Practicing Cultural Sensitivity Locally and Globally

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"Don't come near me! You don't know anything about me!" shouted the tiny woman (I'll call her Mary). It was my first day as an intern at Anishnawbe Health Centre, a CCNM student clinic serving members of Toronto's First Nations community. I don't recall what I said or did to trigger her, but she reacted immediately and strongly to my presence. The supervisor knew Mary well, and calmed her with smudging and body work as I stood frozen and out of my league. I was acutely aware that while I had done nothing "wrong", my simple presence had stirred up strong feelings for this woman based almost solely – I imagined – on our different cultural backgrounds.

It was a startling plunge into the necessity of cultural sensitivity. Cultural sensitivity in health care can be defined as attention to the cultural forces and factors that influence an individual's experience and perception of illness and recovery. The culturally-learned responses which impact an individual's personality and perception of the world play an important role in making sense of health and disease. Being familiar with cultural or collective trauma (such as the multi-generational impact of the residential school system in Canada), perceptions of health and disease (which may include the role of spirituality and religion in many cultures), and typical determinants of health (such as the parasitic infections typical in a shanty-town, or food insecurity issues among street-involved youth) helps a practitioner to create a more meaningful assessment and management plan. It also moves us closer to dissolving power differentials and building trusting therapeutic relationships.

Over the following four months I carefully created space for Mary, and we allowed trust to build. She remained my patient while I was a student, and continued attending the clinic while I was a resident supervisor. Mary became one of my favourite people at Anishnawbe, and as I learned about and experienced Indigenous healing practices from her and other patients, I felt more able to facilitate learning and connection to flow in both directions. Mary played a key role in helping us establish a loose herb dispensary at Anishnawbe while I was a supervisor, an important development since teas are more congruent with First Nations practices than bottles or tinctures. A dream catcher that Mary made for me over a decade ago still hangs in my home, reminding me frequently of her early lessons.

In 2007 I travelled to Kenya to volunteer with a natural health organization. The clinic where I was placed was staffed by local Kenyans who practiced predominantly homeopathy, although we did have lab facilities and access to some herbs. I had a translator (critical for developing cultural competence!) and was practicing constitutional homeopathy; in contrast, the local practitioners focused almost solely on the presenting physical concern, taking brief cases and prescribing acutely. My translator told me that I was being told things that local practitioners may not have been, that the local people tended to be closed about sharing

personal information with the Kenyan homeopaths because of concerns about gossip. It was assumed that I would hold their confidence. In addition to this being an interesting reflection, I noted how beautifully and inherently homeopathy fosters cultural sensitivity. The intake process relies on curiosity and inquiry, asking about meaning-making and perception. My intakes gathered information about individual cultural experience that enhanced my management plans with culturally relevant lifestyle recommendations.

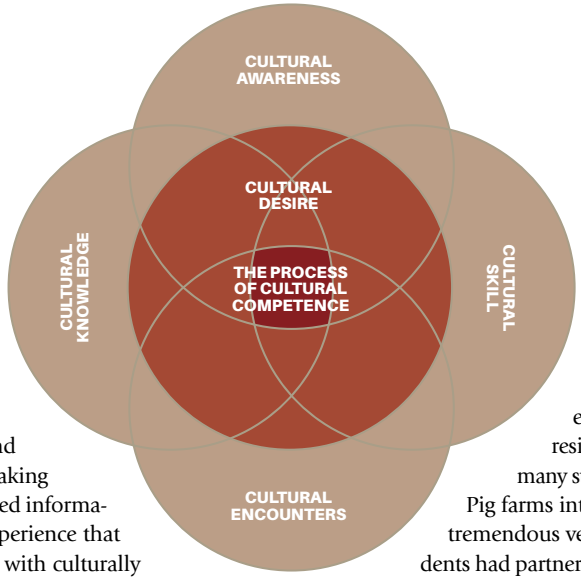

Figure 1: A Model of Cultural Competence

Cultural sensitivity is an ongoing, dynamic process. There is far more variation within certain populations than between them, and there is a direct relationship between a practitioner's ability to provide culturally responsive health care[1] and their efficacy in practice. Josepha Campinha-Bacote provides an excellent model of cultural competence in health care, illustrating that it is the intersection of cultural knowledge, awareness, skill, encounters and desire that depicts the true process of developing cultural competence (*Figure 1*). This involves exploring one's biases and assumptions about others (awareness); honing the skills of mindfulness is a valuable way of attending to this in particular. Cultural competence involves seeking information about an individual's beliefs about the world, as well as how disease prevalence, epidemiology and treatment efficacy in particular populations affects the person under care (knowledge). Cultural competence depends on the ability to ask pertinent questions and perform objective assessments relevant to the individual's cultural background (skill). The process of actively engaging with individuals from varied cultural backgrounds (encounters) provides the practitioner with opportunities to develop awareness, skill and knowledge. Most critically, the practitioner must authentically *want* to develop cultural competence (desire), which requires attributes of compassion and humility.

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In 2014 I was invited to travel with 15 CCNM students to a *pueblos nuevos*, or "new town" outside Lima, Peru. The community was created by the migration into Lima in the 1980s and 90s due to the threat of terrorist activity in rural Peru. Over 20,000 people live within about 25 square km. The community was built on the side of the hills, developed over time with whatever materials were available. Most residents have access to electricity, but many still lack running water or plumbing. Pig farms intermingle with homes, acting as a tremendous vector for infection. One of the students had partnered with a local non-governmental organization to hold a pop-up naturopathic clinic. Knowing the conditions in which our future patients lived allowed us to start to build cultural knowledge.

The students solicited donations and carried suitcases full of natural health products down to Lima. We transformed a small shack into our clinic. The space was tricky to navigate, and we ended up doing physical exams out in the open (although I did do some more sensitive exams in a private space we found off to the side). We started to see patterns and themes arise in the concerns that were presented to us, and we became more efficient at asking the relevant questions and performing relevant exams (cultural skill). As the only ND supervisor for 15 students (we had a chiropractor with us as well), and with only two translators, it was chaotic, and I certainly felt a bit helpless. However, people valued our listening and the space we created for them to express their concerns. They were appreciative that we cared enough to come at all, and some folks attended the clinic multiple times simply because they enjoyed the experience of being touched and listened to. I have never seen people so eager to have a pelvic or digital rectal exam performed, simply because they have never had anyone take the time to care for their health concerns in that way. They certainly offered us a plethora of opportunities for cultural encounters!

The students quickly realized that the products they had brought with them were not a sustainable solution for this population. We sat as a group and reflected on the assumptions that we may have made prior to arriving, and checked in with our intentions (cultural awareness). By asking questions, and brainstorming with community members, we visited the local market and purchased herbs and honey to give our patients, along with education on how to best use them. We encouraged them to share knowledge with their families and communities, knowing these local resources were available right down the road. We taught the basics of nutrition, exercise, mindfulness, herbal medicine and hydrotherapy to individuals and groups, intending to introduce some cohesion to a community that despite being densely


Medical Brigade
2014


Medical
2014

populated we learned is often fraught with social isolation. We provided Diva Cups to all women of reproductive age, having good laughs as we mimed their use and involved our male translators. In a community with no waste removal infrastructure, this intervention alone could have a tremendous impact. The desire of the group to make a difference in a culturally meaningful way was palpable and admirable.

To truly have an impact on marginalized communities, however, it is important to have at least a semi-permanent presence so that follow-up and long-term strategies are possible. There are a number of models that do a beautiful job of sensitively and sustainably engaging with communities, expressing curiosity about and helping to collaboratively address their unique needs. Although I am grateful to have had these international adventures, I struggle with the privilege inherent in global medical volunteer work. The money spent to fly 15 people to Lima could have been used to address a number of health factors in that environment, including equipping local practitioners to provide the kind of culturally-relevant care needed by the community. The project in Kenya has done a nice job of this, having established staff for both permanent and regular mobile clinics. The organization has grown to include a school to teach Kenyans the skills of homeopathy and other complementary therapies that they can take back to their villages, an initiative that both provides a skill set and livelihood to some, and a source of much needed health care to their communities. While cultural discord may still exist between individuals from within the same community, similarities in ethnicity, language and lifestyle may enable more culturally sensitive and effective care.

In the fall of 2015, I began volunteering in the health clinic at the Evergreen Centre for Street-Involved Youth in downtown Toronto. I have discovered many opportunities here for developing cultural competence and sensitivity. The youth that attend Evergreen have diverse ethnic and community backgrounds, socioeconomic circumstances, sexual orientation, degrees of drug use; even identifying as "street-involved" shapes their cultural experience. Non-judgment and awareness of these dynamics, as well as curiosity about how they affect the experience of the individual are critical to my ability to be of service at Evergreen. Skills of active, intentional, and compassionate listening are central. I am aware that I can't fix everything in the often traumatic lives of these young people, but I can help the person in front of me feel heard/seen/valued right now by being open and responsive to the experiences that they share – or choose not to share. Over the past two years I have built trust with a group of "regulars", and have become more comfortable holding them accountable, both of us seeing the benefit that comes from our work together. We keep it simple; I lay it out, provide rationale, and let them make the decision that works for them. Lending my ear and listening to the needs of my patients helps me avoid making assumptions. Exploring each youth's unique life circumstances (Do they live in a shelter? Do they work or receive disability or unemployment benefits? What access do they have to healthy food? Are they safe in their relationship?) enables me to negotiate a feasible plan with them. Certainly themes have emerged, but I am always conscious to not make assumptions about what might work for them or what they are willing to do.

Health care interventions need to be relevant to the individual and their community. Familiarity with the traditional diet allowed me to more competently provide nutritional counselling to the anemic mothers in Kenya. Using local plants resonated with the people of San Juan de Miraflores in Peru, and was far more appropriate for their social and financial realities than an encapsulated natural health product. Being open to integrating Indigenous healing practices at Anishnawbe was critical to maintaining therapeutic relationships. Extending compassion to the pregnant Evergreen patient as we engage in harm reduction around smoking and alcohol use motivates her to continue to seek prenatal care. However, one need not travel to developing countries, nor seek out work with marginalized communities at home in order to develop skills of cultural competence. The core naturopathic principle of treating the individual requires practitioners to be curious and open with *all* patients. Assumptions can never be made about a person's past trauma, financial status, dietary habits, religious or spiritual beliefs, or even ethnic descent. No matter which population we work with, principles of cultural sensitivity prompt us to be attentive to the unique factors and forces that affect the experience of illness and recovery for the individual.

KEY PRINCIPLES OF CULTURAL SENSITIVITY FOR NDs

- Practice humility
- Foster mindfulness of personal biases and assumptions
- Manifest non-judgmental curiosity
- Treat the individual
- Engage each patient in creating a culturally-relevant plan

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