Cultural Competency in Short-Term Medical Missions

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Cultural competency as popularized by Cross et al's seminal work in 1989 refers to 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 professions to work effectively in cross-cultural situations."[1] Campinha-Bacote further developed a culturally competent model of care that comprises five core components: (1) cultural awareness – developing sensitivity and self-awareness of one's biases, (2) cultural knowledge – understanding of cross-cultural worldviews and beliefs, (3) cultural skill – being adept at making cultural assessments, (4) cultural encounter – real-world practice and exposure to different cultures, and (5) cultural desire – commitment and motivation to improve one's cultural competency.[2] Since then, over the past two decades, there has been extensive literature surrounding this concept, with more than 5000 search results in PubMed identified using the search terms cultural competence or cultural competency (title/abstract). For instance, recent articles have described cultural competency in relation to broader social justice endeavors, where there is honest introspection on discriminatory behaviors, bias, privileges, power dynamics, and resultant health inequalities across cultures.[3]

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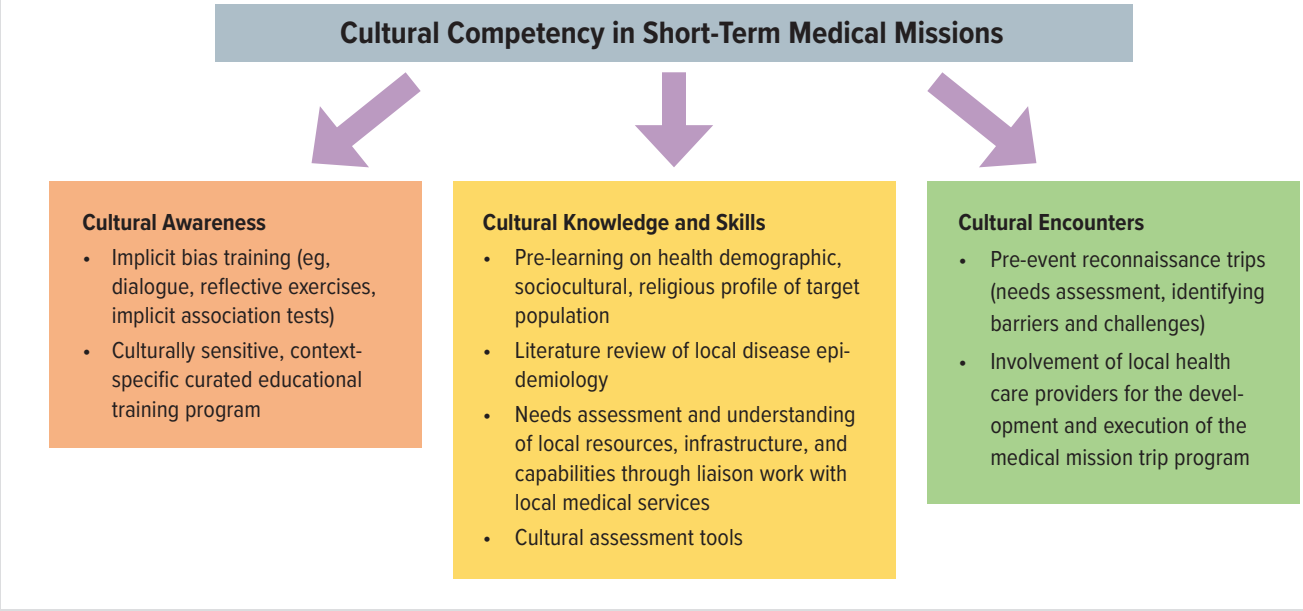
In recent years, there has been a surge in interest among members of the medical community – particularly in more affluent nations – to embark on "short-term medical missions" (STMMs) to rural, developing countries and cities for the purpose of medical volunteerism (eg, conduct health screening, diagnose and provide medical treatment, perform surgical procedures), cross-cultural exchanges, and experiential learning. The duration of these STMMs can range from 1 day to 8 weeks.[4] While on the surface, STMMs appear to be highly beneficial to both the providers and recipients of medical care, training, medical infrastructure and resources,[5] there are also glaring pitfalls related to poor quality of clinical care (eg, use of substandard medical treatments, offering services that do not address real clinical needs, unethical practices, medical errors, lack of continuity of care), cultural insensitivities, and secondary, self-serving/political agendas that have been highlighted.[5-7] In particular, most criticisms against these types of health volunteerism are directed at incompetence in dealing with cross-cultural clinical care, such as disrespect/ignorance toward local customs and practices, arrogance or presumed superiority of Western medicine/practices, undermining of local medical services, unfamiliarity with local disease prevalence and rare conditions, and inadvertent perpetuation of colonial/neo-colonial relationships.[7] However, the idea of formalizing cultural competency training for medical personnel planning to embark on STMMs has hitherto only been discussed in a handful of articles.[8,9]

Therefore, herein I relate the concept of "cultural competency" in medical training/practice to STMMs by discussing multipronged practical strategies contingent to the traditional cultural competency model to improve the standards of cross-cultural clinical care provided by medical trainees and clinicians embarking on STMMs.

Figure. Cultural Competency in Short-Term Medical Missions



Adapted from Campinha-Bacote Model.[2]

Multipronged Approach to Promote Cultural Competency in STMMs

The following practical strategies are adapted from the traditional Campinha-Bacote culture competency model[2] to improve the cultural competency of medical volunteers engaging in STMMs through appropriate training and preparation in cultural awareness, knowledge, skills, and actual cross-cultural exchanges (Figure).

Cultural awareness in STMMs reflects the ability of the medical provider to accurately recognize and self-reflect on personal biases/stereotypes/assumptions towards their patients. In general, biases can be both explicit or implicit, depending on whether one is conscious about the existence of personal attitudes and stereotypes towards others. Anti-bias clinical training, including simulation experience, debriefing, group discussions, and dialogue, has been reported to be a useful pedagogical modality to improve clinicians' ability to engage and address bias and racism in clinical settings.[10] When adapted for volunteer training prior to STMMs, it is important to elicit possible areas of implicit bias towards patients given what is known about their sociocultural backgrounds.[11] This can be achieved through formal tests, such as implicit association tests, or dialogue or reflective exercises to prompt the participant to consider how their management of patients would be different if they were of a different sociodemographic status.[11] In 2014, Steinke et al reported that a 2-hour culturally sensitive education program specially curated for medical providers traveling to Haiti for STMM was able to improve cultural competency levels among the volunteers.[9]

Additionally, cultural knowledge and assessment in STMM involves attaining a holistic understanding of the health demographic and sociocultural/religious profile of the beneficiary patient population that may influence health behaviors and treatment considerations. Prior to any STMM trips, it is important for medical providers to partner closely with local health services/authorities for needs assessment of the patients, obtain health demographic information, and ascertain local resources, infrastructures, and capabilities in order to optimize the utility of the medical missions program and ensure continuity of care in the longer term.[12] In addition, it would be useful for medical volunteers to review existing literature on the typical disease profile of patients based on sociodemographic data and geographical location.[13] Ultimately, the local disease epidemiology, needs assessment, and health/volunteer resources available will affect the appropriate health services, including screening, investigations, and treatment that should be offered during the STMM.

Another fundamental aspect of cultural knowledge pertains to understanding specific health behaviors, concerns, and practices that may be influenced by sociocultural and religious beliefs. For example, in end-of-life care, patients in Asian societies generally place greater value on collective decision-making (ie, familial involvement) in terms of extent of medical treatment and life-sustaining interventions versus those in Western countries where patient autonomy is prioritized.[14] Moreover, "collusion" (ie, family hiding unfavorable or terminal diagnosis from older persons) still remains a common and accepted practice in many Asian cultures.[15,16]

In addition, health behaviors and treatment considerations may be influenced by local cultural and religious practices. For example, Muslim patients who observe Ramadan will need specific adjustments for diabetic medications, including insulin injections, and education on dietary habits, precautions, and glucose monitoring during the fasting period.[17] Vaccine hesitancy is another issue related to religious beliefs and practices, where there

is perceived moral or ethical impermissibility of receiving vaccinations or specific vaccine components.[18] For instance, religious objections to vaccinations may include objections to vaccine components (eg, presence of nonhalal ingredients), production methods (eg, use of aborted fetal cells in vaccine creation), or the concept of trying to "artificially" prevent illness through man-made medicines.[18] It is important, therefore, for medical volunteers to be privy to and respectful of a patient's wishes and preferences, which may be guided by deeply held religious and cultural beliefs. At the same time, where appropriate, partnership with local religious/community leaders to educate and correct misperceptions of religious permissibility of certain medical interventions can be highly effective.[19]

Finally, cultural encounters with the target patient population prior to formal STMMs are important to improve cross-cultural health communications and interactions through real-world experiential learning. This usually can be achieved through pre-event reconnaissance trips where medical providers travel to the host country to carry out a smaller scale volunteer event. Such pilot outreach events are useful not only for direct needs assessment, but also to identify local/cultural barriers and challenges to health interventions prior to the actual STMM trip. In addition, there is also great utility in involving local health care providers in the missions' program to incorporate greater diversity of medical views and ensure that health interventions proposed are suitable and impactful for the target patient population.

Conclusion

Medical volunteerism in the form of STMMs to developing countries will continue to be prevalent in our increasingly globalized world. Those who wish to engage in such volunteer work must be committed to enhancing their cultural competencies to provide high-value and culturally appropriate clinical care.

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