Patient Centeredness and Cultural Competence

Patient Centeredness
Patient centeredness was originally ‘coined’ in 1969 to express the belief that each pt has to be understood as a unique human being, complete unto themselves.

Patient-centered interviews, Lipkin 1984.
Patient centered interviews approach each patient as a unique human being having their own story to tell. This:
- Promotes trust and confidence
- Clarifies and characterizes the patient’s symptoms and concerns. These are the patient’s concerns and symptoms. In TCM speak, this would be their chief complaint…which may or may not be their most serious problem!
- Understands biological and psychosocial dimensions of illness No condition is strictly a biological problem, but is generated from many more sources than that. Look at the client as a complete, complex individual: psychological, spiritual, social, biological. And probably more. You don’t disrupt one system without disrupting the others. Hence illnesses.
- Creates the basis for an ongoing relationship. The single most important thing that happens in care giving is the relationship between doctor and patient – these are 2 people meeting around a common concern/need. The quality of the relationship has much to do with the quality of the outcome!

Evolution of Patient Centeredness
Steward (1986) identified the “patient-centered clinical method.” McWhinney (1989) said: “The physician tries to enter the patient’s world, to see the illness through the patient’s eyes.” There are 6 dimensions of patient-centered care:
- Explore the illness experience with the patient What has that been like for them? Let them tell you their story. You may spend more time at the initial assessment phase than you might with a repeat patient. You need to understand the experience from the patient’s perspective. Patients (and everyone really) want to feel heard: to feel listened to and understood. It is in the understanding of that experience that you can find other ways of treating, evaluating, find markers of success.
- Understanding the whole person Not just physical, but psychological, social, etc. See them as more than just their biology! They are complex, integrated, wholistic.
● Enhances the doctor-patient relationship
  If patients believe you genuinely care about them and are engaged with make things better for them they can’t help but feel positively toward you. And you get better outcomes.

● Finds common ground regarding management of the patient’s care.
  You are as a provider seeking to integrate care with their expectations and life and to understand what they expect, will tolerate or not, etc. If the patient isn’t onboard with you or trusts you your care plan is for crap…no matter how good it is.

● Incorporating prevention and health problems.
  They come to you for a reason, not just to hang out with you.☺ Part of your job is to help your patients grow, broaden their understanding and encourage them toward better health…overall, not just biologically. Use your relationship with patients toward this end. Focus on all of their needs. This is a full patient centered approach.

● Being realistic about personal limitations
  Gives you an opportunity to understand what a patient will and won’t be willing/able to do. If there’s something unacceptable to them, then you just don’t go there. You cannot help someone without their consent! It’s not ethical, it crosses their boundaries, it does not give them proper respect as a person.

Patient centered care is NOT disease centered, doctor centered, or paternalistic/maternalistic.

Summary:
Key points of patient centered approach:
  1. Treat patients as unique individuals
  2. Use wholistic model for health
  3. Have shared responsibility and power for treatment and management of health
     This is an active partnership!
  4. Based on communication and empowerment
     What is your patient’s definition of health? Some people just want to be able to function. If you don’t have basic food, shelter, etc. then it’s really hard to have a wholistic view of your own health. Optimal health is whatever the patient decides it is!
  5. Both the health care provider and the patient are viewed as PEOPLE.

Cultural Competence
Early programs included cross cultural medicine, cultural sensitivity, transcultural nursing and multicultural counseling. They focused on those “whole health beliefs may be at variance with biomedical models.” Original approaches called for awareness and respect of different traditions but recognized that:
  ● Detailed knowledge about all cultures was impractical.
  ● Realization that viewing patients as members of ethnic/cultural groups might lead to stereotyping.
Early models recognized the need for ‘generic’ attitudes not specific to particular cultures. This includes:

- Respect the legitimacy of patients health beliefs.

- Shifting from a paradigm of viewing patient’s complaints as stemming from a disease to that of an illness occurring within bio-psycho-spirituo-social context.

- Eliciting patient’s explanatory model of illness. Their understanding/explanation of their illness. This tells you a lot about what their health beliefs happen to be. It’s not your job to change or deconstruct their beliefs, but to respect them and work within them.

- Explaining the clinician’s explanatory model of illness in language accessible to patients. Your patient has to understand what you are saying. You have to find ways to make your treatment and explanations ‘click’ for your patients.

- Negotiating an understanding within which a safe, effective, and mutually agreed upon treatment plan could be implemented. This is an interpersonal relationship in which there is constant negotiation between HCP and patient.

In 1985 the Dept of Health/Human Services published a report regarding the health of black and minority health status. Basically, nothing good has come of this report which stated that there is indeed unequal treatment of health care in the US based on race and ethnicity…to say nothing of money or the lack thereof. The upshot of this is that the rules of cultural competency changed somewhat.

Culture is:

- Patterns of arrangement, behaviors whereby a society achieves collective achievement.
- Patterns of behaviors transmitted by symbols.
- Sets of rules and norms that promote stability and harmony within a society.

Beliefs, which all cultures have, are:

- Structure of values
- Common language
  - Meaningful words, phrases, symbols
- Similar life experiences
- Shared within a culture to a major extent.

Cultural Competence is:

- Set of congruent behaviors, attitudes, policies that come together in a system, agency, professional individual.
  - This is where values ➔ beliefs ➔ practices which illustrate the values and beliefs.
- Enable the entities to work effectively in cross/or multicultural situations.

Cultural competence implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups. To be culturally competent implies you have the capacity to function effectively with groups/members of groups that are different from your own!
Culturally competent systems of care acknowledges the importance of…

- **Culture**
  Might wanna do a cultural assessment in your intake!

- **Assessment of cross-cultural interactions**

- **Vigilance toward the dynamics resulting from cultural difference**
  This is awareness that there are differences and being diligent about recognizing and identifying them. Example: if you don’t understanding ethnic patterns of eating, you cannot be effective for counseling them about nutrition!

- **Expansion of cultural knowledge**
  Learn what you can. Ask for help with what you don’t understand.

- **Adaptation to meet culturally unique needs.**

There are 6 key points along a continuum ranging from Cultural Destructiveness to Advanced Cultural Competence. That continuum is…

**Cultural Destructiveness**

- Attitudes, policies, practices that are destructive to cultures and individuals within them
- Purposeful destruction of a culture
- Assumes one race is superior

**Cultural Incapacity**

- Not an intent to be culturally destructive…but…
- Lack of capacity to work with ‘minorities’ or other cultural groups
- Extreme bias and belief of racial superiority of dominant group

**Cultural Blindness**

- Midpoint on continuum
- System/agency provides services within a philosophy of “unbiasedness”
- Belief that color/culture makes no difference
  That’s a whole bag of bullshit…
- Belief that dominant culture approaches are universally applicable
  This too is blind…but kind of well-meaning.

**Cultural Pre-competence**

- Implies movement toward competence…
- Recognizes weakness working with minorities
- Attempt to improve practices and increases knowledge of cultural differences
- There is however, a danger of ‘tokenism.’
  We have our ‘token ____ person.’

**Basic Cultural Competence**

- Acceptance/respect for differences
- Continuing self-assessment regarding culture
  What do I know, am I dealing effectively, how can I get better…
- Pay careful attention to dynamics of difference
  Look for and see the differences
- Continuous expansion of cultural knowledge and resources.
  Constant growing, tailored toward the clientele you see. Look at your patient population and see whom you serve. Learn ‘bout that!

**Advanced Cultural Competence**
Culture is held in high esteem
Knowledge base of cultural competence sought by:
  o Conducting culture based research
  o Develop new approaches based on culture
  o Publish and disseminate results of culturally sensitive/competent research.

As you are moving toward cultural competence you are best served to:
  ❖ Change your attitude.
    Become less ethnocentric and biased!
  ❖ Change your policies.
    Become more flexible, less culturally partial.
  ❖ Change your practices
    To become more congruent with cultures. What are those cultures about, what do they find important, what are the variations within the culture?

You cannot have patient centered care without cultural competence. In the overlap of the circles above there is:
  ❖ Respect of a patient’s uniqueness
  ❖ The wholeness of the biopsychosocial model (as described copiously and previously)
  ❖ Exploration and respect for the patient’s culture (beliefs, values, etc.)
  ❖ Rapport and trust
  ❖ Awareness of your own biases
  ❖ Conveyance of unconditional positive regard for patients
  ❖ Allows for inclusion of others in the plan of the patient’s care
  ❖ Information and education tailored to the patient’s understanding

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Homework:

1. Pretend you are putting together a patient satisfaction survey. You want feedback about what their experience is in your practice. Generate 5 questions to ask to determine if what you are providing is patient centered. What would you want to know that would let you know that your practice is patient centered.

2. Self assessment for cultural competence…Go to this website and take the survey! We’re doing this one for ourselves…not to turn in. This could make your student clinic better…or at least make you more aware…and enhance your future practice as well. This is specifically keyed toward health care providers. 
https://www4.georgetown.edu/uis/keybridge/keyform/form.cfm?formID=277