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CULTURAL COMPETENCY AND DIABETES. CHALLENGES FOR THE PHYSICIAN-PATIENT COMMUNICATION

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Abstract

Successful diabetes care depends on effective communication between health services providers and patients and their families. The health care provider's cultural competency promotes or discourages the ability to manage and to live well with diabetes. Understanding the broader cultural context in which families are enmeshed can serve as important background data for conducting assessments and planning intervention strategies.

This study intends to reveal the leading questions in physician-patient communication research. The paper uncovers the most important cultural competency principles applied to health literacy in order to improve diabetes control. We envisage, also, the relationship between intercultural elements and physician-patient communication. This paper aims at practitioners and management, serving as a starting point for deepening the understanding of cultural issues involved in the physician-patient communication diabetes care.

This paper uncovers the implications of cultural issues involved in an effective communication between health services providers and patients and their families. The paper, based on cultural clusters, offers cultural competency abilities for practitioners and management in order to improve diabetes control.

Key words: Cultural competency, communication, diabetes care, cultural issues, patient, management.

Introduction

Modern societies have illness-related practices and beliefs. There is a specific medical culture system, analogous to a religious, an economic or a political system. The medical culture determines the ways an individual is recognized to be ill, the ways one presents illness to others, the way illness is dealt with.

This study intends to reveal the leading questions in physician-patient communication research. The paper uncovers the most important cultural competency principles applied to health literacy in order to improve diabetes control. We envisage, also, the relationship between intercultural elements and physician-patient communication. The main questions that should be answered are: "Which are the intercultural communication principles in healthcare?", "What is the relationship between intercultural elements and diabetes care?" and "How to achieve cultural competency abilities for practitioners in order to improve diabetes control?".

Our contribution to the physician-patient communication literature consists in improving the current understanding of cultural competency aspects in diabetes control. We look for a common understanding of cultural issues involved in the physician-patient communication diabetes care. Cultural competency does not focus exclusively on cultural factors, but rather more generally on the behaviours, attitudes and policies that enable effective healthcare in intercultural situations. Moreover, cultural competency is also about how the concept of respect is operationalized to ensure that the cultural diversity, rights, views, values and expectations of diverse patients are respected in the delivery of culturally appropriate diabetes health services.

Intercultural communication principles in healthcare

In the deep topography of social and human space, things like race, gender, technology, politics, economies, and cultural hierarchies complicate both disease and illness. At its full, globally scaled dynamic, diagnosis exists within the broadest context of science, where the politics and power struggle of specific actors create medical definitions that are refined and deployed to achieve certain goals. This space is inhabited by both professionals and patients, both experts and laypersons, consumers and producers. This space is inhabited by both professionals and patients, both experts and laypersons, consumers and producers. So, to arrive at a diagnostic decision depends on the evidentiary technologies available, the authority of both patient and healer, and the ability of patient and healer to communicate effectively. Work toward a diagnosis is uncertain, an approximation (Smith-Morris, 2016).

Comparative studies of the functioning of health-care systems in European Union member countries have shown that, not surprisingly, the level of power distance in a society is also reflected in the relationship between doctors and patients. In countries with larger-power-distance cultures, consultations take less time, and there is less room for unexpected information exchanges. These differences also affect the use of medication. In countries with large-power-distance cultures, doctors more frequently prescribe antibiotics, which are seen as a quick general solution; in these countries antibiotics are also more frequently used in self-medication. These findings are important in view of the danger of germs' becoming resistant to antibiotics if these treatments are used too frequently (Hofstede, Hofstede, & Minkov, 2010).

Our research on risk literacy and medical decision making shows that across different cultures, people often have severe problems grasping a host of concepts that are prerequisites for understanding health-related risk information (i.e., numbers, graphs, and knowledge about basic medical facts). As a consequence, they are prone to errors in risk perception and decision making. Prominent examples of such difficult numerical concepts are the incidence and prevalence of different diseases, risk reductions due to medical screenings and treatments, and risk increases due to side effects of treatments and unhealthy behaviors. In addition, informed medical decision making is heavily reinforced these days by the legal requirement for informed consent in most, if not all countries and critically depends on communication of quantitative medical information. With this challenge, understanding how health-related risk information can be effectively communicated is more essential than ever (Garcia-Retamero & Galesic, 2013).

A particular view of culture masks a whole range of other forces that are also cultural in character: institutional practices, the discursive representations of technology and the politics of access and allocation of healthcare resources. However, the lesson is not to get caught up in working out what culture is and how it ought to be applied, but to show how it emerges as the product of exclusionary technologies – those used to mark out zones of difference. Cultural diversity in organizations can be both an asset and a liability (Kierans, Kingdon & Bell, 2016; Warter & Warter, 2015a).

Ethnic characteristics such as values, beliefs, customs, and family patterns may be used as clues, as a piece of the total information gathered regarding clients with chronic illness. Ethnicity is also a critical variable in how people with diabetes are perceived and treated by their family and how their family, in turn, is viewed by their community at large. Cultural factors mediate ways in which symptoms are identified and interpreted, appropriate modes of expression of pain and discomfort, whether a particular chronic condition is highly stigmatized or accepted, and whether the dependency that accompanies chronic illness is disvalued or considered part of the normal cycle of life. Finally, ethnicity may influence ways in which families interact with health professionals and considerations that practitioners must give for their care to be most effective (Tripp-Reimer, Choi, Kelley, & Enslein, 2001; Mocanu, 2013).

There is widespread agreement that the reasons for inferior health outcomes are complex, involving socioeconomic factors (income, education, occupation), area-based factors (quality of water, sanitation, shelter, transport, nutrition), sociopolitical factors (gender, race, ethnicity), and sociocultural factors (values, rules, beliefs, behaviors). Culture forms part of the multifactorial etiology of disease operating in concert with social, economic, and political factors. At the same time, we want to avoid the situation where cultural explanations can be misused to blame people for their action or inaction. This situation arises when outsiders consider cultural matters to reflect ignorance or irrationality, rather than trying to understand local rationalities in relation to health and sickness (Banwell, Ulijaszek, & Dixon, 2013; Roman et al., 2013).

The differences in norms, language, and thinking patterns can create more uncertainty and greater potential for misunderstanding and conflict. A comparative study of doctor-patient interactions in ten European countries showed that doctors in uncertainty- tolerant countries on average had more eye contact with the patient and paid more attention to rapport building. Doctors in uncertainty-tolerant countries more often send the patient away with a comforting talk, without any prescription. In uncertainty-avoiding cultures, meanwhile, doctors usually prescribe several drugs, and patients expect them to do so. It is said that in France when a village is slowly depopulating, the local pharmacy survives longer than the local pub. This is certainly not the case in (lower UAI) Ireland (Warter & Warter, 2015b; Hofstede et al., 2010).

Part of the challenge of becoming culturally responsive or culturally competent clinicians requires learners to stretch beyond their personal comfort zones and be able to comfortably interact and work with people who are both similar and markedly different (Ring, Nyquist, Mitchell, Flores, & Samaniego, 2008; Roman et al., 2013). Information formats that exploit people’s inherent capacity to recognize relationships in naturally occurring problems (i.e., transparent information formats) can dramatically enhance risk comprehension, communication, and recall and foster better decisions in a wide range of cultures. Transparent information formats can be a starting point for improving risk communication and promoting interdisciplinary research in these domains. Designing good information formats will only be possible if scientists from these areas look beyond the boundaries of their own disciplines and share their ideas and expertise to achieve a common goal: transparent communication of risks across cultures (Garcia-Retamero & Galesic, 2013).

Intercultural elements and diabetes care

If anxiety and stress can affect eating behaviors and weight, then given the relationship between obesity and Type II diabetes, anxiety and stress may be a factor in the onset of Type II diabetes (at least indirectly, if not directly). It is possible that such environmental factors as cultural, social, and/or familial influences on eating behavior may have developed in a way in which an individual had the opportunity to observe, learn, practice, and be reinforced for eating in stressful situations, provided the availability of food (Pine, 1988).

Cultural Competence has been viewed as the panacea to build the capacity of health services and those who work for the health service to deliver safe and effective care to those who are marginalised within the broader society. In its many iterations, it has not always been successful in attaining the outcome of providing equitable care to those in need. Evidence explored suggests that there is more to why Cultural Competence has not been a truly triumphant strategy. It is not about the patient's ethnicity, poverty, or linguistic difference or gender. Cultural differences are examined to have a broader reach than race and ethnicity. The social cultural mosaic is also examined, and these determinants impacting on healthcare access and outcomes are extensive (Jongen, McCalman, Bainbridge, & Clifford, 2018).

Understanding your history and family dynamics is an essential component of becoming a compassionate, culturally responsive practitioner. Understanding your colleagues' cultural and family backgrounds can help build positive and empathic teams (Ring et al., 2008). Particular expertise is demanded from mental health professionals dealing with migrants and refugees. Ways of dealing with health concerns and disability differ considerably between collectivist and individualist societies. The high level of acculturative stress in migrants puts them at risk for mental health disorders, and methods of psychiatric treatment developed for host country patients may not work with migrants, again for cultural reasons. Most countries with a large migrant population such as Australia recognize transcultural psychiatry (and transcultural clinical psychology) as a special field. Some psychiatrists and psychologists specialize in the treatment of political refugees suffering from the aftereffects of war or torture (Hofstede et al., 2010).

Diabetes mellitus, as a component of the metabolic syndrome may be considered a paradigm of chronic non-communicable diseases. Psychological, social and cultural factors have an intimate role in the course of managing the disease, and in some ways may have a role in the cause of the disease. Generic psychological instruments of health must be supplemented by disease-specific measures such as quality of life, well being, adjustment to diabetes, barriers to care and integration of diabetes. A comprehensive biopsychosocial model for living effectively with diabetes must be generated, fine-tuned and finally implemented (Sridhar & Madhu, 2002).

Diabetes is a long-term, serious and challenging metabolic condition and a major health issue worldwide. Although diabetes affects every society, some populations are particularly susceptible but also lack understanding of the condition. Evidence suggests that, where members of susceptible populations are in the minority, they may not receive equitable diabetes care. This is attributed to a mixture of cultural factors and some service providers' lack of cultural competence. Healthcare practices should be designed to ensure that health workers take into account the individual patient's background and deliver tailored services (Zeh, Sandhu, Cannaby, & Sturt, 2014).

The cultural consensus analysis found that patients shared a single cultural belief model about the diabetes prevention, causation, symptoms, complications, and treatment. The participants with higher cultural knowledge scores were younger at the age of type 2 diabetes diagnosis suggests that over time they accumulated more cultural knowledge about the disease than their counterparts with lower cultural knowledge scores. These findings support the cultural schema theory argument that it is through collective memory and social framework that cultural belief models are constructed and shared in communities (Smith, 2011).

According to economic theory, consumers require this information to compare alternatives for markets to function efficiently. Accessible information about the risks and benefits of health options presumably accomplishes this by making qualities of health care (otherwise unobservable to the individual) more transparent. As a result, everyone involved in a transaction – policy makers, healthcare providers, and patients – has access to essential information and can use this information in making choices. Providing more information and more access to information about choice options is intended to empower patients and other decision makers and to motivate efficient markets. Thus, the increasing emphasis of public policy in health domains has been to provide information and choice in order to tap into the power of informed consumers and improve health outcomes and the efficacy of health care (Garcia-Retamero & Galesic, 2013).

Distrust itself contributes to racial disparity in health outcomes. Trust in a physician has been shown to increase the likelihood of compliance with a medical regimen, despite cost pressures and other influences. Patients with lower levels of trust were less likely to comply with a medical regimen for diabetes. Furthermore, the quality of patient–physician communication may be lower when Caucasian physicians treat African American patients. The physicians were more verbally dominant and less engaged in patient-centered communications when dealing with African Americans. In another study, African Americans were less trusting of Caucasians regarding medical research participation (Eiser & Ellis, 2007).

The need to consider cultural factors in the care of people with diabetes has been identified for several decades. Yet we are not close to effectively addressing this issue in practice. A key reason is that the patient's culture is often seen as a problem, causing a barrier to care. We "problematize" the patient and the culture. Further, by thinking that culture is what other people have, we objectify culture and distance ourselves from it and from ethnic patients. Marginalization of culture and of ethnic patients minimizes our responsibility to address culture in practice; the problem is situated in our client's culture. We would make greater progress inverting this "problem" and viewing the barriers as resulting not from patients' cultures but from the values and beliefs inherent in biomedical culture, insufficient professional training, and care system barriers. We have failed to adequately address our responsibilities as practitioners for having competent knowledge and skill sets and using them effectively when working with ethnic clients (Tripp-Reimer et al., 2001).

Barriers to insulin therapy include socioeconomic issues (eg, cost, insurance status), language difficulties, poor health literacy, and cultural beliefs that impact the patient-provider relationship and negatively affect patients' perceptions of diabetes and insulin. Healthcare providers can help overcome these issues and improve patient-provider communication by practicing culturally competent care. Patient education and enhanced patient-provider communication are necessary to optimize treatment adherence and outcomes. In particular, providing culturally competent care may result in greater patient satisfaction, understanding, and compliance with insulin therapy (Campos, 2007).

Presenting a health/mental health education program in a culturally relevant way would help the diabetic patient to better understand his/her health and mental health circumstances and to comply with needed lifestyle (behavioral) changes. Individual and family counseling and psychotherapy could also be made more useful by incorporating the consideration of cultural variables. Introducing information on· stress management techniques, for example, by using language/expressions easily understood and accepted by the people should increase the probability of success of a treatment program. Also, an important factor is to include members of the community as part of the intervention team whenever possible. The reason for this is that indigenous team members should already be accepted members of the community and therefore should also have established credibility within the community. Given this credibility, they should be able to more easily introduce intervention strategies with greater acceptance on the part of community members (Pine, 1988).

Transparent information formats can be a starting point for improving risk communication and promoting interdisciplinary research in these domains. Designing good information formats will only be possible if scientists from these areas look beyond the boundaries of their own disciplines and share their ideas and expertise to achieve a common goal: transparent communication of risks across cultures (Garcia-Retamero & Galesic, 2013).

Conclusion

The need to consider cultural factors in the physician-patient communication has been identified for several decades. Cultural competency is a key strategy for reducing inequalities in healthcare access and the quality and effectiveness of diabetes care received. It works to enhance the capacity and ability of healthcare systems, management and practitioners to provide more responsive healthcare to diverse cultural populations. From a human rights perspective, cultural competency is also about how the concept of respect is operationalised to ensure that the cultural diversity, beliefs, values and expectations of diverse groups are respected in the delivery of culturally appropriate healthcare.

This paper presented the most important intercultural aspects in physician-patient communication. We have envisaged, also, the relationship between cultural competency principles and diabetes control. We have sought to summarize the findings from the healthcare research and to suggest new research directions. We have attempted to answer the questions: “Which are the intercultural communication principles in healthcare?”, “What is the relationship between intercultural elements and diabetes care?” and “How to achieve cultural competency abilities for practitioners in order to improve diabetes control?”.

The relationship between successful diabetes care and effective communication is a key topic in literature in last decades. Despite the advances, important research gaps and paradoxes remain. Do our findings point to a need for healthcare scholars to deepen the research? Our answer is a clear yes. We believe that the key success factors in physician-patient communication remain less well understood. The picture emerging from our findings shows a lack of consensus about the intercultural aspects in diabetes care. On the same time, the common underlying belief is that cultural competency abilities have a strong influence on diabetes control.

Future studies might explore the broader cultural context specific for different patients. To summarize, future research should concentrate on effective communication between health services providers and patients and on the relation between cultural and non-cultural aspects in diabetes care. We consider our paper contributes to a deeper understanding about the cultural competency issues by revealing some inconsistencies in specialized literature and presenting different interpretations expressed by scholars and practitioners.

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