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Culture, Cultural Competence, and Clinical Care

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Abstract

Culture competence is a concept that can be traced back to health care considerations in the 1960s and 1970s, and in particular to nursing education. Critics of the concept have argued that this was not simple a listing of cultural facts, behaviors, and practices, but instead follow a more ethnographic understanding of culture. In this article, I recognize that culture is not simply about the other, but something we all possess, and is also always changing throughout our lives. Understanding and respecting diversity and culture is key to improving services, including lactation support.

Keywords

anthropology, breastfeeding, cultural competence, cultural humility, cultural safety

Background

Cultural competence enables individuals to respect and appreciate the diversity of experiences we all have, and to create an inclusive environment for clinical care. Culture influences us all, and is connected to all aspects of life, including the protection, support, and promotion of breastfeeding. There is evidence that "culturally appropriate interventions can increase breastfeeding rates" (Noble, 2009, p. 221). In lactation clinical services, cultural competence is important to healthcare history taking and assessment skills (International Board of Lactation Consultants Examiners [IBLCE], 2018), in situations where we need not only to respect a client's individuality, but also their cultural background. In order to effectively understand the concept of culture in relation to others, we need also to better understand our own culture, recognizing that we all have a number of cultural frames that are dynamic and always changing. Cultural competence is not about learning many cultural behaviors that are different from our own; instead, it is about being aware that culture is about the way we all make sense of the worlds we live in, and accepting that there is diversity and difference in the world (Davis, 2020).

Pickett (2012), in *Lactation Matters*, an ILCA blog, discusses cultural issues and breastfeeding, offering an interesting story from a Canadian mother (Ruth Kamniter) who moved to Mongolia and who ends her story by saying,

> Probably the most valuable thing about raising my son in Mongolia was that I realized that there are a million different ways to do things, and that I could choose any of them. Throughout my son's breastfeeding career, I struggled with different issues, and picked up and discarded many ideas and practices, in my search to forge my own style. (Kamniter, 2009: 7)

Of particular importance when experiencing other cultures is the recognition that there are different ways of doing things, and that throughout our lives we learn new ways things can or could be done, and that we can also change the way we do things ourselves.

Thinking about culture also means that we can and should engage with anthropology, the discipline that has framed the study of culture, but also has a long history of thinking about breastfeeding. In this brief discussion, I explore the meaning of "cultural competence," a term originally from the United States, which may also have cultural implications, but, significantly, is also linked to thinking about diversity and service provision for minority groups. Based on a conflation of two forms of expert knowledge, those related to health services (competence), and the others linked to diversity and difference (culture), I also discuss how cultural competence has been critically discussed in health services and by anthropologists, leading to expansions of concepts such as "cultural

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safety" and "cultural humility." Reclaiming indigenous frames of knowledge, while taking into consideration the local and the global in relation to equality and diversity, are key to understanding cultural competence, clinical care, and breastfeeding.

Cultural Competence and Beyond

Cultural competence is made up of two terms. Competence implies training of some sort, and hence the original link to training healthcare providers. We all use the term "culture" on a regular basis but may not be actively aware that we are using this term in different ways, based on our own cultural experiences. Many anthropologists feel culture is a problematic concept, but still see the value of incorporating it into our understanding of how people navigate life and living. This is especially true when we are navigating health services. Cultural meaning permeates all aspects of infant feeding, and these are different for everyone. Culture is individualistic, and, at the same time, highly dynamic, and is key to why and how we do things in life.

Cultural competence has been argued to derive from work integrating culture and care from the 1960s and 1970s (Hofling & Leininger, 1960; Leininger, 1970; Ray, 2019). Anthropologists have been critically discussing the concept of culture since the 1950s (Kroeber & Kluckhohn, 1952), often returning to Tylor's original broad 1871 definition: "that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society" (Tylor, 1871: 1), while arguing that it is too broad a concept. Despite these critical and difficult discussions regarding exactly what culture means, it has continued to be considered a useful concept not only in the social sciences, but also increasingly in clinical care.

The specific term "cultural competence" is widely recognized as being first introduced in 1989 by Cross et al., although, as I discuss in a moment, it is rooted much earlier in links between anthropology and health, in particular nursing. In their monograph, Cross et al. (1989) are considered by many to be the first to define the concept of cultural competence, which they say is a "developmental process" to which "professionals, agencies, and systems can strive" (p. v). They write,

> Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations. The word "culture" is used because it implies the integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is used because it implies having the capacity to function effectively. (Cross et al., 1989, p. 13)

Key Messages

- Dealing with diversity and difference should be part of clinical care, indicating the need for service providers to obtain cultural skills or competencies, such as those associated with the discipline of anthropology.
- Cultural competence as a specific term was introduced in 1989, but the roots of this concept in clinical care can be traced back to the 1960s, linked to transcultural nursing education.
- Cultural Safety and Cultural Humility are alternative indigenous clinic expansions that recognize the dynamic nature of Cultural Competence.
- Developing cultural skills leads to Cultural Competence, improving outcomes in clinical care.

Cross et al. (1989) argue that cultural competence can be viewed as part of a continuum from "cultural destructiveness" to "cultural proficiency," with at least six possibilities between these two ends, with cultural competence being one of them. It is, therefore, also part of a system:

> A culturally competent system of care acknowledges and incorporates—at all levels—the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally-unique needs. (Cross et al., 1989, p. 13)

This important early discussion also links cultural competence to thinking about and embracing diversity, and how this can lead to better care. The complexity of this original discussion in practice was not adopted by many services, leading to a number of criticisms of the perspective both from anthropologists and other healthcare perspectives.

More recently, some authors (Ray, 2019) have argued that although they do not use the term cultural competence, the early writings by the nurse Madeleine Leininger and the physician Charles Hofling (Hofling & Leininger, 1960) use the term culture, which they actually talk about in the plural, that is, "cultures," and link this to healthcare service provision, saying that cultures are,

> Complex technics of adaptation to the environment are developed over many generations and, to a large extent, once developed, are not lost. All sorts of technics and customs reside in the culture: the use of fire and the wheel, the wearing of clothing, marriage, religious and educational practices, etc. (Hofling & Leininger, 1960, p. 129)

At the beginning of the 1970s, Leininger (1970) wrote a text linking nursing and anthropology, and then

incorporated this into her larger work, in what became known as "transcultural nursing," which she saw as a direct transfer of anthropological theory into clinical care. At the same time, many anthropologists were also thinking about lactation, and these ideas directly influenced Leininger. Arguably one of the most famous anthropologists of all time, Mead (1930, 1963) had long talked about culture and breastfeeding, and in 1973, she opened the first research center for the cultural study of human lactation with her student Raphael (1966, 1970, 1973; Connell, 1978). Raphael is remembered also for introducing the terms doula (supporting mothers) and matrescence (becoming mothers) to the world in her dissertation (1966) and in her later book (1973). For both Mead and Raphael, understanding cultural difference and lactation were important for both themselves and others.

Recognizing the need to link culture and clinical skills, Arthur Kleinman, who trained as both an anthropologist and a physician, argues that the main problem with the concept of cultural competence is that it is difficult to define, and, for many, it is viewed as "a technical skill for which clinicians can be trained to develop expertise" (Kleinman & Benson, 2006, p. 1673). They argue for a "revised cultural formulation" (Kleinman & Benson, 2006, p. 1673), which includes the need to elicit "illness narratives," something Kleinman (1988) wrote extensively about many years earlier, and which could be seen to be part of history taking and assessment skills in clinical care (IBLCE, 2018). According to Kleinman's (1988) Explanatory Model, the following culturally sensitive questions can be adapted or used by clinicians to have culturally sensitive interactions, for example, when taking a client's history, which could potentially improve outcomes:

> What do you call this problem?
> What do you believe is the cause of this problem?
> What course do you expect it to take? How serious is it?
> What do you think this problem does inside your body?
> How does it affect your body and your mind?
> What do you most fear about this condition?
> What do you most feat about the treatment? (Kleinman, 1988: 304)

By emphasizing the individual nature ("What do you . . .") of these questions, the individual—and not a group, ethnicity, or category—is being explored; therefore, the individual nature of healthcare is supported better.

Within healthcare services, there have also been criticisms of cultural competence, some of which come from often marginalized groups, and therefore follow a more anthropologically informed knowledge production. "Cultural safety" in the 1990s was offered as an alternative framing by Māori nurses in *Aotearoa* (the Māori word for New Zealand; Papp & Ramsden, 1996), and originally defined as, "the effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on own cultural identity and recognizes the impact of the nurses' culture on own nursing practice" (Nursing Council of New Zealand, 1992). Cultural safety argues for the need to incorporate thinking about power relations in health services, and to consider patient's rights, specifically connected with the indigenous Māori peoples of Aotearoa. Recently, the New Zealand government has integrated these considerations into discussions about health equity (Manatū Hauora (Ministry of Health, 2019), and these health inequalities are exacerbated by climate change with direct impacts on infant feeding.

> Similar discussions about inequity arose in the United States around the same time, but the term "cultural humility" was offered instead (Tervalon & Murray-García, 1998). Tervalon and Murray-García (1998) argue that cultural humility is linked to becoming "reflective" lifelong learner practitioners, who recognize power imbalances—thereby calling for mutual respect—understanding that healthcare provision is a dynamic partnership. Perhaps because it is associated with the United States, but also perhaps because it is linked to physicians, cultural humility has gained momentum in recent years (Robinson, et al., 2021), although original conceptions of cultural competency are still being connected as well. In a recent consideration of how unconscious bias can have negative impacts on care, Robinson et al. (2021) discuss the five Rs involved in cultural humility (Reflection, Respect, Regard, Relevance, and Resiliency). Thinking, feeling and doing are all linked to deep understandings of the other and the self, which is a very anthropological way of viewing the world. Cultural humility, Nolan and colleagues argue, "promotes health equity through the lifelong operationalization of cultural competence and sensitivity" (Nolan, et al. 2021, p. 6).

By way of building bridges, Canadian indigenous nurses have connections between cultural safety and cultural humility, suggesting that both are needed for wellbeing (First Nations Health Authority [FNHA], 2021a). Indigenous knowledge has also been key in thinking about the planet's wellbeing, as is evidenced by the title of a pamphlet from the FNHA: *Creating a Climate for Change* (2021b). Another FNHA publication states that maternal milk is "the first traditional food" and it "flows through our ancestors and to our future generations" (FNHA, 2020: 1) and is connected to the wellness of individuals as well as whole communities, and the planet as whole. Respect for equity, diversity, and inclusion are at the heart of these cultural sensitivities towards lactation care and services, improving clinical care and potentially providing better outcomes for everyone.

Conclusion

In my discussion, I offered insights into the practice of cultural competency, and how it was originally developed and evolved, while anthropologists themselves gave advice about how service providers, including lactation support providers, could improve cultural competence in practice. Service

providers, themselves often from indigenous communities from around the world, have offered new terms such as cultural safety and humility, and help to build bridges connecting these culturally informed knowledge frames. It is important to remember that culture is more accurately thought of as plural (cultures) and dynamic, meaning it is always changing for all of us. Cultural meanings and experiences are still key to understanding all aspects of life, by acknowledging major events such as giving birth and feeding our infants. Lactation support providers, by borrowing from the anthropological toolkit (Guest, 2015), can help themselves and their clients by including culture in practice and incorporating the local and the global as one. If we follow what the anthropologist Tett (2021) has recently called Anthro-vision, we will better understand individual difference and diversity, while building better protection, support, and provision for breastfeeding, and, as a result, improving wellbeing for everyone.

Author Contributions

Tanya M Cassidy: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Writing – original draft; Writing – review & editing.

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