I once asked an Ojibwa elder what she thought her family members expected from their health care professionals.

“Why, the medical care the doctors thought necessary,” she replied easily.

I probed further: “What else would they expect?”

“Respect as a person,” she answered quickly.

We were quiet for a moment and then she said softly, “No, no they wouldn’t expect that—but they would want it.”
Cultural competence has become a prominent topic in North American health care and medical education literature—one that is on par with issues such as health disparities, quality of care and timely access to care. Culturally competent care comprises elements of the patient-physician interaction that should be taught to, and ultimately expected of, all doctors in Canada. Respect, trust and understanding are the initial outcomes of a culturally competent professional relationship; the ultimate outcome is simple but profound—improved patient care.

Our beliefs, traditions and values can significantly impact not only our perceptions of health and illness, but also our expectations and choices of medical care. A culturally competent physician considers a patient’s cultural background when discussing and providing medical advice and treatment, and communicates effectively to enable patients to understand their treatment options. With this understanding, patients play an active role in their medical care. Culturally competent communication leaves our patients feeling that their concerns were understood, a trusting relationship was formed and, above all, that they were treated with respect. As physicians, we must make multiple communication adjustments each day when interacting with our patients to provide care that is responsive to the diverse cultural backgrounds of patients in our highly multicultural nation.

**The scope of diversity in Canada**

Canada is one of the most culturally diverse nations in the world with 18 per cent of us born on foreign soil—a trend that is increasing according to Statistics Canada’s 2001 census. A growing number of Canadians are from non-European countries, expanding the range of cultures merging into the Canadian landscape. Overall, 13 per cent of Canada’s population consists of visible minorities with some cities such as Toronto and Vancouver having greater than 35 per cent of their populations in this category.

Over three per cent of Canada’s population is Aboriginal and this diverse group has been too often lumped together into an array of culturally insensitive stereotypes. We do not need to look at cultures stemming from immigration to see the challenge we have in understanding one another. Our nation’s Métis, Inuit and multiple First Nations cultures each have their own distinctive histories, challenges, needs and belief systems, often keeping culturally competent care an elusive goal and an ongoing challenge for many physicians today.

**We speak loudest when we don’t say a word**

Non-verbal communication is a key component of culturally competent patient care, yet it is often overlooked even when we are actively struggling to connect with our patients. It is frequently the most challenging form of communication as there are varying cultural expectations regarding non-verbal elements such as eye contact; personal space; body language; sense of time; gender equality; and voice volume, tone or cadence. Take a simple example: in some Aboriginal cultures, a person does not look into another’s eyes. The eyes are the “window to the soul” and eye contact is considered disrespectful; avoiding this violation clearly conveys respect without a word being spoken. In North American culture, however, eye contact conveys interest, concern or honesty. While lack of eye contact from Aboriginal patients may be intended as a sign of utmost respect for their doctors, the physicians may interpret this lack of eye contact as a sign that the patient is untrustworthy or uninterested.

A soft tone of voice and low volume also signal respect, rather than a lack of interest or confidence, from an Aboriginal patient. A similar change in tone and volume by a sensitive, knowledgeable physician can reflect this respect back...
to the patient. Similarly, an Aboriginal patient often will speak slowly and deliberately, perhaps responding to a physician’s question with a story that may seem circuitous but holds within it not just the answer, but a perspective, emotion or message that would otherwise be difficult to share. We physicians with pagers on our hips and busy office schedules value brevity and efficiency, but we must be aware of this gap in communication styles and adjust accordingly—or our names may be forever inscribed in patients’ memories as “the doctor who didn’t care.”

By acknowledging such differences and adjusting our non-verbal communication style appropriately, we can create a comfortable communication space for our Aboriginal patients and a more successful, respectful physician-patient encounter.

Verbal communication
"It does not require many words to speak the truth"

—Chief Joseph (Nez Perce)

Despite the importance of non-verbal communication, we tend to think exclusively of verbal exchanges when evaluating our communication skills. In medical school we are taught what to ask when taking a patient’s medical history. “History of present illness,” “past medical history” and “review of symptoms” quickly become comfortable terms for even the newest medical students. However, what is not taught so clearly (or even taught at all) is how to obtain this vital clinical information from a patient who does not understand our questions or intent because of cultural and language barriers.

Treat the patient, not the illness
Traditional Aboriginal communication is balanced and calls for an equal sharing of information. The Assembly of First Nations’ National Chief, Phil Fontaine, explains that it often helps if physicians ask questions that will allow them to learn about the whole patient rather than just the ailment itself. Physicians could also share “a bit of themselves” to provide a more balanced exchange of information. Most First Nations’ traditional medicine has its roots in their basic philosophy of balance, often symbolized by the medicine wheel. True wellness includes not only the physical, but also the mental, emotional and spiritual elements. However, physicians tend to only ask patients about their “physical element”—their specific clinical concern. The more serious the illness, the more we break away from treating the whole person. Acknowledging these fundamental differences in the philosophy of wellness is a good starting point for physicians to gain the important understanding required in the treatment of First Nations patients.

In addition, equal status among all members of the group is implicit in many First Nations cultures; status is not influenced by titles, education or income, which is a stark contrast to North American culture where such elements dictate power and prestige. Traditions such as the “talking circle,” which gives any individual who holds the talking stick, feather or stone the time and space to speak and be listened to without interruption, are based on this assumed equality. Although it is important for the patients and families to hear their physician’s opinions, it is equally important for the patients and families to share theirs.

Finding the words
A baseline requirement for positive verbal communication is a shared knowledge of the language spoken, and the unfilled need for professional medical translators is a common barrier to effective communication. While using hospital staff or family members to translate medical knowledge and professional opinions may seem like a tempting solution, relying on someone who does not have adequate expertise to translate diagnoses
and other aspects of physician-patient consultations can in fact hinder clear communication and preclude the patient confidentiality that lies at the core of our professional standards. Yet, with over 50 Aboriginal languages in Canada, it remains a constant challenge to ensure medical advice is understood.

Bridging cultural communication gaps can be especially challenging when language barriers hinder important messages. In the article “How clients’ choices influence cancer care in northern Aboriginal communities,” published in Circumpolar Health in 2003, the authors put it simply: “consider, for example, the challenge of discussing with an Oji-Cree patient their pancreatic cancer when there is no word in the Oji-Cree language for pancreas.” The personal topics discussed in the context of medical care can further this challenge as the subjects can be embarrassing, frightening and sometimes culturally taboo.

Merging traditional and modern medicine

“My doctor told me I had cancer and that it was too advanced. I had six months to live, but our Medicine Man gave me herbs and performed healing ceremonies. I went to our sweat lodge. And now, four years later, here I am.”

Why would we not believe this story when we marvel at similar stories heard in our own physicians’ lounges? “It was stage IV cancer. Some wouldn’t have even done the chemo, but we gave therapeutic treatments and it responded. The last CT scan was completely clear!”

Is one story myth and the other reality? Perhaps the first step in bridging a cultural divide is to recognize that there is no dichotomy between such stories. Referring to traditional medicine as “alternative” medicine implies an either/or option.

Why not treat traditional and western medicine as complementary? It is not our role to convince patients that the medicines their people have trusted for hundreds of years are not what they need; we have no basis on which to do so and we likely would not succeed. In addition, if we did, we could be undermining a belief that is paramount in their culture. To deny patients’ trust in their own traditions is to risk creating frustration, distrust or animosity. What we can do is explain clearly and effectively what we recommend and why. We can support our recommendations with the studies and statistics that western medicine endorses. Our knowledge and expertise, communicated in a culturally effective manner, will be evident and help to create the trust and understanding we strive for with all our patients. We can then help patients safely merge their traditional options with our recommended treatments by inquiring about their intended complementary treatments and maintaining an open atmosphere for discussion. It is hard enough for patients to choose a treatment option, but the choice becomes more difficult if it interferes with their cultural beliefs and traditions.

Walk a mile in their moccasins

We must have knowledge of history in order to understand the present. When it comes to First Nations patients and families, the anguish we witness in our offices can stem from more than their medical ailments. Sadness, anger or indifference in our First Nations patient may represent the struggles of generations before them and be linked to a history that has not been resolved. Consider the tarnished history our nation has stamped on generations of
Aboriginal Canadians. When the National Chief, Phil Fontaine, was asked what he thought would most likely bridge the gap between First Nations patients and their health care professionals, his first, most urgent request was, “to know our history—our true history, not what they teach in school.” He went on quickly to mention residential schools, Indian agents and lost generations, as well as how sensitivity and understanding of this history should not be optional. This recommendation that physicians have knowledge of the impact of colonization on the health and well-being of Aboriginal Peoples was formally articulated in the Society of Obstetricians and Gynaecologists of Canada’s (SOGC) policy statement, “A Guide for Health Professionals Working with Aboriginal Peoples: The Sociocultural Context of Aboriginal Peoples in Canada.”

How can we improve our cultural competence in health care?
The first step to improving cultural competence is to recognize what cultures are predominant in the regions we serve and learn more about their histories, values, beliefs and perspectives on health issues. Appropriate adjustments to curricula in medical school, residency and continuing medical education should be made accordingly. Moreover, input from community elders, leaders and patients themselves can be instrumental in obtaining the understanding that leads to cultural competence. Aboriginal leaders would be thrilled with our willingness to learn the history behind their people that will help us to better understand the health problems and communication challenges we experience with our Aboriginal patients.

Another step is to work on developing the general skills, attitude and awareness that culturally competent patient care requires. Being born to or residing within a particular culture does not automatically generate the understanding or adoption of the values or beliefs of that culture. Individual personality, experiences and outside influences can dictate what each patient desires and respects just as much, if not more, than the culture to which they belong. It is imperative that we as physicians avoid generalization and make no assumptions about our patients. Background knowledge of a culture is important, but simply observing and asking questions can clarify uncertainties. Overwhelming as it may seem for physicians to understand the background of the many diverse cultures in our nation, taking small steps toward that understanding through communication and education will start to bridge the cultural gap that has become acceptable in the medical community.

Cultural competence is a necessary currency in managing medical conditions today. Remember my Ojibwa elder’s reply when I asked what her family expected of health care professionals: “respect as a person.” We can do that. We have to.

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