

CULTURAL COMPETENCE TRAINING AND IMPLEMENTATION:
PRACTITIONER AND STUDENT PERSPECTIVES

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Abstract

Cultural competency training has increased clinician awareness of ethnic disparities in accessing care, however, it has not improved the clinical outcomes of patients (Sequist et al. 2010). Part of the problem for this lies with the models of culture employed in training and clinical practice, which are often simplistic and facilitate stereotyping. This thesis presents a medical anthropological approach to culturally competent care, one that employs a more nuanced and sophisticated understanding of culture. This research explores the extent to which models of “culture” characteristic of cultural competency theorizing, training and implementation are translated into culturally appropriate care in the multicultural community of Thunder Bay, Ontario. Person-centered narratives were collected through interviews with health care administrators, physicians, health care practitioners, nurses, and medical students, concerning their experiences with cultural competency models and their implementation in clinical contexts. This thesis concludes that health care practitioners invoke individualized models of cultural competence, ones that are formed on first-hand experience, and often denounce the generalized “cultural” teachings of educational competency programs. From these narratives, a call for the provision of care services according to individualized and subjective needs emerged. These findings support the need to re-examine educational curricula and the models of cultural competency employed in Canadian care settings.

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Chapter 1: Introduction

1.1 Introduction

Cultural competency can be described as a professional understanding of the manner in which people of diverse cultural backgrounds and belief systems perceive health and illness, and respond to various symptoms, diseases, and treatments (Crandall et al. 2003). In this research, cultural competency will refer to an expertise and skill-set, while cultural competence denotes a distinctive attribute or quality. References to other cultural standpoints (i.e.: sensitivity, awareness, humility, etc) are used synonymously.

The requirement for cultural competency training emerged from the recognition that culturally diverse patient populations generally have low-quality care experiences and potentially poorer clinical outcomes (Sequist et al. 2010). As such, cultural competency programs have materialized as an effort to respectfully and effectively address the health needs and issues related to race, ethnicity, and language, and reduce disparities in health services (Nova Scotia Department of Health 2005). However, while cultural competency training has increased clinician awareness of ethnic disparities in accessing care, it has not improved the clinical outcomes of patients (Sequist et al 2010), particularly those who are members of cultural minorities. Part of the problem for this may lie with the models of culture employed in training and clinical practice, which often seem simplistic and lead to stereotyping. A medical anthropological approach to culturally competent care, one that employs a more nuanced and sophisticated understanding of culture, would lend valuable insight into the validity of cultural training.

The purpose of this research is to explore the extent to which models of “culture” characteristic of cultural competency theorizing, training and implementation are translated into culturally appropriate care in the multicultural community of Thunder Bay, Ontario. According to the 2011 census (Statistics Canada 2015), Thunder Bay has a population of 108,359 people and is recognized as a multicultural community based on a review of the primary language most spoken at home. Residents speak roughly 53 non-Aboriginal languages, although the primary languages are English, French, and select Aboriginal languages. Northwestern Ontario is less populated than any other region in Ontario, with approximately 235,000 residents living across a large geographic area (Ontario Immigration 2016). As such, Thunder Bay serves as the central

health care hub in Northwestern Ontario, because of the access to and the provision of specialty services and care.

It has been well documented (Waldram et al. 2006) that culturally appropriate care is pivotal to the overall “success” of the administration of health services. This knowledge is derived through an understanding of what constitutes a successful consultation, diagnosis, and treatment, and varies with every person who seeks care within a medical system. The extent to which cultural models are employed, lead to satisfactory clinical encounters, and reduce health disparities, remains an open question.

1.2 Models of Culture

Determining the validity and usefulness of specific cultural models in health care, requires an examination of the cultural models applied in health care organizations, and those which form anthropological definitions. There is a distinct contrast to these models. Hudelson (2004) explains that within healthcare organizations “culture is defined as an “attribute”, something the organization “has”, along with other attributes such as structure and strategy.” Hudelson (2004) explains that culture is seen as an independent variable that can be manipulated through management interventions in order to achieve organization goals. Corporate and organizational understandings of culture often go further and apply a generalized group membership for patients based on a perceived or self-identified cultural identity, like Greek, Finnish, or Indigenous. However, anthropologists take a very different approach to culture. Hudelson (2004) states “most anthropologists would define culture as the shared set of (implicit and explicit) values, ideas, concepts, and rules of behaviour that allow a social group to function and perpetuate itself. Rather than simply the presence or absence of a particular attribute, culture is understood as the dynamic and evolving socially constructed reality that exists in the minds of the social group members” (Hudelson 2004:345). Laurie Anderson and colleagues (2003:68) further define culture in health care as “integrated patterns of human behaviour that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.” Anthropologists have pointed out that virtually all complex societies (including health care organizations) tend to have a number of co-existing, overlapping and competing subcultures (Hudelson 2004:345).

Generalized constructs and all encompassing definitions of culture have been challenged

in contemporary anthropology. Lars Rodseth (1998:55), for instance, notes that such definitions of culture have been widely criticized by many anthropologists. Rodseth (1998:55) explains that because culture has become “tainted by essentialism, by holism, by ahistoricity,” that “the concept inevitably suggests that human variation comes packaged in neatly bounded systems of unchanging forms: primordial, homogenous and overtly coherent.” A distributive model, as described by Rodseth (1998:56), “allows anthropologists to reconceptualize cultures as variable and interactive populations of meanings, historically particular and internally diverse.” This model is advantageous because it rejects traditional anthropological concepts that stress sharing within cultures and boundaries between cultures. Kirmayer (2012:155) adds that “contemporary anthropology emphasizes that culture is not a fixed, homogeneous, intrinsic characteristic of individuals or groups.” Instead, Kirmayer (2012:155) describes culture as a “flexible, ongoing process of transmitting and using knowledge that depends on dynamics both within communities and at the interface between ethnocultural communities and institutions of the larger society, like the health care system, as well as global networks.” Importantly, Kirmayer (2012:155) adds that “because culture provides the concepts through which individuals and communities interpret the world and construct their hierarchies of goals and values, cultural processes remain central to the ethics and pragmatics of health promotion and health delivery.” As such, the development of a model of culture that is compatible with Rodseth’s distributive model, and representative of Kirmayer’s insights, can be derived when a person-centered approach is taken in research, health care practitioner training and organizational understandings of culture.

Person-centered ethnography, as described by Hollan (2001:48) is an “experience-near way of describing and analyzing human behavior, subjective experience and psychological processes.” A primary focus of person-centered ethnography is on how an individual’s psychology and subjective experience both shape, and are shaped by, social and cultural processes (Hollan 2001:48). A person-centered approach in healthcare would facilitate health practitioner understanding of how patients interpret the world around them, when they perceive that they are sick, in good health, and when a treatment has been successful or not. Hollan (2001:48) adds that with a person-centered approach, “human behavior and subjective experience is represented from the perspective of the acting, intending and attentive subject, to explore the emotional saliency and motivational force of cultural beliefs and symbols, and to avoid unnecessary reliance on overtly abstract, experience distant constructs.” An influential

aspect of the person-centered perspective is that it recognizes the importance of individual experience and how these processes shape a person's responses to the world. Primarily of value are the concepts of experience-near description, analysis of human behaviour, subjective experience and psychological process. The experience-near concept refers to an individual's understanding and definition of the world around them, others, thoughts, viewpoints and beliefs. These concepts, along with an appreciation for the great diversity and variance within cultures, will serve as the cultural model for this study. As Kirmayer (2012:155) notes, an approach to cultural competence based on a more contemporary view of culture must consider how to meld recognition of, and respect for, the identity of individuals and communities with attention to the dynamic, contested and often highly politicized nature of individuals' interactions with collectivities, both local and global.

1.3 Culture in Clinical Settings

In cultural competency training, culture is understood in numerous ways resulting in variances within every model or program of study. As an example, Purnell's *Guide to Culturally Competent Health Care* (2009:1) identifies culture as the "totality of socially transmitted behavioural patterns, beliefs, values, customs, lifeways, arts, and all other products of human work and thought characteristics of a population of people that guide their worldview and decision making." Purnell's depiction of culture focuses on a holistic sharing of ideals and meanings amongst individuals, a viewpoint contrary to a distributive model. What is neglected by such generalized descriptions of culture is the governing influence of individual perceptions, encounters, knowledge and meaning. Reductionist conceptions of culture, such as this, poorly capture and comprehend an individual's experience.

While there are many different models of culture, training manuals and modules, Purnell's work was selected for analysis and serves as an influential case for critique, as his work is an exemplar of the common approach taken in cultural competency training courses. Purnell's work in culture and healthcare is widespread and well-rooted in cultural competency curricula.

Cultural competency, as described by Purnell (2009), incorporates the development of self-awareness, demonstrating knowledge and understanding of a client's culture, continued cultural education, recognition of primary and secondary characteristics and finally, accepting and respecting cultural differences. In a clinical setting this notion of cultural competence is

dependent on the physician's training, ability and time allowance to conduct an extensive cultural assessment. Betancourt and colleagues (2003:297) describe cultural competence in health care as "understanding the importance of social and cultural influences on patients' health beliefs and behaviours; considering how these factors interact at multiple levels of care and devising interventions that take these issues into account to assure quality health care delivery." Undoubtedly, this will be a difficult task as health facilities continue to offer incentives for reduced wait times at service centers (Priest 2011:1). Cultural competency descriptions tend to reinforce the essentialist terms that encourage health disparities, most particularly "race." There is no justification to assume that classifications based on such generalizations of individuals are appropriate in the delivery of health services. In short, competence needs to be understood as the care provider's ability to uncover subjective meanings and administer care in a fashion congruent to patient's perceptions.

1.4 Outline

In the chapters that follow, a review of medical conceptions of culture and the importance of subjectivity in health care will be examined. Specifically, this thesis will examine the biomedical model, cultural competency training, the medical understanding of culture, subjectivity, physician perspectives, patient perspectives, impact of culture on the consultation process and anthropological theories regarding culture. As an understanding of cultural competence develops, an examination of what constitutes "culturally competent care" to the participant and the determination of what issues exist in implementing culturally competent training into a clinical care context are reviewed. Additionally, this thesis explores the health service delivery conditions necessary to support sustainable local culturally competent care services and defines resolutions that support sustainable culturally relative health services. The primary argument of this research is that while culture consists of symbols and these symbols can be shared, symbolic systems are differentially learned, understood, enacted, experienced and expressed. Therefore cultural competency models that assume symbolic homogeneity across a presupposed "group" risk denying or misinterpreting this individuality. This research aims to inform and contribute to health policy changes that are based on subjective experience, not homogeneity.

Chapter 2: Literature Review

This chapter presents a critical examination of “culturally competent health care” through considering: the biomedical model, cultural competency training, the medical understanding of culture, subjectivity, physician perspectives, patient perspectives, impact of culture on the consultation process, and anthropological theories regarding the “concept of culture.”

2.1 Biomedical Model

The organization and administration of health services in Canada is primarily conducted according to a biomedical model. George Engel (1977:130) states, “biomedicine assumes disease to be fully accounted for by deviations from the norm of measurable biological (somatic) variables.” Engel (1977:130) adds “it leaves no room within its framework for the social, psychological and behavioural dimensions of illness.” Engel (1977) contends that the biomedical model not only requires that disease be dealt with independent of social behaviour, it also demands that behavioural irregularities be explained on the basis of disordered bodily processes. From Engel’s description of the biomedical model it is clear that culture and an individual’s subjective perspective on illness and health are not taken into account. Under the Canadian model of care, health practitioners generally serve as independent contractors within the hospital system. In hospital, physicians undertake the provision of care according to an organizational mandate; however, the actual care a patient receives is largely based on an individual physician’s interpretation of patient need. The variation among physicians in this regard is as complex and diverse as the subjective patient experience. Physician determination of a care modality should be consistent according to the biomedical model. Additionally, it would be assumed that most physician variation occurs in their subjective interpretation of the patient’s experience. It is the responsibility of the physician to have no predetermined assumptions of a patient’s experience, as these preconceptions could influence actual needs of the patient.

2.2 Cultural Competency Training

Recognizing the diverse nature of Canadian society, cultural competency training has been instituted as a way to improve the care a patient receives. Laurie Anderson and colleagues (2003:68-69) describe competence in health care as “having the capacity to function effectively

as an individual and an organization within the context of the cultural beliefs, behaviours, and needs presented by consumers and their communities.” The need for cultural competency is derived from the ineffective delivery of health services and its link to health inequalities (Olavarria et al. 2005). Olavarria et al. (2005:3) argue that “One speculated partial explanation for these health inequities is that the theoretical basis and delivery of health services were, and continue to be, at odds with the cultural attitudes, beliefs, and needs of a significant proportion of minority clients – a model of cultural competence argues for equity in treatment – that is, different clients may require different services to be delivered to meet their specific needs equally effectively.” Crandall et al. (2003:588) note that cultural competency training is designed to “demonstrate an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness, and respond to various symptoms, diseases, and treatments.” As such, all of Ontario’s 14 Local Health Integration Network’s (LHIN’s) support advancing cultural competency within their respected catchments (LHIN 2015).

The understanding that an increased appreciation of culture could benefit the care provided to patients under the biomedical service model led to the formation of specific cultural training programs in an attempt to address health disparities and improve cultural safety. Cultural safety (within an Indigenous context) is defined by the National Aboriginal Health Organization (NAHO) (2013), as the ability of “the educator/practitioner/professional, whether Indigenous or not, to communicate competently with a patient in that patient’s social, political, linguistic, economic, and spiritual realm.” In 2012 for instance, the Health Council of Canada reported on creating cultural safety for Aboriginal people in urban health care settings. In the report it was documented that there are many underlying factors that negatively affect the health of Aboriginal people, including poverty, the intergenerational effects of colonization and residential schools (Health Council of Canada 2012). It was further noted that many Aboriginal people do not trust, and therefore do not use, mainstream health services because they do not feel safe from stereotyping and racism, and because the Western approach to health care can feel alienating and intimidating (Health Council of Canada 2012).

In this thesis, it is assumed that any individual, identifying as a member of a minority cultural group, would have also undergone unique experiences which would alter their perceptions and understandings of the Canadian health care system, with a similar outcome to those noted in the Health Council of Canada report. Cultural competency programs have

developed out of the understanding that cultural groups have unique experiences that influence their understandings, perceptions and access of health services. In addressing these issues, cultural competency programs problematically embrace the notion that a majority of members within a particular cultural group have the same lived experience, interpretation of meaning and understanding. While these training programs are intended to build trust and improve both the health care experiences and health outcomes of people of varying cultural backgrounds, these curricula tend to reinforce stereotyping and a generalized understanding of culture and subjectivity.

One example of a large-scale, health service based, cultural competency training initiative is in the South West Local Health Integration Network (SWLHIN). The South West LHIN is one of the largest LHIN's in Ontario encompassing the area from Tobermory to Long Point and Stratford to Newbury (SWLHIN 2015). The South West LHIN supported a LHIN-wide cultural competency program in October 2014 (SWLHIN 2015). With the ultimate goal of building system capacity to address the needs of the region's Indigenous population, the South West LHIN provided \$250,000 in one-time funding for the initial implementation of "Indigenous Cultural Competence (ICC) Training" (SWLHIN 2015). To further support the sustainability of the training initiative, the LHIN provides annual base funding allocations to the Southwest Ontario Aboriginal Health Access Centre (SOAHAC) - the body responsible for launching the ICC training program (SWLHIN 2015). The first of its kind in Ontario, this program was adapted from the ICC training program that is provided by the Provincial Health Services Authority of British Columbia, who has mandated this training for all health services authority staff for over five years (SWLHIN 2015). This training program was adopted as the SWLHIN identified that "our own healthcare system is not well equipped to provide culturally sensitive care to this population" (SWLHIN 2015).

Ontario has the highest Indigenous population of any Canadian province and 78% of its Indigenous people reside in off-reserve (rural, non-reserve and urban) communities (SWLHIN 2015). Thunder Bay's population is comprised of 9.8% indigenous peoples (Statistics Canada 2015). This minority group serves as a major population of focus for most northern Ontario healthcare facilities (Strong 2013). Generally, vulnerable populations requiring specialized and focused efforts to improve care are identified based on hospital/service usage and health outcomes. From these findings the governing provincial agencies (NWLHIN) develop high-level

areas of focus for care centers and providers. While it becomes the responsibility of the hospital/provider to engage in culturally appropriate care delivery, this is dependent on organizational mandates. Additionally, health care facilities have the freedom to develop mandates as priorities emerge. As such, training programs, like the ICC, are designed to “increase knowledge, enhance self-awareness and build on existing skills toward a culturally-safe health care system for Ontario’s Aboriginal communities” (SWLHIN 2015). The ICC training is an eight hour, web-based program, intended to develop cultural competency (SWLHIN 2015). Conceptually, such programs are intended to assist in reducing health disparities for marginalized populations, by educating health care providers as to the idiosyncrasies, perceptions and understandings of members of these identified groups. Undoubtedly, individuals who undergo these forms of formal education do develop, or at the least are introduced to, concepts and practices that they can employ to deliver improved care. However, the level of competence obtained in an online, eight hour training program can be questioned and should be assessed to demonstrate improved patient experiences and outcomes, in order to ensure validity.

2.3 Problems with Cultural Competency Education and Training

Understanding that patients respond to hospitalized care in different fashions is not a new concept, however, the operationalization of providing “culturally appropriate care” seems to be practically challenging. Toolkits, training modules and educational lessons aim to assist health service providers to engage and offer effective education and care to individuals and families. However, these programs are often based on the generalizations and preconceptions of group membership. According to the Thunder Bay Regional Health Sciences Centre (hereafter TBRHSC) , cultural competency training in health care and the implementation of learned tactics is to “deliver culturally safe and culturally sensitive care with an understanding of the preconceived notions and beliefs the practitioner brings to the clinical encounter” (TBRHSC 2012:24). However, the educational material engineered to identify these preconceived ideas often serves as the catalyst for constructing generalizations. A toolkit developed for practitioners at TBRHSC, intended to assist in interactions with Aboriginal people in Northwestern Ontario, notes that “Ontario is home to a diverse mix of Aboriginal groups and cultures. There are three main Aboriginal groups in Ontario; First Nations, Inuit and Métis. For this toolkit, the term

‘Aboriginal’ refers collectively to these Aboriginal groups and cultures living in Ontario” (TBRHSC 2012:1). This toolkit is intended to educate care providers, but it easily generalizes the lived experiences of all Aboriginal people living in Ontario. Additionally, the toolkit adds a review of historical events, “first European contact, The Indian Act, Indian Residential Schools Legacy, Forced Sterilization and Indian Residential School Settlement and Official Government Apology” to frame the accounts of “all” Aboriginal peoples in Ontario (TBRHSC 2012:3-7). The TBRHSC (2012:14) toolkit generalizes that “depending on the situation of your Aboriginal client, the term ‘family’ may only refer to immediate relatives, such as spouse, parents, siblings or children. However, ‘family’ may also include an extended network of grandparents, aunts, uncles and cousins.” Additionally, the toolkit (2002:14) adds that “similar to contemporary Canadian families, each Aboriginal family is responsible for nurturing children and preparing them to function well in society.” The problem with these scenarios is that they are not dependent on culture, or geographic location, but in fact dependant on the individual and their lived experience. These well-intentioned measures, when not thoroughly thought out, can help in furthering the disconnection between care and individual need.

Brach and Fraserirector (2000) note that although “there is substantial research evidence to suggest that cultural competency should in fact work, health systems have little evidence about which cultural competency techniques are effective and less evidence on when and how to implement them properly.” The challenge for health service providers originates in the very conceptualization of culture and in turn the deployment of care models that reflect the needs of the general population (not the individual), while operating within the confines of a limited budget.

2.4 An Overview of *Purnell’s Guide to Culturally Competent Health Care* (2009)

A commonly used educational tool in cultural competency training is Purnell’s *Guide to Culturally Competent Health Care* (2009). This manual provides a good example of the kinds of cultural lessons imparted to service providers. Purnell’s model of culture includes both primary and secondary characteristics. Purnell (2009:3-4) describes that primary characteristics consist of nationality, race, colour, gender, age and religious affiliation, while, secondary characteristics include educational status, socioeconomic status, occupation, military experience, political beliefs, urban versus rural residence, enclave identity, marital status, parental status, physical

characteristics, sexual orientation, gender issues, reason for migration and length of time away from the country of origin. What Purnell fails to recognize is that regardless of “cultural characteristics” any one person’s approach to illness, health, and treatment is inherently individualized and subjective.

Purnell’s *Guide to Cultural Competent Health Care* (2009) breaks down twenty seven “heritage” groups, including African American, Amish, Arabic, Chinese, Cuban, European, Filipino, German, Greek, Irish, Mexican, Navajo Indian and Somali. There is an introduction for each heritage group, accompanied by a review of appropriate communications, family roles and organization, workforce issues, biocultural ecology, high-risk health behaviours, nutrition, pregnancy and childbearing practices, death rituals, spirituality, health care practices and the heritage group’s viewpoint on healthcare practitioners. To provide further insight into how Purnell’s *Guide to Culturally Competent Health Care* (2009) operationalizes culture, I offer a review of African American Heritage (Purnell 2009: 21-36) and Navajo Indian Heritage (Purnell 2009: 303-320).

2.4.1 People of African American Heritage

“Overview and Heritage”

Purnell (2009:21) describes that most (African American) families place a high value on education and make great sacrifices so at least one child can go to college. Additionally, African Americans are more likely to be employed in hazardous occupations, which results in occupation-related diseases and illness.

“Communications”

“Many (African Americans),” according to Purnell, “tend to be high-keyed, animated, confrontational, and interpersonal” (2009:22). As such, “health care providers are instructed to note that this loud voice volume does not necessarily reflect anger, but merely dynamic expression, they should also be aware that maintaining direct eye contact may be misinterpreted as aggressive behaviour, and finally to greet clients formally as Mr., Mrs., or Ms., and the last name, until told to do otherwise” (2009:22).

“Family Roles and Organization”

Purnell’s overview of the organization and roles in families, explains that “even though many African American families are headed by single women and are economically

disadvantaged, it does not equate them with broken family structures” (2009:23). He adds that “the extended family structure is important for teaching health strategies and providing support” (2009:23). Purnell (2009:24) urges “health care professionals to recognize the importance of including women in decision-making and disseminating health information, and to not disclose same-sex relationships to others.”

“Biocultural Ecology”

The description of African American people is continued as Purnell illustrates that “pallor in dark-skinned people can be observed by the absence of the underlying red tones that give brown and black skin its “glow” or “living colour” (2009:25). Health care professionals should dispel myths that darker-skinned people are not at risk for skin cancer, and ensure to counsel African Americans on the best shaving method to keep razor bumps to a minimum” (2009:26).

“High-Risk Health Behaviours”

In an attempt to mitigate high-risk behaviours, Purnell (2009:27) encourages “health care professionals to teach prevention and safe sex practices at every opportunity with individual clients, in churches, and in community settings, as these programs may be best initiated in community and church activities where the entire family is present.”

“Nutrition”

Purnell (2009:28) explains that “health care professionals need to be sensitive to the meaning attached to food because individuals who reject the food are also perceived as rejecting the giver of the food.” Purnell (2009:28) adds “care professionals should negotiate with clients to determine an acceptable weight.” Finally, Purnell (2009:28) states that “food may be perceived negatively in the context of witchcraft, as it is thought that witchcraft promotes intentional poisoning by food. With this it is important for care professionals to watch carefully what one eats and who gives them food.”

“Pregnancy and Childbearing Practices”

In preparation for pregnancy and childbearing, Purnell describes that “health care providers need to provide factual information regarding the consequences of eating non-food substances that may be harmful to the mother or fetus” (2009:29). Additionally, he stresses that “just because someone seems to not have prepared for the newborn does not mean that the baby is not wanted. Dispel myths and provide factual information associated with childbearing practices” (2009:30).

“Health Care Practices”

“In treating an unnatural illness, health care providers should seek clergy for assistance and recognize, support, and encourage the client to pray to a supreme being” (Purnell 2009:33). Additionally, Purnell (2009:33) adds that “to render services that are effective and culturally acceptable, health care providers should do a thorough cultural assessment and become partners with the community. Focus groups in churches and community groups can provide health care professionals with insight into health care practices acceptable to African Americans. Form partnerships between public health and faith communities.”

“Health Care Practitioners”

Care Professionals are instructed to “include spiritual leaders and voodoo practitioners in care if the client wishes” (2009:35). Purnell (2009:35) also stresses that “because interpersonal relationships are highly valued in this group, it is important initially to develop a sound trusting relationship.

2.4.2 People of Navajo Indian Heritage

“Overview and Heritage”

Purnell (2009:303) describes American Indians as the original inhabitants of North America. “Although these groups are referred to as Native Americans and Alaskan Natives, many prefer to be called American Indians or names more specific to their cultural heritage” (2009:303). As such, Purnell (2009:303) adds that “the amount of Indian blood necessary to be considered a tribal member or American Indian varies with each tribe.” It is noted that “the Navajo Indians are the largest tribe in the United States with a population of 250,000” (2009:303). Purnell (2009:303) adds to the overview stating that “the Navajo Indians are nomadic and wander great distances, searching for adequate grazing grounds for their sheep.”

“Communications”

Purnell describes that “talking loudly among the Navajo Indians is considered rude” (2009:304). As such, Purnell describes that “most Indians are comfortable with long periods of silence” and “direct eye contact is rude and possibly confrontational” (2009:304-305). It is added that “very little planning is done for the future because the Navajo view is that many things are outside of one’s control and may affect or change the future” (2009:305).

“Family Roles and Organization”

Purnell instructs health care providers that “when providing family care, it is important to note that no decision is made until the appropriate elderly woman is present” (2009:306). Purnell describes that “there are few nursing homes, and hospitals are forced to keep patients until nursing home placement is found, when nursing home placement is found, it may be a great distance from the family, making it difficult for family visits” (2009:307). Finally, Purnell also describes that “the use of formula has become popular, resulting in an increased incidence of bottle caries because many babies go to bed with a bottle of juice or soda pop,” he adds that “this practice causes children to lose their teeth by the age of 4 years” (2009:306).

“Workforce Issues”

Purnell depicts that “many American Indians avoid people with whom they are in conflict” and that these issues are resolved through third-party compromise (2009:307). Purnell also notes that “most American Indian students are not good test takers” (2009:308).

“Biocultural Ecology”

Purnell suggests that Navajo’s “skin color varies from light brown to very dark brown” and that “newborns and infants commonly have Mongolian spots on the sacral area” (2009:308). Purnell instructs health care practitioners to “not mistake these spots for bruises, and suspect child abuse” (2009:308). It is added that “the Navajo appear Asian, with epithelial folds over the eyes (2009:308). Finally, Purnell summarizes that “the Navajo have traditionally been good runners and excel in relay races and long-distance running.” Purnell does add that “these characteristics are not seen in everyone; variations in this populations do exist” (2009:308).

“High-Risk Health Behaviours”

In an attempt to describe high-risk behaviours in the Navajo, Purnell (2009:310) states that “spousal abuse is common and is frequently related to alcohol use. It is added that “the wife is the usual recipient of the abuse, but occasionally the husband is abused” (2009:310). Additionally, Purnell states that “noncompliance with seat-belt use is high” and he encourages health care professionals to “teach clients about the importance of using child safety seats, helmets, and seat belts” (2009:310).

“Nutrition”

Purnell (2009:310) explains that “sheep are a major source of meat and sheep brains are a delicacy,” and that “access to fresh fruits or vegetables is minimal except during the fall.” As

such Purnell encourages health care professionals to teach clients about the importance of health food choices and preparation practices (2009:310).

“Pregnancy and Childbearing Practices”

In preparation for pregnancy and childbearing, Purnell describes that “traditional Navajos do not practice birth control and, thus, do not limit the size of their families” (2009:310). Purnell (2009:310) adds that “twins are not considered favorably and are frequently believed to be the work of a witch, in which case one of the babies must die.” Purnell also illustrates a number of Navajo taboos regarding expectant women, including:

1. Don't wear two hats at once; you'll have twins.
2. Don't hit babies in the mouth; they'll be stubborn and slow to talk.
3. Don't have a weaving comb (rug) with more than five points; your baby will have extra fingers.
4. Don't have a baby cross its fingers; its mother will have another one right away.
5. Don't swallow gum while you are pregnant; the baby will have a birthmark.
6. Don't kill animals while your wife is pregnant; the baby will look like a bird.
7. Don't stand in the doorway when a pregnant woman is present
8. Don't make a slingshot while you are pregnant; the baby will be crippled.
9. Don't go to ceremonies while pregnant; it will have a bad effect on the baby.
10. Don't eat a lot of sweet stuff while you are pregnant; the baby won't be strong.
11. Don't sleep too much when you are about to have a baby; the baby will mark your face with dark spots.
12. Don't look at a dead person or animal while you are pregnant; the baby will be sickly because of bad luck.
13. Don't jump around if you are pregnant or ride a horse; it will induce labor.
14. Don't cut gloves off at the knuckles; the baby will have short round fingers.
15. Don't cut a baby's hair when it is small; it won't think right when it gets older.

“Health Care Practices”

“Asking clients questions in order to make a diagnosis fosters mistrust” Purnell explains, adding that “this approach is in conflict with the practice of traditional medicine men who tell people what is wrong without their having to say anything” (2009:316). Additionally, “pain

control is frequently ineffective because the actual intensity of the Indian's pain is not obvious to the health care provider and because clients do not request pain medication" (2009:316). Purnell (2009:316) encourages health care providers to establish trust with clients, so clients fully disclose herbal treatments used for pain control. Finally, it is noted that "autopsy and organ donation are unacceptable practices to traditional American Indians" (2009:318).

"Health Care Practitioners"

Purnell (2009:318) notes that "Native healers are divided primarily into three categories: those working with the power of good, the power of evil, or both." Purnell adds that "generally, these healers are divinely chosen and promote activities that encourage self-discipline, self-control, and acute body awareness" (2009:318). Care professionals are instructed that "many health concerns of American Indians can be treated by both traditional and Western healers in a culturally competent manner when these practitioners are willing to work together and respect each other's differences" (2009:318).

2.5 Review of Purnell's Guide

Based on a review of Larry Purnell's *Guide to Culturally Competent Health Care* (2009), there is a clear need for a re-conceptualization of culture within medical practice. Practitioner preconceptions, assumptions and generalized approaches to culture when providing medical care need to be eliminated. Purnell's (2009:v) model for cultural competency is used worldwide in many medical and nursing school curriculums, and by numerous individual and family health care programs. Purnell's guide, like other competency programs, is undoubtedly intended to build awareness and increase understanding for practitioners when interacting with individuals of varying cultures/ethnicities, however, such manuals and programs often just fall short of overt cultural racism. This understanding is supported by Sonia Lawrence (2001:107) who identifies that "...the problem is with how we identify these practices in the first place. This 'identification' process is often a form of cultural racism, and is sometimes masked as an effort at cultural sensitivity."

In Purnell's overview of African American and Navajo heritage, it can be suggested that Purnell's position is intended to provide historical context for modern thought formation and understanding and Purnell's description could be the lived experience for some individuals/families. However, this synopsis infers that all Navajo and similarly, African

Americans undergo the same experience, are motivated by the same personal and social drivers and experience the same root-causes of ill-health. This stance reinforces an unsophisticated concept of culture and an overly simplistic approach to care provision. Arguably, the experience that Purnell describes is dependent on elements of social and economic environment, physical environment, lived experience, and individual characteristics and behaviours. The characteristics noted of both groups are not homogenous within the particular group, but are instead experiences that, regardless of heritage, ethnicity, or culture, can be interpreted and conveyed differently based on the individual.

Purnell (2009:1) does recognize that approaches and interventions may need to be adapted based on an individual's perspective, however, his model is constructed around crude generalizations of specific "cultures" and the deployment of a simplistic model of "culture." Hence, culturally competent health care models must avoid the issuance of generalized categorizations and instead offer a more advanced understanding of culture and subjectivity (to be explored later in this review). Lawrence (2001:107-108) notes importantly that "not only is cultural information incompletely collected and imperfectly understood, it also tends to be considered only against the unarticulated, unexamined norm of North American mainstream culture."

Most cultural competency programs assume that culture is a group property and that group members are relatively homogeneous in cultural terms. These paradigms fail to comprehend 'intra-cultural' variabilities and subjective experiences. As Purnell (2009) notes, "health care providers must recognize, respect, and integrate clients' cultural beliefs and practices into health prescriptions to eliminate or mitigate health disparities and provide client satisfaction." However, care needs to be delivered according to individualized perceptions and understandings, not generalized categories and therefore there is a need to re-examine system mandates that encourage outdated practices. Programs based on simplistic, essentialist and reductionist conceptions of culture are likely not effective as these reinforce cultural stereotypes, like those portrayed in Purnell's guide and effectively teach an error filled curricula of how to interact with people. As such, there is little point in implementing cultural competency without a sophisticated understanding of the concept of culture and subjectivity. The implementation of cultural competency training models/methods and the determination of best practices, has occasionally been met with trepidation and challenge. This variance is best illustrated with a

review of a lawsuit that was the result of the implementation of Purnell's *Guide to Culturally Competent Health Care* (2009).

2.6 Controversy over Purnell's (2005) "*Guide to Culturally Competent Health Care*"

The controversy surrounding the usage of such training material can be seen in the reported firing of a former nursing professor at the University of Central Florida. As Barbara Liston noted in a *Reuters* article on November 18, 2010, the professor's dismissal is allegedly based on the refusal to use Purnell's (2005) "*Guide to Culturally Competent Health Care*" (the first version of the 2009 textbook discussed in this thesis), stating, "the book is required as part of the nursing curriculum at the College of Nursing and it contains serious and offensive racial, ethnic and other stereotypes about selected cultures of people" (Liston 2010:1). Liston (2010:1) adds that a spokesman for the university declared that "the book is one of the best-selling publications about nursing cultural trends in the country, and it won the American Journal of Nursing book award in 2005." Additionally, the American Association of Colleges of Nursing includes teaching the book in its tool kit of resources (Liston 2010). In her article, Liston (2010:1) notes that Betty Paulanka, a co-author in Purnell's 2005 edition of "*Guide to Culturally Competent Health Care*," declared that "these descriptions refer to attitudes that might be held by new immigrants based on their native culture." The co-author also noted that "sections describing each racial, ethnic or cultural group were written by either a recognized expert or a native of the culture" (Liston 2010). These statements are problematic as they are founded on ideas of a uniform experience amongst members of a culture. Attitudes are subjective and formed by the individual. Attitudes are not uniformly accepted by those who identify to a particular culture. These perceptions of culture may in fact be true for some individuals, however, they cannot be generally applied to all people within a group. Similarly, these general descriptions cannot be assembled by a lone individual's understanding of a culture, which does not account for variation amongst the lived-experience of individuals. Subsequently, Liston (2010:1) adds that Purnell stated that "culture is very sensitive – the statement may be true but that doesn't mean they like it ... its true for the group, not for the individual." A critique of this statement exposes the underlying problem with gross, widely applied descriptions. The description cannot be true for the group, if it is not true for the individual. Individuals make up

the group and if the lived-experience of all individuals is not uniform, then these descriptions cannot be relevant to a group.

The former nursing professor stated that when “students began coming to her complaining about stereotypes in the textbook, she urged the college faculty to replace the text and was fired after she notified the school she would not use the book in her community health nursing course (Liston 2010). To date, the conclusion of the lawsuit is unknown.

Purnell’s (2005) “*Guide to Culturally Competent Health Care*” has served as a curriculum component for numerous post secondary programs, including the University of Wisconsin (Madison) School of Social Work (2017), Mennonite College of Nursing at Illinois State University (2014), Decker School of Nursing at State University of New York at Binghamton (2014), and College of Health and Human Services at Indiana University – Purdue University Fort Wayne (2013), among others. Additionally, Purnell’s work is referenced by the American Association of College of Nursing’s recommendations for cultural competency in baccalaureate education (Carey 2011). Recently, Purnell’s model for cultural competence was utilized in the nursing care of an Afghan patient from a university hospital in Turkey (Dogu et al. 2016). Dogu and colleagues (2016:44) state that Purnell’s model has been translated into 30 different languages, and ensures that the cultural backgrounds of individuals are taken into account in the protecting and promoting of health. The Purnell model was preferred as “it makes cultural differences visible in care, makes it easier to reach data in more standardized and systematical ways, and is efficiently usable in every phase of care from planning to application (Dogu et al. 2016). Additionally, Dogu and colleagues (2016) add that their study was presented at the Third International Cross Cultural Nursing Congress, and was found worthy of first place.

2.7 Biomedical Understanding of Culture

Janelle Taylor (2003:555) argues that “the institutional culture of medicine and medical education sees itself as a ‘culture of no culture’ and systematically tends to foster static and essentialist conceptions of ‘culture’ to patients.” The primary focus and concern of biomedicine is on the quantifiable biological and physiological conditions and solutions that affect the human body. Furthermore, there is a significant difference in what health professional’s view as important and necessary, when compared to a patient’s knowledge of illness, disease, treatment regimes, successful outcomes and failure. Taylor (2003:556) continues by noting that health

practitioners find confidence in the *truth* of medical knowledge, understood not as “cultural” knowledge, but *real* knowledge. In short, this viewpoint is constructed by the learned, quantifiable and visible characteristics of biomedicine, as compared to the unseen influences of culture and individual perspectives. Waldram, Herring and Young (2006) declare that biomedical scientists often fail to comprehend the mechanisms (societal, cultural and historical contexts) that shape an individual’s healing and look instead for purely clinical evidence. This is an important understanding as these mechanisms shape the subjective and lived experience of the individual, giving context and understanding to events and situations.

It is clear that in health care the medical understanding of culture is quite limited and in turn relies on broad generalizations to fill this void. It can be assumed that when creating localized models of cultural competence, most health services providers lack the expertise to employ an appropriate model of care. Instead they rely on generalized constructs, often presuming other people share the same ideas and practices. As a result, there is a need to employ a care model that reflects the lived experiences of our everyday lives. As Helman (2007:4) states, “cultures are never homogenous, and therefore one should always avoid using generalizations in explaining people’s beliefs and behaviours.” As such, a more nuanced approach is required to determine the perceptions, understandings and experience of the individual and how these translate into competent care delivery. An examination of subjectivity is imperative to garner this understanding.

2.8 Subjectivity

There is a complexity when trying to define both subjectivity and culture. This complexity can often lead to a tension between defining these concepts, where they differ and where they are the same. How does culture influence subjectivity? Can you have subjectivity without culture?

Good (2008:1) describes subjectivity as the “everyday modes of experience, the social and psychological dimensions of individual lives, as well as the psychological qualities of social life, the constitution of the subject, and forms of subjection found in diverse places.” A focus on the subject or individual provides an avenue to express infinite variances in perception and the occurrences that shape these ideals in individuals. Subjectivity then, focuses on what influences, informs and biases people's actions, their perceptions, experiences, expectations, cultural

understanding and specific beliefs. Therefore, you cannot have subjectivity without culture, as culture contributes to the lived experience and ultimately how subjectivity is formed.

Luhmann (2006:345) suggests that subjectivity refers to “the shared inner life experiences of the subject, to the way subjects feel, respond, and experience.” Luhmann (2006:355) supplements this view by adding, “social expectations reach deep within our bodies – socially regulated words identify the feelings we are thought to feel, the events which trigger them, and the display which governs what a good and proper person should do under provocation or in dread.”

Subjectivity can also be considered as personal experience and it provides a way to understand historic, cultural, economic, social and political differences. In an attempt to organize and understand the social world, as individuals we are conditioned to use models of culturally derived ideas and practices that are embodied, enacted, or instituted in everyday life (Fryberg and Rhys 2015). These models of cognition, the process of acquiring understanding through thought and experience, exists in our daily lives in the formation of concepts, judgment, perceptions, reasoning and moral development. These models are individualized as one’s lived experience; where one is raised, things one is taught, the ideologies which one lives by. There may be similarities between models, however, they are shaped by an individual’s experience. These ideas and practices provide insight about what is good, what is right and importantly, what is not (Fryberg and Rhys 2015). Cultural models give form and direction to individual experiences by shaping and informing perception, cognition, emotion, and motivation (Fryberg and Rhys 2015).

Kleinman and colleagues (1978:251) describe these patient and practitioner perceptions as Explanatory Models of Illness. Kleinman and colleagues (1978:256) explain:

“Eliciting the patient model gives the physician knowledge of the beliefs the patient holds about his illness, the personal and social meaning he attached to his disorder, his expectations about what will happen to him and what the doctor will do, and his own therapeutic goals. Comparison of patient model with the doctor’s model enables the clinician to identify major discrepancies that may cause problems for clinical management. Such comparisons also help the clinician know which aspects of his explanatory

model need clearer exposition to patients (and families), and what sort of patient education is most appropriate. And they clarify conflicts not related to different levels of knowledge but different values and interest. Part of the clinical process involves negotiations between these explanatory models, once they have been made elicited.”

Kleinman and colleagues (1978:254) add that the “patient-doctor interactions are transactions between explanatory models, transactions often involving major discrepancies in cognitive content as well as therapeutic values, expectations, and goals.” In the relationship between patient and practitioner, there is an inherent need for both parties to recognize individualized models of care. Both practitioner and patient have different lived experience, equating to different understandings of the world around them. These perspectives need to be explored, negotiated and understood by all participants in the care process.

2.9 Physician Perspective

Physicians and patients view illness and health in various and sometimes opposing ways. This thesis argues that the perspectives of both patients and physicians are based on subjectivity, varying cultural and social premises and differing evaluations towards the efficacy of treatment. Helman (2007:98) notes that, “health care professionals have a distinguished set of values, concepts, theories of disease and rules of behavior.” Subsequently, the values, concepts and theories of physicians tend to be different from those seeking care and can lead to unsatisfactory clinical consultations. The inability for a physician to establish a common language of health and a satisfactory level of comprehension with a patient can be the result of differing perspectives on illness, health and treatment between both parties. Dein (2007:43) adds that “during illness episodes, individuals are likely to produce several kinds of knowledge, including theoretical, empirical, rationalized knowledge; intersubjective knowledge; and the knowledge a person produces by negotiating the meaning of objects, events, and experiences in interaction with other people.” It can be suggested that it is the responsibility of the physician to create an environment where both doctors and patients can communicate and comprehend messages of health in an

efficient manner, appropriate for both groups. In Julija Kelecevic's (2008) presentation on "Ethical Issues in Emergency Medicine" she reviews consent and patient's decision-making capacity. Kelecevic (2008:8-22) notes that patients need to be able to understand presented information relevant to treatment, value the significance of that information, weigh treatment options and outcomes based on the information presented and express a choice. As such, it is the responsibility of the physician or practitioner to ensure that the information presented to a patient is congruent with the patient's ability to understand the material.

In order to understand a physician's perspective on health and illness, it is important to recognize that these individuals have undergone a form of professionalization. Kelecevic (2008) notes that physician perceptions of care in emergency departments is influenced by "training, medical knowledge, inter-professional relationships, legal responsibilities, issues of supremacy, the ability to speak unreservedly, patient consent, and reservations regarding the morality of procedures." Undoubtedly, all of these factors influence a physician's attitudes towards patients and their individual conceptions of illness, health and treatment. Katz (1984:36) adds that "as medical students, health care professionals acquire perspectives on illness and health that will last throughout their professional lives." As such, a North American physician's perspective on health is generally framed according to a biomedical model, one that dictates patient care primarily on biological and physiological factors and not individualized or cultural conceptions of health. Additionally, it can be suggested that the viewpoint and manner by which a physician provides care differs on an individual basis, informed by their subjective experience. An individualized experience and associated interpretations and perspectives, is also a fundamental factor in the patient experience.

2.10 Patient Perspective

A patient's perspective of health and illness, similar to that of a physician, is directly related to individual subjectivity and experience. Dein (2007:42) states that "patients have cultural understandings of and explanations for their illness, but this may not be very sophisticated, and may not directly relate to decisions about treatments." With this insight it can be assumed that a patient's perspective on health is greatly influenced by their experiences and that these understandings generally do not coincide with a physician's standpoint and training under the biomedical model. Helman (2007:126) adds "the meanings given to symptoms and the

emotional responses of a patient to those symptoms are strongly based on social, political, cultural, and economic contexts.”

Cassell (1976:47) defines illness as “an individual’s interpretation of the origin and significance of poor health, its effects on behaviors and relationships, and the steps taken to alleviate the symptoms.” Helman (2007:127) asserts that the process of defining oneself as being ill usually includes the following experiences: “perceived changes in bodily appearance, change in regular body functions, unusual bodily emissions, alterations to the five major senses and behavioral changes.” From this it can be theorized that an individual’s acceptance of being ill and their interpretation of the significance, symptoms and experience of illness, will greatly influence the consultation process with a health professional. Both physicians and patients bring different and unique experiences, understandings and expectations to the clinical consultation. These varying perspectives can result in a disconnect between a patient’s and physician’s understanding of illness and treatment, one that cultural competency training is intended to at least partially address.

With the argument for individualized approaches to care, it must be recognized that even these experience-based models are formulated on cultural exposure. The impact of culture is prevalent in a patient’s perspective on care, however, the interpretation of that culture and its impact are exclusively individualized.

2.11 Impact of Culture on the Consultation Process

It is a common perception that in the hospital setting a majority of patient care is depersonalized. This depersonalization is facilitated by large numbers of patients, overcrowding, time constraints and the adherence of medical staff to the biomedical model of care. These constraints are the collective norm in Canadian care settings. Kleinman (1988:129) argues “the failure to spend sufficient time with patients and to provide adequate explanations seems to be almost a universal issue.” These system issues facilitate a care environment that is focused on expediency and as a result, often lacks quality. With increasing patient populations and the pressures to decrease wait-times, care facilities are encouraged by governing bodies to foster a service model that pushes for efficiencies and quickness, however, these models seldom allow for focused attention on communication difficulties and quality of care expectations between physicians and patients. Further, Helman (2007:94) explains that “physicians are permitted by

law to question and examine their patients, prescribe sometimes-dangerous treatments or medications, and deprive people of their freedom, by confining them to hospitals based on a diagnosis – further, physicians can also control a patients’ diet, behavior, and sleeping patterns, additionally, patients can be labeled as ill, incurable, malingering, or fully recovered.” These labels and diagnoses are clearly associated with the powerful role of the physician and may contribute to misunderstandings, fearfulness and vulnerability on behalf of the patient.

Additionally, misinterpretations can easily occur during the consultation between a patient and physician. Helman (2007:152) claims “that doctors and patients can misinterpret medical terminology, the patient may use folk terminology, prescribed medication may not be taken, and the success of a treatment method may be evaluated differently between doctor and patient.” Weston and Brown (1989:76) declare that “in order for the consultation process to be a success, there must be a consensus between the two parties about the cause, diagnostic label, physiological processes involved, prognosis and treatment for the condition.” Obtaining consensus between both parties (physician and patient), as to the cause, effect, care protocol and overall success of treatment, can greatly reduce misinterpretations, align patient and provider goals and improve patient outcomes. However, as we have seen in our evaluation of Purnell’s *Guide to Culturally Competent Health Care* (2009), a practitioner’s misinterpretation and inability to reach consensus, may be the result of failed cultural competency training. As we have suggested, cultural competency training needs to be reflective of individualized perceptions of care and treatment, subjectivity and a more nuanced understanding of culture.

2.12 Anthropological Understandings of Culture

A contemporary understanding of culture and its possible implications in health care is best viewed through an anthropological lens. However, there is no uniform consensus on a particular anthropological perspective to employ.

Lila Abu-Lughod (1991:466) argues, “culture operates in anthropological discourse to enforce separations that inevitably carry a sense of hierarchy.” In short, Abu-Lughod maintains that the concept of culture reinforces inequality. And it is due to this discourse that Abu-Lughod (1991) calls for anthropologists to work against the notion of culture in their writings, theories, and practices. Abu-Lughod’s (1991:467) denouncement of culture is derived from her understanding that the “discipline of anthropology is historically constructed as a divide between

the West and non-West.” From this viewpoint the continued use of the concept of culture reinforces a disconnection between “Self” and “Other.” Abu-Lughod (1991:470) states that “culture is the essential tool for making ‘other’ – and as a professional discourse that elaborates on the meaning of culture in order to account for, explain, and understand cultural difference, anthropology also helps to construct, produce and maintain it.” Abu-Lughod (1991:470) maintains that the “most important of culture’s advantages, is that it removes difference from the realm of the natural and the innate – culture is learned and can change.” Abu-Lughod (1991) interprets culture as reinforcing hierarchical inequalities through fixing basic differences among people, in terms of development, character, government and so forth, as innate objects. Abu-Lughod (1991) expresses the need to work against the assumption of boundedness, address the nature of contemporary global interactions, and remove focus from generalizations and homogeneity, to expose apparatuses of structured power and hierarchy. Cultural generalizations both create exaggerated notions of cultural difference and remove the experiences of individuals in relation to particular events.

Health services delivered according to a generalized, modernist conception of culture reinforces many of the dilemmas noted by Abu-Lughod. Care delivery based on such conceptions of culture strengthen an oppressive hierarchy, do not account for individual lived experience and do not address individual comprehensions of illness, treatment and health. Biomedical services also demonstrate a powerful hierarchy with a failure to comprehend the personal experiences and cognitive processes that facilitates understanding in patients, supports a divide between Self and Other, and delineate commonalities to individual perception, experience and variation. Abu-Lughod (1991:476) stresses that “by focusing closely on particular individuals and their changing relationships, one would necessarily subvert the most problematic connotations of culture: homogeneity, coherence and timelessness.” As such, this thesis recommends that culture in health care be addressed on an individual basis, in an open dialog that explores the client’s lived experience, understandings and goals.

Robert Brightman (1995:509) also critiques the modernist construct of culture and supports the call for either a reconfiguration, or total replacement of the culture concept. Thus, the question arises of how to distinguish a conceptual reconfiguration versus an actual conceptual replacement. Brightman (1995:510) states that criticisms of the usefulness of culture are derived from “the current consciousness that the anthropological profession has gotten or

should get 'beyond' culture, can thus be read, in some measure, as the effect of rhetorical strategies that (re)construct an essentialized culture concept in the antipodes of contemporary theoretical orientations." It might be seen that generalized conceptions of culture therefore have no use in contemporary anthropology. Brightman (1995:511) depicts that "recent critics of culture are by no means a homogenous group, and the objections put forth represent a complex assembly of partially convergent influences from political economy, modernist and postmodernist anthropologies, feminist writings, cultural studies, and diverse other sources." Brightman (1995) states that anthropological writing has increasingly focused upon culture as a system constructed, reproduced and transformed in and through the ideation, and practices of agents, either by deliberate design or as contingent by-product. However, Brightman (1995) accepts that there are two main criticisms of the concept of culture: its generalization and its identification as holistic.

Generalization, according to Brightman (1995:515), refers to the "failure to engage the temporal character of particular events in progress and people's subjective experience of them." This is an issue, as generalization simply does not account for individuality. Therefore, generalized approaches to care disregard the lived experiences and understandings of the patient. Furthermore, Brightman (1995:515) states that "in recent cultural criticism, the attribution of holism means variously that the culture construct ignores intracultural diversity and variation, elides contradictory or conflictual elements and represents the constituent forms of culture as globally interarticulated, or postulates that cultures are discrete entities." Hence, anthropologists must account for the distribution of knowledge, interactions between individuals and as Brightman (1995:516) recognizes, "ethnicity, occupation, age, class and gender are the typically fore-grounded sites of intracultural diversity."

Although Brightman does not offer a final position on the replacement or reconfiguration of the culture concept, he does accept the criticisms of generalized and holistic approaches to culture. In a contemporary medical context, cultural generalizations, which are the norm and basis for cultural competency training, repeatedly fail to acknowledge the patient's lived experience, how care is sought after, received and validated. With this insight, a holistic interpretation of culture is also denounced by a definitive lack of recognition to intracultural diversity, variation and interplay between individuals globally.

Applied to health care settings, the critiques suggested by Abu-Lughod and Brightman

enforce the need to rethink overtly generalized accounts of culture as bounded entities with uniformly homogeneous patients-citizens. Abu-Lughod and Brightman argue that most concepts of culture fail to comprehend the cognitive process that facilitates understanding in patients, and also ignore individual lived experiences and variation. As such, the insights of Abu-Lughod and Brightman can be utilized when exploring the validity of culture in healthcare and can support the need to abolish generalized approaches to providing care.

2.13 Anthropological Perspective on Cultural Competence

Lakes, Lopez and Garro (2006) make the strongest case for establishing an anthropological perspective of cultural competence. Lakes, Lopez and Garro (2006) review Kleinman's (1995) socially based conception of culture and Mattingly and Lawlor's (2001) conception of shared narratives, in an attempt to conceptualize personal experience. According to these authors, Kleinman (1995) conveys that experience represents the intersubjective medium or nexus between a person's mind, body and their social world. Kleinman (1995) asserts that for practical purposes this intersubjective medium is what is at stake or what matters in a given local moral world (Lakes, Lopez & Garro 2006:383). From this, it is conceded that "preservation of life, aspiration, prestige, and the like" is relevant for all; however, it is that which is at stake in peoples' daily lives that is tied closely to culture (Lakes, Lopez & Garro 2006:383).

In relation to applicability for medical care, Kleinman (1995) goes on to argue that the central concern for culturally informed clinicians is to identify what is at stake for others given their particular local worlds (Lakes, Lopez & Garro 2006:383). Identifying issues of high priority will help health care providers recognize culture's influence in an individual's behaviour or daily life. Therefore, Kleinman's (1995) model for culture is formulated in the everyday lives of people and lived experience, not presumed notions of race, ethnicity, or "cultural" group (Lakes, Lopez & Garro 2006). As Lakes, Lopez and Garro (2006) summarize, clinician attention will focus on their understanding of the local social worlds of their clients and integrate this understanding into their clinical responsibilities. An approach to care, one that implores an understanding of the lived experiences and perceptions of the patient, would be desirable. Such an approach would allow for an open dialog between health care provider and patient, where fears, wants, treatments and outcomes can be discussed, and understood, in context that is

appropriate for each individual patient and in a manner that allows the practitioner to provide the most appropriate care.

Mattingly and Lawlor (2001) argue that making sense of others' actions requires placing those actions in the context of an unfolding story (Lakes, Lopez & Garro 2006). Thus, the shared narratives approach is based on understanding the actions of others and being able to place those actions in a larger context. According to Mattingly and Lawlor (2001), when clinical encounters are successful it is because the practitioner and client are able to read each other well or create a shared narrative (Lakes, Lopez & Garro 2006). Lakes, Lopez & Garro (2006:383) insist that Mattingly and Lawlor (2001) state that clinical encounters are generally unproductive when mistakes are made in interpreting the patient's behaviours. Mattingly and Lawlor (2001) suggest that a shared narrative between the patient and the clinician is likely to reflect a considered integration of both parties' perspectives. As Lakes, Lopez and Garro (2006:384) demonstrate, Mattingly and Lawlor's (2001) conceptual approach could prove useful in helping practitioners negotiate cultural meanings in health care settings.

Lakes, Lopez and Garro (2006) state that in both conceptions presented by Mattingly and Lawlor (2001) and Kleinman (1995), the central focus is on processes in which meaning is negotiated. This approach clearly differs from the usual cultural competency approaches that focus on cultural differences or "communal" factors of generalized groups and that emphasize the practitioner's need to understand the client rather than the dialogical, bidirectional approach suggested by these authors. Lakes, Lopez and Garro (2006) add that "many of the existing models of cultural competence are limited in their conception of culture – particularly those that equate culture as values, beliefs, and practices of groups delineated by ethnic or racial boundaries." Brightman (1995), Rodseth (1998) and Keesing (1990) among others, adhere to a distributive model of culture, one that allows for individual variation.

Funke (1989:113) describes that "a distributive model of culture takes culture as variably distributed among members of a population. The existence of some important degree of consensus or commonality is not at question but the extent and specific structure of commonality is not to be assumed. It exists within but is not identified as the culture. The culture is defined in its full complexity and diversity." A distributive model of culture would be useful in cultural competency training to assist in the avoidance of the simplistic treatment of culture. Funke (1989:113) further describes that the distributive model "does not assume, nor exclude, any

given degree of commonality, consensus or homogeneity within the population. As culture is learned rather than inborn, its only source is the experience of the individual members of that population and it consists of the stored derivatives of the experience of each individual in all of the events of his life history.”

The literature reviewed in this study pertains to the biomedical model, cultural competency training, issues with cultural competency education, Purnell’s Guide to Culturally Competent Health Care, the biomedical understanding of culture, subjectivity, physician and patient perspectives, the impact of culture on the consultation process and anthropological understandings and perspectives on culture. These works contribute to an understanding of cultural competency and lends light to how this thesis can contribute to the existing literature on cultural competence and cultural competency training. The insights gained from the reviewed literature allow for new interpretations of prior research and those expressed in this work. This research is intended to draw attention to a significant gap in academic literature by demonstrating the extent to which conceptualizations of culture in cultural competency training are inadequate to the understanding of the lived experiences of those seeking care and often result in unsatisfactory clinical encounters. Thus, it will provide direction for a reconceptualization that has greater potential to reduce health disparities and increase clinical efficiency.

Chapter 3: Methods

The present study has the following objectives: (1) to determine what constitutes “culturally competent care” to the participant; (2) to determine what issues exist in implementing culturally competency training into a clinical care context; (3) to determine the cultural health service delivery conditions necessary to support sustainable local culturally competent care services; and (4) to define resolutions that support sustainable culturally relative health services. The primary argument of this thesis is that while culture consists of symbols, and these symbols can be shared, symbolic systems are differentially learned, understood, enacted, experienced and expressed. Therefore cultural competency models that assume symbolic homogeneity across a presupposed “group” risk denying or misinterpreting this individuality.

Health care administrators, physicians, practitioners, nurses and medical students were interviewed concerning their experiences with cultural competency models and the implementation of these models in clinical contexts. Interviewees served as both participants and key informants, providing narratives that were used as a means of capturing the individual’s understandings and perceptions of appropriate care, as well as the impact of the larger social processes. Those interviewed often shifted back and forth between the roles of key informant and participant, which included discussing systemic views, general undertakings and offering their own perspectives and experience.

3.1 Participants

There were two categories of participants in this research, health professionals and medical students. The health professional group consisted of an administrator, two physicians and two nurses. Additionally, there were four medical student participants in the research. For purposes of anonymity no further demographic details of the participants will be provided.

The health professionals included staff members of Thunder Bay Regional Health Sciences Centre and private practitioners. These individuals held a variety of responsibilities within the care system, including the provision of care to patients, governance, operations and process improvement. The cultural competence amongst these Health Professionals was reflective of their previous training and illustrated the priority of this knowledge in clinical care. All participants demonstrated a wide variety of experiences with cultural competency.

The medical school participants were enrolled in academic studies at the Northern Ontario School of Medicine (NOSM) based at the Lakehead University Campus, in Thunder Bay. Medical students were able to provide a current and varied description (depending on academic year) of the ongoing dissemination of cultural competency knowledge in medical school curriculum. These participants demonstrated a wide variety of cultural competence. Their varying degrees of exposure to cultural competency training was reflected in the tutelage received at medical and nursing school, continuing education programs, previous locations of employment, clinical and personal experience.

3.2 Recruitment

Recruitment of the participants for this study focused on individual health care practitioners with various experiences in cultural care, from TBRHSC, private practice and NOSM. Research Ethics Board approval from the researcher's university was obtained prior to recruitment (Appendix A). Recruitment of particular administrators, physicians, nurses, practitioners and students was conducted by the researcher, and intended to reflect variations of experience and exposure to cultural competency education. All recruitment took place during April 2012, with the exception of one participant which was recruited in April 2013. Participants were invited to contribute in the research project by letter of invitation (Appendix B) and by using personal contacts and referrals ("snowball" technique). Participation involved one interview session (approximately 45 minutes – 60 minutes). Responses from participants were kept confidential and were not shared with others outside of the research team. All participants were given a consent form and contact information for the researcher (Appendix C).

Finally, there was no perceived potential for coercion and no risks/benefits in participating in the study. The administrators, physicians, nurses, practitioners and students acting in this study were not paid for their contributions to the research.

3.3 Overview of Questions for Participants

Research questions were designed to produce qualitative information in the form of recorded interviews and transcribed text. Administrators, physicians, nurses, practitioners and students were interviewed regarding their interpretations of the care consultation process, specifically, training and education, the inclusion of cultural awareness or competence and

problems with applying cultural lessons. All interviews were held in private, closed office space, or at an off-site, local public establishment, chosen by the participant.

Questions were developed to gain specific insight into participants understanding of culture, cultural competence, training and physician and patient consultations. These questions were developed to promote an open dialogue that would reflect the lived experience of each participant.

The data collected from this research was digitally recorded to ensure accurate transcription. Transcripts were made available to the participants and they were given the opportunity for feedback and a transcript release form was completed (Appendix D). All transcripts were approved for use by the participants. Finally, participants will be given a copy of the final thesis. In doing so, all parties involved will be made aware of the findings of this research, given the opportunity to voice their thoughts and be privy to any recommendations from the research team.

3.4 Location of Research

The Thunder Bay Regional Health Sciences Centre has an excellent reputation as an acute care centre while combining research and academic agendas into a comprehensive care strategy, based on a patient and family-centered care model. This strategy is designed to ensure safe, high quality care for each patient.

The community of Thunder Bay serves as the regional centre for northwest Ontario and the cultural uniqueness of this region allows for the appropriate study of the role of culture on healthcare. Thomas Dunk (2007:100) describes that “while overall the population declined by some 4% during the 1990’s, the Aboriginal population living in the city grew.” Dunk (2007:100) adds that “Statistics Canada reports an Aboriginal population of 8,200, close to 7%, for the Thunder Bay Census Metropolitan Area (CMA) in 2001. This segment of the city’s population is young. The median age is 25.6 years versus a CMA median age of 39.1 years, with thirty-three percent of the Aboriginal population at 14 years or younger in 2001 compared to 18% for the city as whole.”

According to the 2011 Population Census, Thunder Bay is Canada’s thirtieth largest city with 102,222 inhabitants (Statistics Canada 2015). Of this population, approximately twenty thousand people claim either immigrant or Aboriginal status (Statistics Canada 2015). Dunk

(2007:101) summarizes that “official numbers very likely under-represent the Aboriginal presence in Thunder Bay. This is partly due to the problems involved in capturing a somewhat transient population at census time.” As Thunder Bay is the regional centre for health, social and educational services, the Aboriginal population can fluctuate depending on time of year (e.g. ice road stability for remote community access), hospital utilization, city events and educational scheduling.

Due to the culturally diverse service population of Northwestern Ontario, the TBRHSC maintains a strong focus on the accessibility of health services and the provision of patient-centered care. The TBRHSC maintains an extremely busy emergency department, one of the busiest departments in Canada, with over one-hundred thousand annual visits (TBRHSC 2015). TBRHSC does not have a clear or specific cultural competency policy; instead the organization draws reference to a handful of articles pertaining to cultural competence. Additionally, TBRHSC’s five-year strategic plan includes an Aboriginal Health pillar, and numerous cultural initiatives, including improvements to self-management, access, experience, and respect for traditional knowledge and practices (TBRHSC Strategic Plan 2020).

When the Northern Ontario School of Medicine (NOSM) opened in 2005, it became the first new medical school in Canada in over 30 years (NOSM 2015). In addition, NOSM is the only Canadian medical school to be established as a stand-alone, not-for-profit corporation, with its own Board of Directors and corporate by-laws, and was also the first Canadian Medical School established with an accountability mandate (NOSM 2015). From this mandate, the NOSM community-based Board of Directors called for an extensive reliance on Northern communities to act as hosts for its students - a strategy committed to engaging Northerners in the education process (NOSM 2015). By the time a MD program is completed, the average NOSM student will have spent nearly forty per cent of their time studying in Aboriginal, small rural, and larger urban Northern Ontario communities (NOSM 2015). Specifically, the NOSM curriculum includes “Northern and Rural Health” as a main educational theme. “Northern and Rural Health covers the teaching of cultural competency especially in relation to populations in Northern Ontario such as Francophone and Indigenous peoples, history and geography of Northern Ontario and the history of medicine in the North, health care and service issues in Northern Ontario, and the challenges, benefits and rewards for practicing medicine in Northern Ontario (NOSM 2017).”

The North West Local Health Integration Network (NWLHIN), one of 14 in Ontario, oversees the integration and coordination of local health services in Northwestern Ontario. The North West LHIN is responsible for allocating funding for the following health services: Hospitals, Community Care Access Centres (CCACs), Community support service organizations (e.g. homemaking, personal assistance, etc.), Long-term care homes, Community Health Centres, and Community Mental Health and Addictions agencies. The NWLHIN serves as the primary link between these services and the Ministry of Health and Long-Term Care (MOHLTC). Within the NWLHIN, cross-cultural patient safety is of paramount concern. To ensure the safe and appropriate delivery of care, the region has focused efforts on building culturally-integrated organizations, the allocation of culturally congruent staff, support for culturally competent practice, the effective delivery of services, and a reduction of barriers to identifying patient and client needs (Sioux Lookout Meno Ya Win 2006).

The Sioux Lookout Meno Ya Win Health Centre (SLMHC), as part of the NWLHIN, has developed a mandate to provide a broad set of services to a largely First Nations service population in a manner which addresses both health status and cultural needs (Sioux Lookout Meno Ya Win 2006). The SLMHC identifies that there are numerous impediments and other cross-cultural issues that arise from diversity in service and provider populations, including language, culture, practice, context, systems, genetics, racism/discrimination, power, history and politicization (Sioux Lookout Meno Ya Win 2006). Walker and Cromarty (2010:63) as part of the SLMHC team tasked with program development and implementation of a comprehensive model of care, describe two barriers: a genetic barrier as the “failure to know of or take into account inherent issues in a population (e.g. genetic predisposition to diabetes); and the racism/discrimination barrier as the “manifestations of bigotry, prejudice or intolerance that result in the differential provision of services or care.” The SLMHC states that these cross-cultural issues apply to any diverse population in care, whether Indigenous, assimilated or migrant (Sioux Lookout Meno Ya Win 2006).

The City of Thunder Bay, TBRHSC, NOSM, NWLHIN and SLMHC have all recognized the need for culturally appropriate services and all have introduced mandates to ensure the delivery of resources in a fashion suitable to the needs of Northwestern Ontario residents. This attention illustrates that there is a widespread awareness of the needs of both the city and

regional populations, however, the delivery models for these programs invoke a group membership mentality and a generalized understanding of culture.

The participants in this study, their recruitment, questions utilized, and location of research allowed for a unique, Northwestern Ontario perspective on cultural competence and cultural competency training. Specifically, the questions utilized in this study, allowed for insight into participants understanding of culture, cultural competence, training, and physician and patient consultations and were reflective of their lived experience. Also, the positionality of the participants reflected specific insights into Indigenous health, oncology, emergency medicine, family practice, education and patient experience. With a focus on health care and the delivery of health services, the population diversity of Thunder Bay, along with access to a medical school, and the challenges faced by the regions health centre's and health authorities in the provision of care, greatly contributed to the validity of selecting this area as the location of conducting cultural competency research.

Chapter 4: Data Analysis

Health care administrators, physicians, practitioners, nurses and medical students were interviewed concerning their experiences with cultural competency models and the implementation of these models in clinical contexts. Interviewees served as both participants and key informants, providing narratives that were used as a means of capturing the individual's understandings and perceptions of appropriate care, as well as the impact of the larger social processes. Those interviewed often shifted back and forth between the roles of key informant and participant, which included discussing systemic views, general undertakings and offering their own perspectives and experience. The insights gained in this fashion are comparable to the person-centered approach discussed earlier by Hollan. The utilization of a person-centered, descriptive approach, allowed for the engagement of individual participants and the exploration of the complexities surrounding illness, treatment and health. An analysis of the interview transcripts collected for this research allowed for the determination of shared experiences, patterns and ambiguities, primarily patterns and experiences relating to a participants understanding of cultural competence, cultural competency training and the implementation of knowledge, self-prescribed forms of cultural competency, interpretations of illness, important elements in treating a patient and the determination of a successful treatment.

4.1 Participant Responses and Analysis

What is your understanding of culture?

An analysis of participant responses concluded that culture could be described as collective beliefs, customs, routines, values, traditions, religion, ethnicity, family practices, socially acceptable behaviours and decision-making processes. One physician described culture in the following ways: "I think of culture in the abstract sense, to be a set of social, possibly religious, familial and recreational patterns that govern the way we interact with one another and carry out our lives." This viewpoint is similar to Kirmayer's expression of culture and allows for insight into how meaning is formed by the individual and accounts for variation. Subsequently, another physician added "when I think of culture, I think of a set of values and beliefs that are shared by a group of individuals" and a medical student suggested that "culture is kind of a blanket that you can throw over a group of people, it's more or less a commonality between them [people] and used to identify themselves." These cultural viewpoints serve as perfect

representations of the generalized understandings of culture that have been reinforced in medical circles, allowing culture to be interpreted as holistic and homogenous. Participants noted that these cultural qualities would be shared amongst members of the particular cultural group and therefore, unique amongst varying groups. Furthermore, the participants concluded that the cultural groups also share opinions and an overall outlook on life.

From participant responses it was determined that concepts of culture were greatly formed by education, training and personal experience. As one nurse administrator explained “I have had very minimal cultural training, I think it was first year or second year of the nursing program at the university where they talked about cultural diversity and being respectful, when you came across people with different cultural backgrounds and beliefs and to be cognizant of them, you know, what they may require or allow as far as care went. But I would say that there’s very, very minimal cultural training. It’s something that you end up learning, within the work environment as opposed to being trained.”

Importantly, the analysis also demonstrated that what participants actually applied in their practice was quite different from the approaches to culture that they had been taught. To reflect back to Abu-Lughod (1991) and her interpretation of culture “as reinforcing hierarchical inequalities through fixing basic differences among people, in terms of development, character, government and so forth, as innate objects.” Abu-Lughod (1991) expresses the need to work against the assumption of boundedness, address the nature of contemporary global interactions, and remove focus from generalizations and homogeneity, to expose apparatuses of structured power and hierarchy. Participants in this research illustrated that their understandings of culture was conflicted in practice and as a result, participants demonstrated recognition of patient individuality, subjective experiences and uniqueness. As explained by a nurse participant, “culture is something that’s not static, it’s fluent and always changing ... it’s whatever your experiences are and what you, what your beliefs are basically.”

Participants who had regular contact with patients (consultations) noted that culture served as a construct to categorize people and was not useful in the consultation process. An insightful interpretation of culture comes from one of the physician participants with this experience, as they defined culture:

A set of ideas and thoughts that groups of people share and experience, it shapes their world and how they live, but that’s what

I have been taught. In my personal opinion, and what I actually think, is that culture is something that is somewhat made up. It's something that we try to construct and we try to put people in different categories, and say that somebody lives a certain way or a group of people do. But it really is that everybody has their own thing, even with in a culture. I see now that it's something that's more of a generalization.

This participant's definition of culture reflects the tension in following inaccurate models of culture. The holistic and homogeneous approach to culture was deemed inappropriate, leading to a self-taught cultural model, reflective to Brightman's earlier insight into the denouncement of culture.

From the records of the participants, it is seen that education and training in culture reinforce an approach that groups have shared values, beliefs, social and religious viewpoints. Participants noted that they were instructed that there are shared traits amongst members of groups and that culture can be used as an identifier when interacting with patients. The most interesting finding was that all participants denounced the taught ideas of culture as an appropriate clinical tool and merely served as a construct for categorizing people, which was not useful.

Can you describe your knowledge of cultural competency? / Have you had any cultural competency training?

The interviews revealed that participants interpreted cultural competence as the understanding of a culture, how decisions are made in that group, and the awareness of the practitioner's need to adapt approaches to interactions based on culture, to ensure respect and meaningful engagement. A clinician participant described cultural competency for me:

I guess being culturally confident [sic] to me would be that um, you have an understanding of why, a certain culture is the way it is or why, or how it comes into play into that person's life, and how it might affect their decisions in different ways than it would other people. Being culturally confident would be, being aware of that and maybe, if needed, changing the way you ask a question or the

way you approach something, in order to respect their cultural beliefs or routines.

Interestingly, this participant associated cultural competence, with confidence. Hence, competence was the direct result of knowing and understanding all aspects of an interaction with a patient and their potential reactions. This would create a level confidence that allowed comfort when dealing with individuals. Another student mentioned “one of the drawbacks to the NOSM (Northern Ontario School of Medicine) style, which you can’t really get away from, is the stereotyping which is like a blanket that they throw over everybody, and it just doesn’t work.” It is evident that this participant, early in their medical training, identifies the generalized, modernist approach to cultural competency being applied in their medical school’s curriculum.

All participants, regardless of occupation, had been introduced to the concept of cultural competency; however, none of the respondents had direct experience with a fulsome training program. A medical student participant noted that, “during residency here in Thunder Bay we’d have you know, occasional topics that focused on Aboriginal groups and whatnot, but beyond the occasional sporadic lecture I wouldn’t say I had any formal organized training in cultural competency.” Rather, all participants had received lectures and case studies in nursing and medical school, which predominantly focused on minority populations in the geographic area of the educational facility and reflected the mandate of the institution. Participants did note that specific instruction was received in regards to Aboriginal, Francophone, Middle Eastern, African and Mennonite populations, however, most established practitioners concurred that they could not recall any specific teachings. Specifically, in Thunder Bay, care provider training was focused on Aboriginal and Francophone populations, the two main minority groups in the area. Ultimately, it was recognized that health service providers learn cultural competence within the work environment or on the job, as opposed to receiving formal training and applying the teachings. Great insight came from a physician participant who noted:

I think that cultural competency training would benefit. But from my past experience, and what I just explained in terms of doing it by specific culture, I think it’s more about getting to an individual level, rather than a cultural level. I have found that we’ve been given these generalizations about different cultures that in my

interactions, and the interactions that I have seen by shadowing, that those cultural specific things don't work. Everybody within a different culture experiences their culture differently. Some people follow the traditional practices or traditional lifestyles strictly, some don't. I think it would be more beneficial to train somebody to understand everything about the individual and to take the time to do that rather than to take the time and learn about specific cultures.

This expression of cultural competence is the most closely supported position to those described by Brightman and Rodseth. This participant adheres to a modernist model with a denouncement of cultural generalizations and holism, and an uptake of the importance of diversity, lived experience and understanding. This participant viewpoint is also reflective of a distributive model rejecting the sharing within cultures and the boundaries between cultures.

Participants associated cultural competency with an understanding of decision making processes and the ability to interact with members of unique cultures and groups, in an effective manner. Participants noted that specialized approaches to varying cultural groups were intended to lead to meaningful engagement. Conceptually, participants understood the goals of cultural competency, but none had received any formal training. From this, all participants recorded having developed independent approaches to care that were founded on recognizing the needs and interpretations of individual patients, not based on group membership.

Is cultural competency training beneficial in the consultation process? Do you invoke any form of cultural competency in your health care delivery?

The participants do not support the formalized training of cultural competency. One physician described the utility of cultural competency training:

In my opinion I don't really see a huge role for cultural competency training, in medicine...during my medical training there was a big emphasis on approaching patients in a way that was empathetic and encouraged you and the patient to find some sort of common ground, and approach their medical problems as a team

opposed to say you know, the traditional paternalistic way of, of treating medicine where you know, what the doctor says is right and you know, you don't really listen so much to the patient's feelings and whatnot... So, there's a there's a big thrust towards kind of the empathetic practice of medicine right. And I found that a bit problematic in the same way that I feel the same way toward cultural competency, in that I don't think you can really teach empathy. I think most people either have it and it's a quality that they've cultivated through their life or they don't have it. I see cultural competency as being similar, because I feel the root of cultural competency in my mind is just having a general sense of respect for other people, no matter what cultural group they come from. And I don't think you can necessarily teach people respect, you either are of a mind to respect other people as you would want them to respect you, or you're not of that mind right? And I don't know if having any sort of classroom based or textbook based or formalized approach to teaching cultural competency will change what's really fundamentally driving a person or what their underlying value system is. So I am not personally a big proponent of teaching cultural competency in any sort of formal sense.

Cultural competency was deemed by some to have little benefit, because of its stereotyping and generalized principles, which could not be applied in the consultation process. A nurse participant noted a particular example, "We still have this admitting process where we have to ask people do you consider yourself Aboriginal? And sometimes you ask people that and they looked at you like you're racist." Additionally, one medical student noted the dismissal of a stereotype that was instilled in a teaching:

Well, for instance like I went to, to Pic River and you know, whether it's giving tobacco whenever somebody gives you a teaching, nobody practices that [Okay] unless you are actually in a ceremonial you know, facility and they give you heads up and

everything for that. Pic River doesn't have huge crime rates, it didn't have drug problems or alcohol problems, it had more social organization than most of the little towns surrounding Thunder Bay, so I mean to go there expecting garbage in front of the houses, and you know like drunks and drug addicts walking around at night, it's completely skewed.

From this student's interview, it is seen that the medical school curriculum/training for this specific "culture," linked this community with social disorganization. This was clearly contrary to the participant's experience. From this, we can conclude that though training around cultural competency is intended to diminish bias, it can also facilitate negative, unfounded perceptions towards people and even communities.

Most participants recognized the need for training in interpersonal competence, understanding, acceptance and value determination. Participants reacted to cultural competency training by largely rejecting it as possibly damaging. Instead, participants preferred personal experience, encouraged education in individualized approaches to patients, and sought an introduction to Aboriginal traditional medicines, beliefs and practices. These measures were to assist in establishing respectful relationships with patients.

With this understanding, all participants declared that they engage in some form of cultural competence, will all having different views of the concept. However, the competency model invoked is based on the participants own value systems, formulated on building a quality relationship with their patient and providing the best care possible. The use of cultural competency lessons in the clinical setting was only noted in one example from a participant. All other participants expressed that the teachings were not useful clinically, and that competence should be free from cultural generalizations and based on engaging the patient on a personal level. A student summarized that "some of the things we've learned are more general and encompass different populations as a whole. I don't think this has been overly useful, because you approach every situation and every patient differently."

There was a notable variation in comprehension of cultural competence between the physician group and medical students. The perceptions of culture amongst the students interviewed were reflective of their teachings to date and models shown to them, which in all

fairness, generally describes their experience at the time of the interview. Most student participants noted a general understanding of culture as “a set of values and beliefs that are ... shared by a group of individuals,” and that their knowledge of cultural competency was based on their education. One student explained:

What we've done for cultural competency training was more or less geared towards two different populations, the Aboriginal population and the Francophone population. That is where we spent most of our time with cultural competency training. We were given different cases, Aboriginal patients, francophone patients and then some patients that were more specific or more prevalent in each of those cultures.

There was variability in cultural understanding amongst medical students, depending on the year of tutelage. Early year students tended to provide more textbook responses, undoubtedly formed from their education to date (as noted above). Later year students, primarily those who followed a preceptor in practice, demonstrated a break away from the generic cultural ideologies instilled in early clinical skills classes. When asked to describe how to identify a particular cultural group, a student participant noted:

The best way that like our preceptors have done it, like not through any text books or any literature or anything like that, but they just say ask, ask if you have questions, ask people if you don't understand something. They tell us most people want to learn and show an interest in those people; they enjoy that because most you know, a lot of times they feel left out or neglected, if you show the interest and that you generally do care, they will usually tell you stuff. So if someone comes in and you don't know what they are, they have interpreter with them, what language does your father or mother speak, you know, how much English can they understand? Can they understand nothing that I say or can they pick up words, so just you ask and you be friendly about it and generally care, and I think that would be the, that's the way we have been taught.

This example demonstrates that much of the cultural competency skills are developed and informed through practice, preceptor teachings and ultimately, shaped by organizational mandates, ensuring alignment with community patient populations. These later year students represent a phase in learning between that of an early year medical student and a seasoned physician.

Physicians demonstrated a more nuanced approach to cultural competence, based on their lived experience. As one physician explained:

I think yes, I think definitely that the curriculum at NOSM, the cultural curriculum, really emphasizes the generalizations. Through my clinical experiences in my later years in medicine, also in my early years of medical school, spending time on the different First Nations really opened my eyes to realize that if you just treat patients, and not take the time to get to know the individual and make assumptions based on generalizations of the culture, it really sets you up to treatment failures. Especially, if you don't take time to get to know the individual and get a sense of their own, where they are coming from in their own values and beliefs.

In the findings, participants did not support formalized cultural competency training. Participants added that the stereotyping and the general principles of cultural competency were not beneficial. Instead, participants called for the need to focus on finding common ground and respect for their clients. To accomplish this, participants recognized the need for interpersonal competence, however, as a physician participant noted, this introspective approach should be fundamentally driving the practitioner and would be a hard skill to learn through training. Finally, participants concluded that cultural competency skills were developed and informed through practice.

What is your interpretation of illness? What are the most important elements in treating a patient? How do you determine if a treatment has been successful?

An analysis of all participant responses concluded that illness could be interpreted as the subjective experience of a disease process, a variation from a patient's normal baseline, a general feeling of being unwell and encompasses physical, emotional, mental and spiritual illness. It was accepted that presenting patients expressed their illness experiences differently, reinforcing the need to take an individualized approach to care. Of interest is that a nurse participant noted that their interpretation of illness was of secondary importance to that of the patient's illness experience – this was the paramount concern. Explained one nurse:

I am working currently in a cancer care setting, so these patients will come in and one patient may come in and think they have been diagnosed with a Stage 3 lung cancer and perceive themselves as terminal, and then the very next day, another patient could come in similar age, similar diagnosis and perceive this as a reasonable, fightable disease. So, I don't perceive illness as anything in particular, I think I work off of how the patient perceives it, and then work towards educating the patient on really, "What does this mean?" "What are the options?" "Where do we go next?"

In determining the most important elements of treating a patient, all participants demonstrated that the main priority was developing understanding. This understanding includes patient needs, socioeconomic conditions, cultural ideas, religious backgrounds, effective communication, evidence of improved health status and the treatment of symptoms. Participants stressed that through effective communication, understanding of the whole patient would come to light. With this insight, practitioners inform patients of the care possibilities, treatments, risks and benefits. Explained one physician:

All of these tie into ... who they are and how you can ... most effectively treat the individual, because... if I prescribe a medication to somebody that's expensive and they don't have the funds to pay for it um, it's not going to be effective because they are not going to take it. Also, if I prescribe medication ... and it

conflicts with their cultural or religious beliefs, again it's not going to be effective.

Physician participants in this study determined that the success of a treatment regime is multifaceted, predominantly measured in two ways: physical condition and patient interpretation. Decisions on treatment are generally patient-centered, as much as possible and success is generally associated with patient involvement. Physicians and medical students noted that through follow-up appointments you can assess the appropriateness of an assigned treatment. Physical condition measures would involve the control of a disease process, limiting adverse side effects, the tolerability of treatment and include the prolongation of life.

Similar to other elements of care, as previously discussed, patient interpretation exposes a patient's perception of their health status and it becomes a goal of the practitioner to manage the patient's expectations. Participants in this research shared that treatment regimes were largely founded on nursing guidelines, college standards and organizational mandates, however, it was also concluded that the location in which these practitioners worked (unit within the hospital) also shaped the importance of determining if a treatment was successful. As a physician participant explained, an Emergency Department physician, who sees a new patient approximately every 10-15 minutes, does not know the validity of a prescribed treatment for non-emergent cases, unless that patient is admitted to hospital. This provides the ordering physician the time to directly follow-up on the patient. For all participants, time proved to be the catalyst for not knowing if a prescribed treatment was successful or not. Finally, all participants recognized that having the time to spend with patients was paramount in patient understanding and adherence to care programs. It is this patient-centered care approach that is widely accepted as a central element of cultural competence. Explained one physician: "If you have the time to kind of find out what the patient's expectations are and as well, educate them about how realistic some expectations are, I think maybe that would improve the overall patient physician interaction as well as the patients overall satisfaction with how their treatment is."

The findings presented, proved insightful in determining participant's interpretations of illness, the important elements of treatment and what constitutes success. These questions were designed to reveal the participants understanding of illness, treatment and success, while also serving to determine if there were variances in interpretation. Furthermore, these questions

sought to provide insight into the interactions, and possible power struggle between practitioner and patient. Participants explained that illness is the general feeling of being unwell, as patient's experience a variation from normal health. Participants added that in treatment, the most important element was to develop a mutual understanding between patient and practitioner. This is achieved through effective communication. Success was measured by physical condition and the patient's interpretation of their health status. A particularly interesting finding was that treatment and success was sometimes dependant on the hospital unit and the time allotted to each patient.

4.2 An Alternative Model of Cultural Competency

Participants freely identified shortcomings in their education of how to provide culturally appropriate care and as a result, most participant's, regardless of career, invoked an individualized approach to competent cultural care, founded on the needs and understandings of the presenting patient. As one physician described, "I see cultural competency more being something that's learned in that way kind of gradually over time and rather than in any sort of formal sense. Like from a book or through a classroom, or through a lecture."

Following the conclusion of the interviews, participants expressed interest in the outcomes of this research, based on the volume and diversity of patients seen in practice. Through analysis, it was discovered that competence is learned on the job, and dependant on the individual's self-awareness, and ability to further develop interpersonal skills and values. It was demonstrated that cultural competency training does provide value in introducing practitioners to unique group traits (traditional medicines), however, it also lessened the practitioners ability to provide care that was absent of stereotyping.

From the evaluation of participant interviews, it is evident that all participants' support a client-centered approach that treats patients as individuals, as the best way to be culturally competent. As a medical school participant explained:

80% of the diagnosis can be made just by letting the patient talk uninterrupted, they will give you everything. A lot of times when we interrupt the patients or we start asking the yes, no questions, the close ended questions, they will leave things out...by asking the open ended questions, you get them to really tell their story.

This insight suggests that some clinicians will accept patient narrative as part of the patient-centered approach and reflects Mattingly's (2001) position of the importance of shared narratives between clinicians and patients.

From the insights of all of the participants, it is clear that culture is not denounced entirely. In fact, culture is seen as one of the many unique and distinguishing factors which contribute to the personal lived experience of the patient. However, culture is not viewed as the elusive key to understanding the human experience, as portrayed in modernist models of culture. As a response to the limitations of modernist culture models, many participants have invoked well-developed clinical skills to circumvent the pitfalls of the more generalized cultural approaches. Medical students will continue to hone these clinical skills throughout their careers. These skills are used in unison with the patient's individualized understanding of their own unique culture.

From the insights gained through the participant interviews, the question remains, how is a healthcare environment that fosters individual patient-centered and family-centered care and practitioner accountability to patient needs developed? The Nuka System of Care, as developed by Alaska's Southcentral Foundation (SCF), is recognized as one of the world's leading models of health care redesign (Southcentral Foundation 2015). This system was created, managed and owned by Alaska Native people to achieve physical, mental, emotional and spiritual wellness (Southcentral Foundation 2015). Leizens (2012) describes that "with the Nuka system, rather than the provider trying to decide what's best, the customer-owner makes the decision with the doctor and clinical team providing expertise." With the Nuka model, the customer-owner approach to care allows for individualized patient understandings of health and care to be at the forefront of the care delivery process, regardless of culture.

Key concepts of the Nuka System of Care include: integrating the mind, body and spirit (physical, mental, emotional and spiritual wellness); shared responsibility (commitment to quality and family wellness); and the power of story (Southcentral Foundation Office of the President Administration 2013). Many of the driving concepts of Nuka are reflected in the findings of this research. Nuka addresses cultural competency through a patient-centered and family-centered care philosophy, similar to the participants interviewed in this research. Patient-centered care is demonstrated by the focus on both the physical, mental, emotional and spiritual

wellness, and their commitment to quality and family wellness. Importantly, the Nuka model focuses on the power of story, just as participants in this research identified the need to allow for patient narrative. These core concepts allow for individual variation, unique patient experiences and cultural understandings to come to light. Katherine Gottlieb (2013) describes that the Nuka health care system is the result of a customer driven improvement process of what was previously a bureaucratic system that was centrally controlled. Gottlieb (2013) adds that Alaska's Native people are in control as the "customers-owners" of this health care system, where the vision and mission concepts focus on physical, mental, emotional, and spiritual wellness and working together as a community. Coupled with operational principles based on relationships, core concepts and key points, this framework has fostered an environment for creativity, innovation and continuous quality improvement (Gottlieb 2013).

The Nuka System of Care is founded upon three beliefs: Customer-Ownership, Relationships and Whole System Transformation. Customer-owners are not referred to as patients, they are treated as equals and share in decision-making around their health and wellness. The relationships between the primary care team and the customer-owner are recognized as the most important means to effect change.

In analysis of the participant responses, it became clear that the cultural education received to date reinforced generalized constructs of culture and participants had no experience in a formal cultural competency program. Instead, cultural competence was derived through first-hand knowledge and experience and expressed individually. The Nuka System of Care was examined as an alternative model for cultural competency, as it is based on patient and family centered care, with a focus on physical, mental, emotional and spiritual wellness. Importantly, the Nuka model can be utilized as an appropriate care model, due to its focus on participant narrative, and its recognition of core concepts that allow for individual variation, unique patient experiences and cultural understandings.

Chapter 5: Conclusion

Cultural competency training has been employed as a mechanism to increase clinician awareness of ethnic disparities in accessing care, however, it has not improved the clinical outcomes of patients (Sequist et al. 2010). Part of the problem for this lies with the models of culture employed in training and clinical practice, which are often simplistic and facilitate stereotyping. This research supports a call for the provision of care services according to individualized and subjective needs. These findings support the need to re-examine educational curricula and the models of cultural competency deployed in Canadian care settings.

In this research, participants shared the adaptation of individualized approaches to care, which were based on lived clinical and patient experience and deemed as more appropriate. The development of nuanced approaches to culturally appropriate care contrasted with the limited and informal training they had received in post-secondary education.

Building off of Hollan's (2001) notion of person-centered ethnography, as described in Chapter 1 and his caution to avoid reliance on overtly abstract, experience-distant constructs, this research suggests a parallel to the experience-distant constructs would be the modernist notions of culture that create generalized cultural categories that tend not to reflect the lived experiences of so-called culture "members." An influential aspect of the person-centered perspective is that it recognizes the importance of individual experience and how these processes shape a person's responses to the world. In the clinical setting, the person-centered model is utilized as a Patient and Family Centered Care philosophy. Patient and Family Centered Care (PFCC) is the provision of care that is respectful of and responsive to, individual patient/family preferences, needs and values, and ensures that patient values guide all clinical decisions (Matthews 2015). It is this PFCC philosophy that the participants in this research employ.

This research supports a breakaway from traditional anthropological concepts that stress sharing within cultures and boundaries between cultures, as there is no justification to assume that classifications based on cultural generalizations are appropriate in the delivery of health services. Instead, the findings support that cultural competence be assessed by the practitioner's ability to uncover the individualized perceptions and subjective understandings of their patient. Additionally, within the patient and clinician interaction, the patient must assume an active role in communicating their understanding of the care model. Similarly, both the practitioner and patient are tasked with ensuring that the care being administered is in a congruent fashion to the

patient's perceptions and understanding. It has been well documented (Waldram et al. 2006) that culturally appropriate care is pivotal to the overall "success" of the administration of health services. This knowledge is derived through an understanding of what constitutes a successful consultation, diagnosis, and treatment, and varies with every person who seeks care within a medical system. The extent to which cultural models are employed, lead to satisfactory clinical encounters, and reduce health disparities, remains an open question and should be the focus of additional research.

Cultural competency programs support a perspective in which a majority of members within a particular cultural group share the same lived experience, interpretation of meaning and understandings. Most participants in this research identified some degree of exposure to cultural competency education, however, this training was not very formalized. It is evident that practitioners develop individualized models of cultural competence, each suited towards the patient. The positions in this research support a reconfiguration to the use of such training programs. As such, it is important to note that the removal of cultural competency training would not directly translate into the elimination of health inequalities. Instead, a reconfiguration is suggested so that cultural generalizations and current training programs are replaced with the introduction of teachings around capturing individual experience, interview techniques to do so and interpersonal awareness. Undoubtedly, the application of these skills by practitioners is expected to contribute to better patient outcomes. In all, it is imperative to be aware of the varying dynamics in a consultation, or when seeking care. It was demonstrated in this research that practitioners are responsible to a number of influencing factors when administering care. Practitioners adhere to a biomedical understanding of illness, have accountabilities to medical directors, hospitals and governing agencies and ultimately, are responsible to the patient and their subjective understandings. In each of these interactions, the ability to understand and have common dialogue, portray necessary knowledge and work towards a shared goal is paramount. This research illuminates the need for practitioners to have the skill-sets to gain the trust of their patients.

It was the objective of this study to explore the extent to which models of "culture," characteristic of cultural competency theorizing, training and implementation are translated into culturally appropriate care in the multicultural community of Thunder Bay, Ontario. Cultural competency has been described as an understanding of the manner in which people of diverse

cultures and belief systems perceive health and illness, and respond to various symptoms, diseases, and treatments (Crandall et al. 2003). Cultural competency training has increased clinician awareness of ethnic disparities in accessing care, however it has not improved the clinical outcome of patients (Sequist et al. 2010), particularly those who are members of cultural minorities. This study suggests that part of the problem for this rests with the models of culture employed in training and clinical practice, which are often simplistic and facilitate stereotyping.

Competence involves more than just the ability to speak and understand a language, a culture, a history, or relationships and so on. Rather, competence can be thought of as the ability to understand how people create meaning from lived experience, regardless of generalizations and stereotypes. With this insight, it can be assumed that issues of culture are not solely geographically or group-based, but rather founded on the experiences of the individual.

Health systems need to ensure that the delivery of care is as complex and diverse as each patient's experience. Perhaps a reconceptualization of culture in the Canadian health care environment should be based on patient value determinants, which are health outcomes that matter to the patient, versus cost of delivering these outcomes. The delivery of highly skilled clinical services and improving the overall value for patients is the fundamental purpose of health care. From this, we can assume that value is the only goal that can unite the interests of all system participants. The improvement of value serves as a tangible solution to improve the care experience when compared to costs shifting, restricting services or reducing the compensation of health care professionals. Value is measured for the care of a patient's medical condition over the full cycle of care, where outcome is the full set of health results that matter to a patient's condition over the cycle of care. To create a value-based delivery system, it would be suggested that both outcomes and costs for patients be measured. A new care delivery model would be free or independent of generalized assumptions of culture, and prioritize the individual social, psychological and behavioural experience. There would be a role for an understanding of culture's role in shaping human behaviour, illness response and clinical experience. It also requires that illness be dealt with according to medical need, and in conjunction with the meaning, understanding, and lived experience of the individual.

With the realization that cultural competency models are outdated, the question still remains, how do we effect systematic change and still keep cultural issues salient? The implementation of interpersonal development strategies, in place of cultural competency, must

occur with a number of key supportive factors. This study suggests that the adoption of an interpersonal care model may occur with a patient- and family-centered care philosophy, led by individual practitioners and organizational leaders, a supportive hospital administration, malleable hospital mandate, research into best practice and advocacy.

It would appear that in order to deliver the most appropriate care possible, and in a fashion that is understood and respected by the patient, the participants in this study have already begun to adopt individualized competency models. As previously discussed, these models are based on an intrinsic value system that is co-founded on a patient-centered and medical need philosophy. It is these leaders who will be responsible for driving organizational change, by pressing the patient benefits and anticipated delivery savings that would result in increasingly efficient care. Organizational practice leaders will need to advocate with hospital administration to adopt interpersonal development as a key driver of clinical success. Interpersonal development will need to be introduced in unison with change management, process improvement initiatives and the like. Process improvement strategies, could assist in process efficiencies and the necessary service conditions that will ultimately contribute to increased practitioner time with patients. Increased time with patients is imperative to the success of a client/patient-centered model of care. With the acceptance of interpersonal development as a key priority, a hospital mandate would include allocating and investing staff time for comprehensive educational programs in value determination, effective communication, the management of patient expectations and subjectivity. This mandate would support cultural competence, by fostering a physician's ability to uncover subjective meanings, and administer care in a congruent fashion to patient's perceptions and practitioners knowledge. This approach is supported by Mattingly's (2001) research on developing a shared narrative. As such, learning opportunities for practitioners should be done as an interprofessional team, allowing for a multitude of experiences and potential approaches to care to be shared and discussed. These training programs could be developed, not under the guise of cultural competency, but rather to foster the development of interpersonal growth, free of stereotyping.

An organizational investment of this magnitude is daunting; however, it is of the utmost importance. The implementation of the Nuka System of Care was such an undertaking. By introducing such a mandate, the hospital would strive to become a best practice leader, from which other sites would visit and model similar programs. It would be at this juncture when

medical schools could be approached with suggestions for altering curriculum. With proven outcomes in patient satisfaction, care and health, the facility would then have to advocate with the provincial governing agency (LHIN) to support the sustainability of an interpersonal development strategy.

When considering these proposed changes, we must keep in mind the role of culture and cultural competency. Currently, the health care system views culture as a unique group identifier, one that allows for the specialized delivery of care that can and will improve patient outcomes. With this understanding, cultural competency training is implemented to improve a clinician's practice and promote positive patient outcomes. At first glance, the approaches to culture and subsequent cultural competency training seem appropriate, however as this research has determined, that understanding of culture is too general and actually creates distance from the goal of personalized care. As such, the health care system needs to reevaluate its understanding of culture and adopt a more sophisticated and nuanced approach to individualized care, one based on patient narrative and experience.

Generally, most care providers and employees of the health care system uphold an altruistic view of care and strive to improve the health and experience of all patients. However, health care organizations are faced with limited funding, and are tasked with providing the highest level of care and patient experience, while generally facing expanding patient volumes. In this environment, it is only too easy to forfeit accountability, pull away from the patient's experience and strictly uphold the biomedical approach to health. As such, systems, organizations, health teams and individual practitioners must realign their care mandates and delivery models to not only seek out the elimination of a presenting illness, but account for the client's interpretation of illness and health, their determination of value and the external forces which influence their well-being.

The goal of this study was to address the following objectives: (1) Determine what constitutes "culturally competent care" to the participant; (2) Determine what issues exist in implementing culturally competent training into a clinical care context; (3) Determine the cultural health service delivery conditions necessary to support sustainable local culturally competent care services; and (4) Define resolutions that support sustainable culturally relative health services. These objectives were addressed through an analysis of associated literature, models of care, cultural competency education, models of culture, patient and practitioner

perspectives and a review of practitioner experiences. In determining what constitutes culturally competent care, participants shared their understandings of culture. Culture was depicted as collective beliefs, customs, routines, values, traditions, religion, ethnicity, family practices, socially acceptable behaviours and decision making processes. However, participants recorded that their education in culture and cultural competency training was limited and often inapplicable in clinical settings. This finding was unexpected, as the researcher had hypothesized that cultural training programs would have assisted in facilitating improved patient experiences and outcomes. Ultimately, implementing cultural competency training in a clinical setting proved to be difficult for participants, as their teachings did not translate in the field. Participants shared experiences of being instructed to expect certain general behaviours and expectations from patient populations, even expectations of community conditions, many of which were unfounded in their experience.

It was revealed that regardless of organizational mandates, cultural competency did not effectively occur in the consultation process, mainly as a result of the generalized and stereotypical viewpoints expressed in training. This dissemination of generalized cultural training was seemingly expressed unknowingly, as these organizations often lack the internal expertise to roll-out a truly culturally competent program. It is in this realm where further research is needed to develop culturally competent training that would be applicable to health service providers. It was recognized that health service providers learn cultural competence within the work environment or on the job, as opposed to receiving formal training and applying the teachings. This research recommends that further analysis include interpersonal development techniques, training and implementation measures that could assist in the patient and practitioner relationship.

The findings presented in this research, proved insightful in determining participant's interpretations of illness, the important elements of treatment and what constitutes success. Participants explained that illness is the general feeling of being unwell, as patient's experience a variation from normal health. Participants added that in treatment, the most important element was to develop a mutual understanding between patient and practitioner. This is achieved through effective communication. Success was measured by physical condition and the patient's interpretation of their health status. A particularly interesting finding was that treatment and success was sometimes dependant on the hospital unit and the time allotted to each patient.

Additional research could provide valuable insight in determining if increased consultation time with a clinician translates into improved patient health outcomes.

This thesis concludes that health care practitioners invoke individualized models of cultural competence, ones that are formed by first-hand experience and often denounce the generalized cultural teachings of educational competency programs. As displayed from the key informant interviews, a call for the provision of care services according to a patient's individualized and subjective needs emerge. These findings support the need to re-examine cultural educational curricula and the models of cultural competency employed in Canadian care settings.

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Appendix A:



Behavioural Research Ethics Board (Beh-REB)

APPLICATION FOR APPROVAL OF RESEARCH PROTOCOL

1. **Name of researcher(s)** and/or supervisor (s) and related department(s).

James B. Waldram, Department of Psychology

- 1a. **Name of student(s)**, if a student study, and type of study (e.g., B.A., Hon., M.A., Ph.D.)

Dan A. Ward, M.A. Medical Anthropology

- 1b. **Anticipated start date of the research study (phase) and the expected completion date of the study (phase).**

April 2012 – July 2012

2. **Title of Study**

Cultural Competence Training and Implementation: Practitioner and Student Perspectives

3. **Abstract (100-250 words)**

The primary purpose of this research is to explore the extent to which conceptualizations of “culture” in cultural competency training for clinical personnel are adequate for understanding the lived experiences of patients. Cultural competency has been described as an understanding of the manner in which people of diverse cultures and belief systems perceive health and illness, and respond to various symptoms, diseases, and treatments. Furthermore, while supporting research has demonstrated that cultural competency has increased clinician awareness of ethnic disparities in accessing care, it has not improved the clinical outcome of patients, particularly those who are members of cultural minorities. This study will examine the models of culture employed in training and clinical practice, determine the extent to which such training is clinically useful, and explore the experience of providing culturally competent care from the perspective of clinicians, clinic administrators, and medical students. A medical anthropological approach to culturally competent care, one that employs a more nuanced and theoretically sophisticated understanding of culture, will provide the interpretive lens and insight into this issue. Thus, it is anticipated that this research will provide direction for a reconceptualization of cultural competence that has greater potential to reduce health disparities and increase clinical efficiency.

4. **Funding**

None.

5. **Expertise**

This research is supported from the applicants experience in working amongst professional health providers and patients, as a Clinical Research Assistant and Operating Room Liaison, in health practices in rural North-western Ontario. In addition, the applicant's academic training includes: qualitative data analysis (formal and informal ethnographic methods), in-depth key informant interviewing, direct structured observation, social network examination and the management and analysis of qualitative data. This experience will facilitate the applicant's ability to interview participants efficiently and retrieve reliable results that will support this project. Finally, a medical anthropological approach to this research is necessary, as it employs a significantly sophisticated understanding of culture and its implications when accessing health services; the applicant is currently a graduate student in medical anthropology

6. **Conflict of Interest**

There is no conflict of interest.

7. **Participants**

The research participants of this study will be comprised of two groups: health care professionals (administration/physicians/practitioners) from the Thunder Bay Regional Health Sciences Center (TBRHSC) and private practices, and current medical school students attending the Northern Ontario School of Medicine (NOSM). The location of the research interviews will be at the discretion of the participants (private office/closed room/coffee shop).

The Thunder Bay Regional Health Sciences Centre has an excellent reputation as an acute care centre while combining research, and academic agendas into a comprehensive care strategy for patients and families. This strategy is designed to ensure safe, high quality care for each patient. Due to the culturally diverse service population of Northwestern Ontario, the TBRHSC maintains a strong focus on the accessibility of health services and the provision of patient-centered care. Finally, the TBRHSC maintains one of the busiest emergency departments in Canada, with 95,000 annual visits.

When the Northern Ontario School of Medicine (NOSM) opened in 2005, it became the first medical school in Canada in over 30 years. In addition, NOSM is the only Canadian medical school to be established as a stand-alone, not-for-profit corporation, with its own Board of Directors and corporate by-laws. NOSM was also the first Canadian Medical School established with an accountability mandate. From this mandate, the NOSM community-based Board of Directors issued an extensive reliance on Northern communities to act as hosts for its students - a strategy committed to engaging Northerners in the education process. By the time a MD program is completed, the average NOSM student will have spent nearly forty per cent of their time studying in Aboriginal, small rural and larger urban Northern Ontario communities.

There are two categories of “participants” in this research: health professionals (administrators, physicians, nurses and practitioners), and Medical students. Six participants from each population type will be interviewed.

Health Professionals (6): Administrators will be members of the TBRHSC or private practices, and govern the daily operations of a care facility. Their knowledge of cultural competency will be reflective in their previous training and illustrate its priority in clinical care. All administrators will be adults. Physicians, nurses and practitioners will be members of the Thunder Bay Regional Health Sciences Center (TBRHSC). They will demonstrate a wide variety of experiences with cultural competency. Their varying degrees of exposure to cultural competency will be reflected in their tutelage at medical and nursing school, previous locations of employment, and experience level. All physicians, nurses and practitioners will be adults.

Medical Students (6): Medical school participants will be adult individuals who are currently enrolled in academic studies at the Northern Ontario School of Medicine (NOSM). These participants will provide a current and varied description (depending on academic year) of the ongoing dissemination of cultural competency knowledge in medical school curriculum.

Recruitment of the participants for this study will focus on individual health care practitioners from various institutions. As none of the recruitment or research for this study will be taking place at the institutions of employment for the participants, the researcher will not be seeking the approval of any one institution (TBRHSC, NOSM). Recruitment of administrators, physicians, nurses and practitioners will be conducted by the applicant, and based on personal contacts and referrals through a ‘snowball’ technique. All participants will be given a consent form (see below) and contact information for the applicant.

No previous information for any of the participants will be obtained. The primary mode of communication regarding this research will be oral in order to facilitate anticipated participant variances in language.

There is no perceived potential for coercion. The administration, physicians, nurses, practitioners and students acting in this study will not be paid for their contributions to the research.

- 7a.** The committee will require a sample of all **recruitment material** used.

Letter of Invitation attached (see below).

8. Consent

Medical practitioners from the TBRHSC, NOSM and private practices have agreed to facilitate this research. Multiple meetings between members of the aforementioned agencies, potential participants and the researcher have revealed an expressed interest in this research, due to the quantity and cultural diversity of patients consulted at their

facilities. These meetings were designed to assess the appropriateness and feasibility of conducting such research. In addition, it is likely that these meetings will facilitate participant recruitment in the study.

Participants will be invited to contribute in the research project by letter of invitation (noted above). Participants will be independently interviewed on their experiences during consultations with patients at their respected locations of employment. Participation will involve 1-2 interview sessions (approximately 45 minutes – 60 minutes each).

Participants in this research will be instructed by consent form and applicant that their involvement is not part of their regular health care and/or medical treatment, etc., and is an entirely optional activity. The participant may withdraw and have their information removed from the research at any time, for any reason, and this will not affect the seeking of care, or result in any type of penalty. Participants will also be informed of any new information that may affect decisions to participate. Finally, contributions from participants will be kept confidential, and will not be shared with others outside of the research team (Waldram and Ward).

Data gathered from this research will be used in a graduate thesis and academic conferences. In addition, the results from this research, in report form, will be made available to the participants for potential review. Although the data from this research project will be published and presented at conferences, the data will be reported in aggregate form, so that it will not be possible to identify individuals. Any quotes will have identifying information removed. Moreover, the consent forms will be stored separately from the (materials used), so that it will not be possible to associate a name with any given set of responses.

The benefits of participation in the study are minimal for all acting participants, but are substantial for the future of health care delivery, potentially leading to eliminating unnecessary treatments, and costs, as care is delivered in a more subjective manner. The risks for participants are very minimal.

Participants will indicate that the research project and consent form have been read/read to and explained, that the participant understands them, that the participant has received a copy of the consent and transcript release forms, and agrees to participate and release personal information by signing both documents.

Only adult participants will be approved for this research, and furthermore they must be able to provide consent. Ability to consent will solely be determined by the applicant. Finally, following the interview, and prior to the data being included in the final report, participants will be given the opportunity to review the transcript of their interview, and add to, alter or delete information as they see fit. In addition, participants will be provided with a transcript release form (see below), authorizing the release of their personal accounts to the researchers. No children will participate in this research. Finally, participants will be given a copy of the release form for their own records.

In addition, researchers should consider whether any of the following concerns apply, and address them accordingly:

a) *Alternative consent protocols*

Participant consent will be obtained through signed Consent Forms. In the event that written consent is inappropriate (cultural, literacy, etc.), participants will be verbally instructed of all items incorporated within the Consent Form, by the researcher, to obtain oral consent. As such, Consent Forms will be dated, and signed by the researcher indicating that the Consent Form has been read and explained in full and that the participant understands and consents to be involved in the project.

b) *Recruitment from organizations*

No recruitment will take through any organization.

c) *Children under 18 years of age*

No children will participate in the project.

d) *Participants are in a dependent relationship to the researcher*

There is no dependent relationships between the research and participants.

e) *Participants are not able to give either consent or assent*

Not applicable. There will be no participants who are unable to provide consent.

f) *Participant-Observation research*

There will be no participant observation.

g) *Research involving small groups*

Not applicable. There will be no small group research in this project, only individual interviews.

9. Methods/Procedures

This is an ethnographic-style study that will produce qualitative information in the form of interview transcribed text. Administrators, physicians, nurses, practitioners and students will be interviewed regarding their interpretations of the consultation process, specifically the inclusion of cultural awareness, problems being addressed and the treatments employed. The following interview questions will guide the research:

Administrators:

Administrators will be interviewed privately in a closed office space to eliminate visibility, and maintain confidentiality.

- i. What is your understanding of culture?
- ii. Have you heard of “cultural competency”?
- iii. Have you had any cultural competency training? If so, could you describe this process?

- iv. Do you feel that the consultation process between physicians and patients would benefit from cultural competency training?
- v. Do you believe that cultural competency is useful in a clinical setting? If so could you describe why?
- vi. Can there be cultural competency without formal training? Could you please explain?
- vii. Are there any forms of cultural competency in the health care delivery programs at your current place of employment?
- viii. From your experience, can you recall a time when cultural differences made treating a patient difficult?
- ix. Can you describe your interpretation of illness?
- x. In your opinion, what are the most important elements in treating a patient?

Physicians/Nurses/Practitioners:

Physicians, Nurses and Practitioners will be interviewed privately in a closed office space to eliminate visibility, and maintain confidentiality, or at an off-site local public establishment of their choosing.

- i. What is your understanding of culture?
- ii. Can you describe your knowledge of “cultural competency”?
- iii. Have you had any cultural competency training? If so, could you describe this process?
- iv. Do you feel that the consultation process would benefit from cultural competency training?
- v. Do you believe that cultural competency is useful in a clinical setting? If so could you describe why?
- vi. Do you invoke any form of cultural competency in your health care delivery?
- vii. From your experience, can you recall a time when cultural differences made treating a patient difficult?
- viii. Can you describe your interpretation of illness?
- ix. In your opinion, what are the most important elements in treating a patient?
- x. How do you know if your prescribed treatment is successful?

Medical Students:

Medical students will only be interviewed privately in a closed office space to eliminate visibility and maintain confidentiality, or at an off-site local public establishment of their choosing.

- i. What is your understanding of culture?
- ii. Can you describe your knowledge of “cultural competency”?
- iii. Have you had any cultural competency training at the Northern Ontario School of Medicine? If so, could you describe this process?

- iv. Do you feel that the consultation process would benefit from cultural competency training?
- v. Do you believe that cultural competency is useful in a clinical setting? If so could you describe why?
- vi. Do you invoke any form of cultural competency in your health care delivery?
- vii. From your experience, can you recall a time when cultural differences made treating a patient difficult?
- viii. Can you describe your interpretation of illness?
- ix. In your opinion, what are the most important elements in treating a patient?
- x. How do you know if your prescribed treatment is successful?

All interviews will be digitally recorded and transcribed.

10. Storage of Data

The data collected will consist of: digital recordings of interviews and text transcripts of interviews. While in the field, digital recordings and transcripts will have all identifiers removed; the researcher's computer will be password locked; participants will be given I.D. numbers to be used instead of names, and the code book and field notes will be kept in a locked filing cabinet at the researcher's residence. Following the study, the data will be stored in a locked cabinet in Dr. Jim Waldram's (supervisor) office for a minimum of five years. In five years, if the researcher chooses to destroy the data, it will be destroyed beyond recovery.

11. Dissemination of Results

The data collected will be used primarily in support of a thesis and conference presentations and publications by the applicants. In addition, the results from this research, in report form, will be made available to the participants.

12. Risk, Benefits, and Deception

The benefits of participation in the study are minimal for all acting participants, but are substantial for the future of health care delivery, potentially leading to eliminating unnecessary treatments, and costs, as care is delivered in a more culturally appropriate manner.

The risks for participants are very minimal and there is no deception associated with this project. No invasive or manipulative procedures are used. Participants will not be asked for background medical information and medical files will not be accessed.

To avoid any possible feeling of intimidation and to reduce respondent bias, the participants will be interviewed following after working hours and off-site from their institutions of employment.

- a) Are you planning to study a vulnerable population? This would include, for example, people who are in a state of emotional distress, who are physically ill, who have

recently experienced a traumatic event, or who have been recruited into the study because they have previously experienced a severe emotional trauma, such as abuse.

There is no potential to study people who are considered vulnerable. No invasive or manipulative procedures are used and no background medical questions will be asked. Medical files will not be accessed. Participants will only be spoken with following a regular work shift and off-site from their location of work. It is unlikely that participants will experience conditions of discomfort due to the interview process as the questions, while personal, do not investigate physical or emotional states.

- b) Are you planning to study a captive or dependent population, such as children or prisoners?

There will be no research of a captive or dependent population. Participants will be adults who have consented to participate in the study.

- c) Is there is a institutional/ power relationship between researcher and participant (e.g., employer/employee, teacher/student, counsellor/client)?

There is no power relationship between researcher and participant.

- d) Will it be possible to associate specific information in your data file with specific participants?

The data collected (digital recordings and text transcripts of interviews, and the researcher's observational field notes) will provide no identifiable characteristics. While in the field, digital recordings and transcripts will have all identifiers removed; the researcher's computer will be password locked; participants will be given I.D. numbers to be used instead of names, and the code book and field notes will be kept in a locked filing cabinet at the researchers residence. Following the study, the data will be stored in a locked cabinet in Dr. Jim. Waldram's (supervisor) office for a minimum of five years.

- e) Is there a possibility that third parties may be exposed to loss of confidentiality/ anonymity?

No. There are safeguards in place to eliminate such possibilities (see above).

- f) Are you using audio or videotaping?

Digital audio recordings will be utilized during the interviews with participants. This data will be secured as noted above.

- g) Will participants be actively deceived or misled?

Participants will not be deceived or misled during the course of the research project.

- h) Are the research procedures likely to cause any degree of discomfort, fatigue, or stress?

It is unlikely, that participants will experience conditions of discomfort, fatigue or stress due to the interview process as the questions, while personal, do not investigate physical or emotional states. Interviews should last no more than one hour.

- i) Do you plan to ask participants questions that are personal or sensitive? Are there questions that might be upsetting to the respondent?

The questions asked of participants are quite general, however personal reflection of a recent consultation process will occur. Once again, interview questioning is not designed to be upsetting to the respondent (see above).

- j) Are the procedures likely to induce embarrassment, humiliation, lowered self-esteem, guilt, conflict, anger, distress, or any other negative emotional state?

The interview is unlikely to induce any negative emotional states.

- k) Is there any social risk (e.g., possible loss of status, privacy or reputation)?

There is no social risk. Interviews will be conducted privately in offices and at offsite locations to ensure confidentiality.

- l) Will the research infringe on the rights of participants by, for example, withholding beneficial treatment in control groups, restricting access to education or treatment?

Participants and potential participants will be instructed that this research is not part of their regular health care and/or medical treatment, etc., and is an entirely optional activity. The participant may withdraw and remove their information from the research at any time, for any reason, and this will not affect their seeking of care, or result in any type of penalty. Participants will also be informed of any new information that may affect decisions to participate. As a participant, their contributions will be kept confidential, and will not be shared with others outside of the research team.

- m) Will participants receive compensation of any type? Is the degree of compensation sufficient to act as a coercion to participate?

Participants will not be receiving any form of compensation. However, as a token of appreciation, not intended as inducement, participants can receive a copy of the final report.

- n) Can you think of any other possible harm that participants might experience as a result of participating in this study?

There are no foreseeable issues of harm associated with this study.

13. Confidentiality

With the understanding that provincially run health centers are public areas (though no research will be conducted at these locations), the following steps will be taken to safeguard the identities and data of participants:

- No names will appear on digital recordings files or transcripts.
- Any possible identifying information will be edited out of recordings and transcripts.
- The applicant will utilize a double coding system, in which identification numbers will be assigned to cases which will not be interpretable through cross-reference to a second set of case numbers.
- Data will be reported both in aggregate and also through direct quotation. No identifiable information will be reported..
- All data will be stored in a locked filing cabinet at the applicant's residential office and on password protected computes/hard drives.

Participants in this research will be instructed by consent form and applicant that their involvement is not part of their regular health care and/or medical treatment, etc., and is an entirely optional activity. The participant may withdraw and have their information removed from the research at any time, for any reason, and this will not affect the seeking of care, or result in any type of penalty. Participants will also be informed of any new information that may affect decisions to participate. Finally, contributions from participants will be kept confidential, and will not be shared with others outside of the research team.

Data gathered from this research will be used in a graduate thesis and academic conferences. In addition, the results from this research, in report form, will be made available to the participants for potential review. Although the data from this research project will be published and presented at conferences, the data will be reported in aggregate form, so that it will not be possible to identify individuals and minimize risk to participants. In addition, any signifiers (names, places, ages) will be removed from collected data. Moreover, the consent forms will be stored separately from the (materials used), so that it will not be possible to associate a name with any given set of responses.

14. Data/Transcript Release

Following the interview, and prior to the data being included in the final report, participants will be given the opportunity to review the transcript of their interview, and add to, alter or delete information as they see fit.

d) Included in the consent form are details surrounding the release of data/transcript information. Participants are instructed that direct quotations from the interview will be reported, and that if at any point, they wish to add to, alter or remove the transcript of their interview, they have that opportunity. In addition, participants will be provided with a transcript release form, authorizing the release of their personal account to the research.

No children will participate in this research. Finally, participants will be given a copy of the release form for their own records. This procedure is appropriate for this study as it provides the participant every opportunity to make changes to their interview transcript.

15. Debriefing and feedback

Debriefing will not be necessary as full disclosure of the research will ensure at the time of a consent to participate. Participants will be informed that information and results will be made available to them, should they wish to inform themselves. This information will take the form of a written summary.

16. Required Signatures

Applicant:

Date:

Dan A. Ward

Supervisor:

Date:

James B. Waldram

Department Head:

Date:

Pamela Downe

17. Required Contact Information

Please include name, telephone, fax, email and mailing address of student researcher(s), research supervisor(s), and Department Head.

Student: Dan A. Ward
Tel: (705) 933-4529
adw063@mail.usask.ca

Supervisor: James B. Waldram, Department of Psychology
Tel: (306) 966-6170
Fax: (306) 966-6630
Email: j.waldram@usask.ca

Head: Pamela Downe, Department of Anthropology
Tel: (306) 966-1974
Fax: (306) 966-5640
Email: Pamela.downe@usask.ca

Appendix B: Letter of Invitation

RESEARCH PROJECT ON CULTURAL ISSUES IN TREATMENT

The primary purpose of this **research study** is to explore the extent to which “culture” is important in understanding the experiences of patients who seek treatment. In this study we will be talking to administrators, doctors, nurses, practitioners and students like yourself.

You might be a great participant for this study if you:

- have a cultural understanding of health,
- feel culturally appropriate care is important,
- have patients with difficulties understanding elements of your consultation, or
- feel that addressing specific cultures is important in health care,

Participants will be interviewed on their training and experiences during the consultation process with patients. Participation involves 1-2 interview sessions (approximately 45mins-60mins each).

It is anticipated that this research may provide a direction for changes to culturally competent care.

If you are interested in taking part in this study or learning more about this research, please inquire at the front desk or contact Mr. Dan Ward and more details will be provided.

Dan A. Ward
University of Saskatchewan,
MA Medical Anthropology
Tel: (705) 933-4529
adw063@mail.usask.ca

Appendix C: Participant Consent Form



UNIVERSITY OF
SASKATCHEWAN

Behavioural Research Ethics Board (Beh-REB)

CONSENT FORM

CONSENT FORM

You are invited to participate in a research project entitled *Cultural Competence Training and Implementation: Practitioner and Student Perspectives*.

(Please read this form carefully, and feel free to ask any questions you might have)

Researcher(s):

Student: Dan A. Ward
Tel: (705) 933-4529
adw063@mail.usask.ca

Supervisor: James B. Waldram, Department of Psychology
Tel: (306) 966-6170
Fax: (306) 966-6630
Email: j.waldram@usask.ca

Purpose and Procedure: The purpose of this study is to explore how cultural issues affect clinical care, and if training in cultural competency is useful. Participants will be independently interviewed on their experiences with cultural competency. Participation involves 1-2 interview sessions (approximately 30mins-45mins each). Interviews will take place off-site of the institution. Participants can select a interview location, if so desired.

Data gathered from this research will be used in a graduate thesis and academic conferences. In addition, the results from this research, in report form, will be made available to the participants for potential review. From this review, though highly unlikely, it is possible that participants will be able to attribute specific stories to individual participants.

Although the data from this research project will be published and presented at conferences, the data will be reported in total form, so that it will not be possible to identify any participants.

Potential Benefits: The benefits of participation in the study are minimal for all acting participants. It is hopeful that this research may contribute to recommendations for improving health care delivery in a more appropriate manner.

Potential Risks: The risks for participants are very minimal. Following the interview, and prior to the data being included in the final report, participants will be allowed to review the transcript of their interview, and add to, alter or delete information as they see fit.

There are no invasive or manipulative procedures used in this study. Administration and Care Providers will be interviewed according to their schedules. It is unlikely, that participants will experience conditions of discomfort due to the interview process, as the questions, while personal, do not investigate physical or emotional states.

Storage of Data: A digital recording device will be used during the interview, and participant's

can request that the recording device be turned off at any time. The data collected (digital recordings and written transcripts of interviews, and the researchers notes) will provide no identifiable characteristics. Digital recordings, transcripts and field notes will contain no identifiable characteristics and will be kept in a password locked computers and a locked filing cabinet at the researchers office, for a minimum of five years. In five years from the research date, the researcher can choose to destroy all data, and if so, all collected information will be destroyed beyond recovery.

Confidentiality: To ensure confidentiality, digital recordings and transcripts will have all identifiers removed; the researcher's computer will be password locked; participants will be given I.D. numbers to be used instead of names, and the code book and field notes will be kept in a locked filing cabinet at the researchers residence. Moreover, the consent forms will be stored separately from the (materials used), so that it will not be possible to associate a name with any given set of responses.

Right to Withdraw: Participation in this study is voluntary, and you can answer only those questions that you are comfortable with. There is no guarantee that you will personally benefit from your involvement. The information that is shared will be held in strict confidence and discussed only with the research team. You may withdraw from the research project for any reason, at any time, without penalty of any sort and the decision to do so will not affect your seeking of medical care. If you withdraw from the research project at any time, any data that you have contributed will be destroyed at your request. Your right to withdraw data from the study will apply until May 20th, 2012. After this it is possible that some form of research dissemination will have already occurred and it may not be possible to withdraw your data. Participation in this research is not part of your regular health care and/or medical treatment, etc., and once again is an entirely optional activity. Participants will also be informed of any new information that may affect decisions to participate.

Questions: If you have any questions concerning the research project, please feel free to ask at any point; you are also free to contact the researchers at the numbers provided if you have other questions. This research project has been approved on ethical grounds by the University of Saskatchewan Behavioural Research Ethics Board on April 11th, 2012. Any questions regarding your rights as a participant may be addressed to that committee through the Research Ethics Office at 306-966-2975 or toll free at 888-966-2975.

Follow-Up or Debriefing: All participants (administration, physicians, nurses, researcher and students) will be informed that information and results can be made available to them, should they wish to inform themselves. This information will take the form of a written summary.

Consent to Participate:

(a) Written Consent

“I have read and understood the description provided; I have had an opportunity to ask questions and my/our questions have been answered. I consent to participate in the research project, understanding that I may withdraw my consent at any time. A copy of this Consent Form has been given to me for my records.”

(b) Oral Consent (Researcher ONLY)

“I read and explained this Consent Form to the participant before receiving the participant’s consent, and the participant had knowledge of its contents and appeared to understand it.”

(Name of Participant)

(Date)

(Signature of Participant)

(Signature of Researcher)

Appendix D: Transcript Release Form



**UNIVERSITY OF
SASKATCHEWAN**

Research Ethics Boards (Behavioural and Biomedical)

TRANSCRIPT RELEASE FORM

Transcript Release Form

I, _____, have reviewed the complete transcript of my personal interview in this study, and have been provided with the opportunity to add, alter, and delete information from the transcript as appropriate. I acknowledge that the transcript accurately reflects what I said in my personal interview with Mr. Dan Ward. I hereby authorize the release of this transcript to Mr. Dan Ward to be used in the manner described in the Consent Form. I have received a copy of this Data/Transcript Release Form for my own records.

Name of Participant

Date

Signature of Participant

Signature of Researcher