Commentary: Cultural Effectiveness—Ask and Listen

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The article by Sidelinger et al\(^1\) describes 2 programs for introducing pediatric residents to culturally effective care. Through partnerships with community-based organizations, these programs provide hands-on experiences for residents to learn directly from the community, outside of the academic hospitals in which residents spend most of their time. Residents also read books that highlight how culture interacts with medicine and have discussions lead by community partners or pediatric faculty. Both programs are based on the understanding that the community cannot get the assistance it needs until it is asked what it wants and how it would best receive that assistance. When community groups are involved in developing curricula and programs, they do not feel that residents have been imposed on them. The community and academic center begin to build trust by working together. The onus must be on hospitals to demonstrate that they are worthy of the community’s trust. Immersion experiences such as those described by Sidelinger et al are 1 step toward trustworthiness.

The goal of any cultural-effectiveness training program should be to give residents a general approach to caring for patients and families, not necessarily intimate knowledge about a particular community. Residents’ time in the community is limited, and superficial knowledge about communities can lead to stereotyping, blinding trainees to the heterogeneity within a group or community. A patient or family might self-identify as being part of a cultural, ethnic, racial, regional, or spiritual group, but it does not mean that they subscribe to or follow all (or any) of that group’s beliefs, practices, or tenets. Therefore, community-specific knowledge that residents obtain from immersion experiences will not tell them anything about the particular patient or family in front of them unless the residents also learn a more general approach that includes asking respectful questions and listening carefully to the answers.

Giving residents the clinical skills and tools to ask those respectful questions might start with something similar to questions posed by Kleinman et al\(^2\), which explore a patient’s belief systems and medical explanatory model. Questions such as “What do you think has caused the problem?” and “What do you think your sickness does?” get at the patient’s and family’s worldview. This list of questions, however, often appears daunting and very time-consuming to residents. Here is where it is vital for residents to have the opportunity to watch an experienced clinician model techniques for obtaining culturally or ethnically specific information from a patient or family.

This modeling would be even richer coming from a more diverse hospital faculty. Several recent reports\(^3-6\) address limited faculty diversity in the United States, including a report from the Sullivan Commission, which characterizes the lack of diversity in the physician, nurse, and dentist workforce as a national crisis that will require major changes in the culture of medicine to correct. Black and Latino Americans and American Indian people together account for only 9% of nurses, 6% of physicians, and 5% of dentists nationally while making up 25% of the US population. The number of underrepresented minorities on medical school faculties is only 4.2% nationally.\(^3\) Compelling evidence exists that a more diverse workforce, ie, one that more closely reflects the community in which it provides care, improves patient outcomes and the quality of training and education for all trainees.\(^4,5\) All residents, regardless of their cultural or ethnic identities, benefit from exposure to and working with health care professionals from diverse backgrounds. In a diverse-workforce environment, learning about cultural effectiveness becomes a daily activity.

It is important to note that it is not necessary for health care professionals and patients or families to share cultural or ethnic backgrounds to form and maintain significant, profound, and therapeutic connections with each other. Even with some shared background, there are many other factors that might separate practitioners from the patients and families for whom they provide care, including socioeconomic status, gender, class, education, physical ability, age, and learning style. Thus, although a health care professional might have a superficial similarity with a patient or family and know something about that patient by sharing backgrounds, the practitioner still must ask questions and listen to answers to discover what this particular patient or family is thinking.


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