to understand the patient to the nurses. This will only work if physicians then collaborate with the nurses in transferring the information
gathered from the patient, and use that information to adjust how to interact with the patient and adjust the delivery of health care so that it is better suited for the patient.

**Understanding the Role of Medical Anthropologists**

Medical anthropologists have much to add in this respect to the health care system and to health care delivery. However, many more strides must be taken to better understand the patient's perspective and in applying a more holistic approach in the health care delivery process so that occurrences of miscommunications and misunderstandings can be avoided from the very beginning. The term "noncompliance" must also be reexamined, or even thrown out all together, so that patients do not get labeled with such a term, which may hinder adequate treatment, trust, and communication between the patient and the health care provider. Much research has been done in regards to multicultural health care, yet much more is needed. Health care providers must realize that biomedicine is not the only answer. Medical anthropologists could play a significant role in educating the health care profession about the added benefits of incorporating the patient's perception of what is going on and by incorporating a more holistic approach to their health care delivery. Each individual has his/her own culture that needs to be respected by health care providers, not just the culture of the health care provider. Even a physician with honorable intentions may be unaware of circumstances when differences are present. Doctors and other health care providers must begin to understand that biomedicine is only one
type of health care and that there are many more types of medical systems in the world that address a patient's illness.

**Research Implications**

This study is a specific study of cultural competency at Oregon Health & Science University and should be generalized with caution. It contains data from a select sample of health professionals at OSHU and should not be used to generalize the culture of OHSU as a whole. The data collected was used to gain a better understanding of cultural competency, and to see what was possible regarding cultural competence at OHSU, from selected medical students, physicians and physicians-in-training, administrators and nurses/CMA.
The culture of Oregon Health & Science University is unique to Oregon Health & Science University. Accordingly, we must attempt to understand the meaning of cultural competency by those who are most knowledgeable on the subject. As anthropologists, we learn that the most effective way to work within a community is to speak with the local people involved. The same applies to OHSU. The perceptions and understanding of the local people, the stakeholders, must be examined and taken into consideration before any outside plans or policies can be enacted.

Culturally competent healthcare, provided correctly, can be incorporated into the time allotted to examine and treat a patient, rather than in addition to the available time. By asking the right questions, as opposed to additional questions, the health care provider will be able to show respect for the potentially differing worldview of the patient and him/herself so that both can work together to find a method that is not only effective at treating the illness and disease, but respectful of the patient's cultural beliefs. Further research on health care delivery is needed to examine time constraints, patient outcomes, and the use of culturally competent practices. Perhaps time invested in initial medical visits will result in better outcomes and less time spent in consecutive visits.

In striving to achieve culturally competent health care, defining the term is an obvious, but important, starting point. Before health care institutions can attempt to become more culturally conscious, they must first assess what cultural issues they face most often in the delivery of health
care and what their cultural composition includes. Once a health care
estitution has arrived at a working definition, it must identify and address
barriers to training health care providers in practices that are holistic in
scope and show respect for the worldview of the patient. Administered
correctly, culturally competent health care can be delivered in a timely
fashion, while eliminating the confusions and frustrations between the
patient and provider, thus producing enhanced quality for both parties.

Patients have rights. They have the right to be treated with
beneficence, the right to be free from harm, and they have the right to
autonomy, wherein the choices and actions of a competent person are
respected. In order to uphold these rights, the differences between the
patient and the health care provider must be recognized and respected in
order to better understand the treatments that individual desires.

Ethically, health care providers have a responsibility to treat patients
to the best of their abilities. Being unaware that a patient may not follow
the treatment prescribed because it violates a cultural value, the health care
provider is unknowingly undermining adequate care to the patient. In order
to address the ethical responsibilities in the delivery of health care, the time
must be taken to explain where the physician is coming from as well as to ask
the patient questions that will clarify the cultural issues involved. These
questions should address what the patient believes to be ailing him/her,
recognize differences in the worldviews of the patient and health care
provider, and come to an understanding of how to adequately treat the
illness.

Continued research and study is needed in order to understand the
relationship between the health care provider and the patient. Research is
also needed to demonstrate to health care institutions the benefits of cultural competency so that programs and policies can be changed to incorporate its fundamental principles. Before any training programs, teaching sessions, or comprehensive discussions of cultural competency are initiated, the institution must step back and examine the meaning cultural competency holds in relation to its operations. If this groundwork is not laid out, examined and discussed, the institution runs the risk of generating one-sided definitions and policies, and the opportunity for successful programs will be lost.
BIBLIOGRAPHY

American Medical Student Association
2001a Cultural Competency in Medicine.

2001b PRIME Culture and Diversity Curriculum: On-Year Model Curriculum Topics and Core Competencies.

Arcia, E., M. Skinner, D. Bailey & V. Correa

Baer, Hans A., Merrill Singer & Ida Susser

Baquet, C.R., & P. Commiskey

Basch, Paul F.

Bernard, H. Russell

California Pan-Ethnic Health Network (CPEHN)
2001 Diverse Patients, Disparate Experience: The Use of Standardized Patient Satisfaction Surveys in Assessing the Cultural Competence of Health Care Organizations. Oakland, California: CPHEN.
Cross, T. & B. Bazron, K. Dennis, M. Issacs

Fadiman, Anne

Feder, Kenneth L. & Michael Alan Park

Freimuth, Vicki S. & Sandra Crouse Quinn, Stephen B. Thomas, Galen Cole, Eric Zook, Ted Duncan

Glidewell, Barbara
1987 Penetrating the Cultural Fog and Deciphering the Cultural Code. Presentation paper used In-service Training on Cultural Awareness at OHSU: Oregon Health & Science University.

Guarnaccia, Peter J.

Hahn, Robert

Healthcare Benchmarks
Hunt, Linda M. & Nedal H. Arar

Keshavjee, Salmaan

Kleinman, Arthur


Kleinman, A, L. Eisenbert, & B. Good

Lassiter, Sybil M.

Lawson, Erma Jean

Leclere, F. et al.
Ma, Grace Xuequin and George Henderson


McCarthy, Nyla

McElroy, Ann & Patricia K. Townsend

Meadows, Michelle

Miller, Nancy Houston

Mutha, S., C. Allen & M. Welch
Nunez, Ana E.  

Oregon Health & Science University  


http://www.ohsu.edu/.


Robins, Lynne S., Casey B. White, Gwen L. Alexander, Larry D. Gruppen, & Cyril M. Grum  
2001 Assessing Medical Students' Awareness to Diverse Health Beliefs Using a Standardized Patient Station. Academic Medicine 76: 76-80.

Rojas-Burke, Joe  

Rose, Verna L.  

Schepider-Hughes & Margaret M. Lock  
Schilder, Arn J., Cornelius Kennedy, Irene L. Goldstone, Russel D. Ogden, Robert S. Hogg & Michael O'Shaughnessy

Sheifer, S.E., J.J. Escarce, & K.A. Schulman

Singer, Merrill

Strömberg, Anna, Anders Broström, Ulf Dahlström, Bengt Fridlund

U.S. Census Bureau
2002 Website: http://census.gov/.

U.S. Department of Health and Human Services (DHHS)

1999b State Profile for Oregon: Health Resources and Services Administration.
http://stateprofiles.hrsa.gov/1999/OR199903.htm 6/16/02


Working Groups on Cultural Competence in Managed Health Care Services

1999 Cultural Competence Standards in Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups. Center for Mental Health Services: Substance Abuse and Mental Health Services Administration.
Research Questions for Medical Students, Physicians/Physicians-in-training, & Administrators

1. Ask about background of subject. Are you a medical student, physician or physician-in-training, nurse or administrator?

2. How long have you been working in the medical community?

3. How would you define cultural competency?

4. What does cultural competency mean to you as you practice medicine or take part in the medical community?

5. How important is cultural competency to you?

6. Do you believe it is something achievable? If so, how achievable?

7. Do you practice being culturally competent?

8. If yes to question 7, how difficult is it?

9. If no to question 7, why don't you practice being culturally competent?

10. What do you think your colleagues here at OHSU think about cultural competency?

11. What do you think the future holds for health care delivery regarding cultural competency?

12. What are some of your concerns regarding cultural competency?
APPENDIX B

Research Questions for Nurses/CMA

1. Could you give me a brief background of yourself?

2. How long have you been working in the medical community?

3. How would you define cultural competency?

4. What does cultural competency mean to you as you practice medicine or take part in the medical community?

5. How important is cultural competency to you?

6. Do you believe it is something achievable? If so, how achievable?

7. Do you practice being culturally competent?

8. If yes to question 7, how difficult is it?

9. Do you ever face situations where the patient is stereotyped?

10. Have you ever been in a situation where your views of the patient differ from that of the physician?

11. What do you think your colleagues here at OHSU think about cultural competency?

12. What are some of your concerns with cultural competency?