Chapter 7
What is Next?

Abstract The chapter discusses the possible real application of the Arab American cultural beliefs model of diabetes and how medical professionals can use it to gain a better understanding of patients' cultural knowledge. This chapter argues that the current culturally competent healthcare services provided in hospitals—if any—have missing links. Using cultural beliefs models of illness built using cultural consensus models as part of cultural competence techniques can enhance medical professionals' understanding of their patients' cultures.

Keywords Cultural beliefs · Cultural competence

This book aimed to build the cultural belief model of diabetes among Arab American Muslims in Dearborn, Michigan. Results showed that Arab American Muslims share an overall cultural model of diabetes that does not contradict with the biomedical knowledge. Although they share an overall model of diabetes, the data also showed some variation in the level of knowledge based on age, education level, and generation.

In addition, this research presented data related to different aspects of Arab American Muslims and diabetes, such the role of family in providing care, fasting in Ramadan, and diabetes healthcare access. This research presents evidence that although Arab Americans Muslims established a long-lasting community in Dearborn, MI, they still face major difficulties related to receiving healthcare especially for chronic illnesses such as diabetes. So, what can be done next?

Statistics are not available regarding how many Arabic-speaking doctors are available in Dearborn, MI, but by just walking down the city's streets, it is impossible to deny the number of hospitals and clinics that Arab Americans operate. Although hospitals and clinics have an apparent number of doctors and medical staff who are Arabs (they have the same or similar culture as their patients and they speak Arabic to some extent), it is still apparent, as shown in Chaps. 4 and 5, there are difficulties in obtaining access. This happens mainly due to the large number of Arabs in Dearborn, or due to the unavailability of some of the doctors' specializations. Additionally, the data shown in Chap. 4 evidence a lack of information provided to patients during the

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doctor visits. In addition, in some cases, the data also suggested the care provided to Arab American Muslims was challenged by patients' cultural beliefs that minimized the importance of receiving mental health services.

Is Dearborn unique? Do the issues found among Arab American Muslims not exist among other immigrant populations? The answer is no. As shown in Chap. 1, many immigrant populations in the Unites States and in other parts of the world share similar difficulties and suffer from high prevalence of different illnesses compared to the general populations. So, how can this be fixed?

For such a complex issue, the solution is not easy. One of the core solutions is to provide an effective culturally competent healthcare services to immigrants. In this chapter, I review the main principles of providing culturally competent healthcare services and I challenge the missing links on different elements used in those strategies, showing how this study can help fill the gaps.

7.1 Culturally Competent Healthcare System

Cultural competency is defined as, "a set of congruent behaviors, attitudes, and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations" (Brach & Fraser, 2002; Brach & Fraserirector, 2000; Cross, 1989, p. 182). For some, cultural competency can be seen as being "culturally sensitive" or being "culturally aware," but it is more than that. Cultural competency "includes not only possession of cultural knowledge and respect for different cultural perspectives but also having skills and being able to use them effectively in cross-cultural situations" (Brach & Fraserirector, 2000, p. 183).

Having culturally competent healthcare system is not an option, it is a must at this point; estimates in the United States show that by the year of 2050, 47% of the population will be minorities (Brach & Fraserirector, 2000). This trend is not any different cross the globe; the United Nations stated that "the world is on the move, and the number of international migrants today is higher than ever before." (Handtke et al., 2019, p. 2).

Previous efforts in providing culturally competent healthcare mainly focused on providing language interpretation services. White et al. (2019) conducted a study in Australia, where the population is very diverse and consists of people who migrated from 190 countries and have up to 300 different ancestries, that focused on studying the effect of using interpreters in doctor–patient communication for people who have limited English proficiency. The study results showed that using interpreters was not very effective, mainly due to the lack of collaboration and the interpreter reliance on family members to do the translations.

Pocock et al.'s (2020) study focused on the difficulties migrants and refugees face in accessing health services in Thailand and Malaysia from the stakeholders' perspective. The study focused on the lack of using interpreters for the immigrants and refugees in the hospitals to make the health services accessible to them. The

study showed the health stakeholders in Malaysia had a lack of understanding on the need and benefit of using interpreters in medical settings; for these stakeholders, "Malay was perceived to be an easy language that migrants could learn quickly" (Pocock et al., 2020, p. 1). The study showed that "Health workers in Malaysia used strategies including Google Translate and hand gestures to communicate, while migrant patients were encouraged to bring friends to act as informal interpreters during consultations" (Pocock et al., 2020, pp. 1–2). In Thailand, the situation was different, "formal interpreters, known as Migrant Health Workers (MHW), could be hired in public facilities, as well as Migrant Health Volunteers (MHV) who provide basic health education in communities." (Pocock et al., 2020, p. 1).

Brach and Fraser (2002) study in the United States showed that in every five Americans, one has difficulties in communication with their healthcare provider. The study also showed that 27% of Asian Americans and 33% of Hispanics have issues related to communication. The study suggested that people who have language proficiency issues are more likely to have "fewer physician visits and receive fewer preventive services, even after controlling for such factors as literacy, health status, health insurance, regular source of care, and economic indicators" (2002, p. 16). The study emphasized that reducing disparities would require "surmounting not only these linguistic barriers but broader cultural ones as well" (Brach & Fraser, 2002, p. 16).

7.2 Cultural Competence Techniques in Healthcare System

Providing culturally competent healthcare services goes beyond providing language interrupters. Efforts had been made in developing cultural competence techniques that can be used to provide better healthcare services across cultures by decreasing disparities in healthcare. Brach and Fraserirector (2000) study composed a set of culturally competent techniques that have been discussed in the literature, including the following techniques: using interpreter services, recruiting staff who have a similar culture and language to the different cultures represented in the population, cultural competency training for staff to increase cultural knowledge and awareness, collaborating with a traditional healer to increase patient adherence, hiring community health workers, involving the patient's family, creating culturally competent health promotional programs, and additional accommodations such as related to the clinic's location and the working hours. Other studies have also shown similar strategies (Anderson et al., 2003; Kagawa-Singer & Chung, 1994; Weech-Maldonado et al., 2012).

In addition, Campinha-Bacote's (2002) model of cultural competence was developed to encompass many important aspects to navigate patients from different cultural backgrounds. The model sees "cultural competence as the ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client" (Campinha-Bacote, 2002, p. 181). This

dynamic model "requires healthcare providers to see themselves as becoming culturally competent rather than already being culturally competent" (Campinha-Bacote, 2002, p. 181). Having cultural competence in the Campinha-Bacote's model means becoming involved in the "integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire" (Campinha-Bacote, 2002, p. 181). Cultural awareness means accepting the idea that people from different backgrounds will have different thoughts and behaviors as well as not have an ethnocentric position regarding others. Furthermore, cultural knowledge means having educated knowledge about people's cultural beliefs; this education "must focus on the integration of three specific issues: health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy" (Campinha-Bacote, 2002, p. 182). Cultural skill is "the ability to collect relevant cultural data" (Campinha-Bacote, 2002, p. 182). Health professionals should conduct a cultural assessment where they obtain information from their patients regarding their beliefs, values, and cultural practices to provide them with the best medical interventions. Additionally, cultural encounters entail putting healthcare professionals in direct contact with people from different cultural backgrounds. In this model, such interactions would help in minimize wrong assumption and stereotypes and it would promote a better understanding of other people's cultures. Lastly, cultural desire focuses on building the "motivation of the healthcare provider to want to, rather than have to, engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and familiar with cultural encounters" (Campinha-Bacote, 2002, p. 182).

Why would providing culturally competent healthcare services make a difference? Studies have shown that people who receive care that is more customized toward understanding their language, cultural knowledge, and behaviors will more likely to have successful diagnoses, treatments, and adherence to treatment plans (Kagawa-Singer & Chung, 1994). In addition, studies have found that "differences between patients and providers will lead to diagnostic errors; missed opportunities for screening; failure to take into account differing responses to medication" (Brach & Fraser, 2002, p. 16). Furthermore, studies have shown that culturally competent healthcare services provide healthcare professionals the opportunity of having a better understanding of people from across cultures, and to manage their behavior inside and outside of the hospital setting. Culturally competent service can go as far as understanding the traditional medicine patients take and the possible harm it could cause, as well as helping to direct patients to traditional healers that the medical provider trusts to aid in the healing processes (Brach & Fraserirector, 2000).

Having a culturally competent healthcare system is not an easy task. Studies have shown that there are many barriers that prevent applying such techniques. The first barrier is related to a lack of resources regarding providing training to the staff and martials to the patients (White et al., 2019); studies have proposed different training programs that can extend between 3 and 6 months to establish the necessary cultural knowledge (Kagawa-Singer & Chung, 1994). These programs have shown to be difficult to accomplish mainly due to financial capacities. Furthermore, the second and most important barrier is the actual realization of the importance and benefits of cultural competency (Weech-Maldonado et al., 2012).

7.3 How Can This Study Help?

Cultural knowledge is one of the core aspects of all cultural competence techniques and models used in healthcare discussed in this chapter. It is impossible to create a culturally competent healthcare system without knowing the culture of the people who are seeking healthcare. Having the cultural knowledge in small countries where few ethnic groups exist is possible, but in countries such as the United States, it is almost impossible to follow the cultural competence techniques as detailed in this chapter. Conducting a cultural assessment per Campinha-Bacote's model of cultural competence—in each patient level—is more likely to hinder the process and will return the system to the limitations and challenges discussed above.

This study suggests utilizing the studies on cultural beliefs of illness conducted by using cultural consensus models to fill the cultural knowledge gaps in the cultural competency strategies. The model has been used across cultures and tested to be effective in creating cultural models of different illnesses. The data collected to create the cultural beliefs model of illnesses produced two main beneficial outputs that can be utilized in cultural competency strategies in healthcare: (1) a set of questions that elicited the cultural beliefs related to the illness and (2) people's overall cultural beliefs answer key to those question, which represent their cultural belief related to each item. To explain the ways in which those outputs can be used, I will use the Arab American cultural belief model of diabetes collected in this research.

First, as shown in Chap. 6, the Arab American diabetes culture belief model contains 52 true/false statements. The statement measures the knowledge related to the cause of diabetes, symptoms of diabetes, treatments of diabetes, fasting in Ramadan, fears of having diabetes, the belief of the evil eye and its effect on diabetes, depression and diabetes, and many others. Those statements have been tested and shown to elicit the cultural beliefs of diabetes among the study population. This means that those statements are appropriate ones to ask patients to answer in a hospital setting, where the questions will aid healthcare professionals to build a clear understanding of the patient's cultural knowledge at each level and provide better healthcare services.

The 52 statements can be used as one set, or they can be used within categories for a faster assessment by healthcare professionals. Therefore, I divided the true/false statements into nine categories (Appendix D):

1. Diabetes and diet, including 6 statements.
2. Diabetes, weight, and physical activities, including 5 statements.
3. Diabetes and fasting in Ramadan, including 4 statements.
4. Diabetes and age, including 5 statements.
5. Diabetes and mental health, including 4 statements.
6. Diabetes and comorbidities, including 7 statements.
7. Diabetes treatment and cure, including 4 statements.
8. Diabetes other causes, including 4 statements.
9. Diabetes effect on the body, including 15 statements.

Health professionals can identify the categories they can use depending on their patient's health condition. For example, if the patient is obese, then the category "diabetes, weight, and physical activities" that contain five questions can be the section on which they focus.

Second, health professionals can use—as a guide—people's overall cultural beliefs key answers (in Chap. 6) to quickly and efficiently build their cultural knowledge related to diabetes by reading only 52 statements (in my research case and around 60 in most cultural consensus models). For example, if the cultural consensus model for the common illness in each culture group within the population is built, it will be easy and more time and cost efficient for health professionals to build their "cultural knowledge."

This solution does not dismiss the other important aspects of cultural competence techniques and models followed in healthcare systems, but it provides a different outlook that requires an interdisciplinary approach to find a solution that can increase the benefits and decrease the challenges and difficulties related to the cultural knowledge of illnesses.

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