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Product or Process: Cultural Competence or Cultural Humility?

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Editorial

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The Institute of Healthcare's Triple Aim Initiative (TAI) identifies the improvement of patients' experience as one of three key components necessary for optimizing the American health care and cost-delivery systems.[1] Widely adopted today, the TAI's focus on patient-centered care[2] also implicitly embeds the idea of care that is culturally-sensitive. Perhaps nowhere in the health-care delivery system is this emphasis on patient-centered, culturally sensitive, care more important than for those addressing life-limiting illness[3] or for frail elders who are coping with the advanced stages of multiple chronic conditions.[4]

These two patient populations have been the target of numerous studies in cross-cultural research, much of which has shown that dialogue surrounding palliative care and hospice is eased when caregivers, both clinical and laypersons, are culturally sensitive.[5] Cultural sensitivity supports the development of trust and rapport with patients.[6] The crucial question is how cultural sensitivity can best be achieved when working with a diverse patient population. The purpose of this editorial is to provide insight into the meaning of culture and to examine two leading methods for acquiring some degree of cultural sensitivity: cultural competence and cultural humility.

Culture is an umbrella term that subsumes within it values, beliefs, customs, rituals, practices and behaviors. In short, culture is a combination of the material and non-material components of human society that is as fluid as it is diverse. Over millennia, humans have learned to adapt culture as a tool for survival in a resource-challenged, often volatile environment. Seen from an evolutionary perspective, culture empowers individuals to work together in relatively cohesive social groups. Over time and generations, culture enables us to communicate with each other in meaningful ways that facilitate the development of substantive survival strategies and transmit this useful knowledge to progeny.[7] As human environments vary widely so, too, do adaptive behavioral strategies.[8]

Culture plays a salient role in health. Culture determines how we distinguish health status from sickness and configures the patient experience.[9] It influences diagnosis[10] by contouring the way that we legitimate symptoms and separate objective disease from subjective distress.[11] In effect, culture influences all facets of the illness experience. However, the landscape of cultural diversity is broad, encompassing human characteristics ranging from, but not limited to, race/ethnicity, gender identity, sexual identity and orientation, socio-economic status, urban/rural, age/generation and religion. Nonetheless, whether motivated by the morality of social justice as in UNESCO's (2001) *Universal Declaration on Cultural Diversity*[12] or the efficiency of best practices demands,[13] clinicians and service providers are increasingly called on to master an understanding of cultural diversity in order to improve care, especially for underserved groups.[14]

Cultural diversity embodies the idea that all societies generate a catalogue of distinctive differences that separate groups from one another often leading to social stratification.[15] In practice, cultural diversity is manifested in a broad range of ever-changing behaviors, beliefs, rituals, restrictions, traditions, norms, institutions, and relationships that form the basis of cul-

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tural knowledge. This makes cultural mastery something akin to trying to grab onto a cloud.

The issue of the frequent collision of social and political worlds also complicates cultural understanding. Gender provides a salient example. Gender, long conceptualized as a binary social construct is used to attach social roles and behaviors to a binary concept of sexual identity. Social order runs smoothly when people behave in a way that supports a match of gender to sex; a mismatch between gender and sexual identity challenges the existing social and political order. Although the notion of a third gender is socially unremarkable in some societies, such as the Hijra of Southeast Asia, in the U.S. the gender/sexual identity mismatch has shifted into the clinical realm. Earlier versions of the diagnostic and statistical manual (DSM) identified gender identity disorder (GID) as a condition in which one is at odds with the gender identity assigned at birth. The 2013 version acknowledged a conceptual diagnostic shift and destigmatized the condition by changing the classification from GID to Gender Dysphoria.[16] Now, four years later, social dialogue about gender has shifted to conversations about gender diversity, the concept that gender exists on a spectrum idea rather than being binary.[17] Thus, in a span of less than ten years, a person who was born with female genitalia but self-identified as predominately male has "transitioned" from having a psychiatric disorder to being gender-non-conformist.

Such shifts in cultural ideas leave clinicians and service providers with major challenges when working with patients/clients from diverse cultural backgrounds. Nonetheless, patient- or client-centered care depends on respecting the values, practices, and beliefs that matter most to individuals and their families, particularly near the end-of-life. Although, a universal approach to addressing cultural differences would be ideal, culture's very complexity makes this strategy nearly impossible. Two commonly used approaches to bridge the cultural sensitivity gap are cultural competence and cultural humility.

Competence is often used interchangeably with terms such as skill, proficiency, and expertise. Cultural competence is conceptualized as having four elements: cultural awareness, knowledge, attitudes, and skills.[18] The concept implies a delineated product and suggests a mastery of something, in this case, of a theoretically finite body of knowledge.[19] The underlying idea is that awareness and understanding of the cultural backgrounds and beliefs of others facilitates communication.[20] In contrast, cultural humility is a dynamic process that includes self-reflection, personal critique, and growth.[22] On the plus side, competence is more easily standardized, taught, and implemented than cultural humility; however, the danger is that it can lead to essentialism or stereotyping.[18,21] Using a sociological framework that focuses on the reality of human cultural diversity, cultural humility (process) better serves patient-centered, culturally sensitive care when used in tandem with competency (product). Cultural competence has long been viewed as the cornerstone of fostering cross-cultural communication, reducing health disparities, improving access to better care,[23] increasing health literacy and, in general, promoting health equity.[24] The problem is that much of the recent work done to address health inequities has focused on increasing cultural competence among providers as if this could somehow empower at-risk groups to overcome decade's worth of social disadvantages that are at least partially responsible for poor health outcomes.[24] Additionally, despite decades of theorizing about and researching cultural competence certification, there is a lack of consensus about its key components.[25] Adding cultural humility, a process of openness, collaboration, and self-reflection rather than a presumption of competency,[26] to cultural competence could be uniquely beneficial.

Cultural humility provides a distinctive approach to exploring, understanding, and appreciating the differences among us. Cultural humility begins with self-examination of one's own cultural beliefs and practices with the goal of developing respectful relationships.[20] It "involves the ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the client".[26] Cultural humility has both an intrapersonal, self-reflective dimension and an interpersonal dimension that includes respect for others, lack of superiority, and a focus on others rather than self.[26] Cultural humility is a lifelong process; the goal is the process, not the end product.[19]

Sociologically speaking, cultural humility shuns ethnocentrism in favor of a culturally relativistic approach to others. It is rooted in the belief that one culture may not impose its value system on other cultures; this may be considered part of professionalism.[27] The other-focused nature of cultural humility requires the practice of cultural sensitivity, seeking out, perceiving, and striving to understand cultural information provided by the other person.[26] Biases may be explicit to the individual and to others or implicit and unrecognized by the interacting individuals.[28] Ideally, self-reflection enables people to make their implicit biases explicit, acknowledge them and take them into account when working with others.

Essential to the cultural humility perspective is the idea that we are all members of multiple, intersecting cultures, not just one culture related to our race or ethnicity.[29] Our multiple identities and perspectives encompass a myriad of factors such as gender, social position, and geographical location that affect the way we view the world and influence the ways in which we interact and communicate meaningfully with others. The practice of cultural humility puts us in the potentially uncomfortable position of being learners, rather than experts, about cultures other than our own. Communication and understanding occur more easily among people who have shared cultural ideas and beliefs about how the world works; it is more difficult to acquire among people who do not have shared core beliefs.[20]

Thus, cultural humility may complement, rather than replace, cultural competence.[29] To interact effectively with an increasingly diverse population, we need both process (cultural

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humility) and product (cultural competence), awareness and openness to other world views combined with some knowledge about other cultures and ways of thinking to know what to look for, what questions to ask. Beginning with self-reflection of our own attitudes, beliefs, and practices, we must then learn as much as possible about the beliefs, values and behavioral practices of the cultures/groups with which we interact. Cultural knowledge, such as concepts of personal space, how people like to be approached, and whether direct eye contact is desired or considered disrespectful, can facilitate positive and productive initial interactions. The initiator should be aware of subtle signs like body language and adjust the communication and interaction style accordingly. This demands sensitivity that depends upon willingness to acknowledge we must be perpetual learners with our reach always exceeding our grasp. Throughout this process, we must be mindful that we are all members of multiple cultures and interlocking identities that are continuously influenced by factors such as racial/ethnic identity, gender, age, cohort, family composition, socio-economic status, living situation, educational level, and life experiences.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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