Component 2/Unit 1a

Audio Transcript

Slide 1

Welcome. This is the first of two lectures which serve as an introduction to the subject of studying the culture of healthcare and healthcare professionals. It is meant as an introductory unit for a full course on the culture of healthcare covering the people who work in healthcare, the settings in which health care is delivered, the practices and processes of healthcare delivery, some of the professional values, beliefs, and ethics which drive that behavior, and how health information technologies interact with health care professionals in their work. In this first lecture we discuss what we mean by the word “culture” when we talk about healthcare and healthcare professionals. In a second lecture we will discuss why this is important and how we can learn more about it.

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But first let’s define some terms. We talk a lot about health care, healthcare professionals, health information technology-but what do we mean by these term? Well first let’s define disease and illness. Kleinman, In a often cited 1978 article emphasized the distinction between disease and illness. According to Kleinman, when we talk about “disease” we are referring to malfunction or maladaptation of biologic or physiologic processes. This is the traditional focus of physicians when they diagnose and treat disease. But Kleinman emphasizes the importance of “illness” referring to the individual experience of the person who is suffering, their personal, interpersonal, and cultural reactions to disease or discomfort. While disease is determined mainly by biologic and physiologic processes, illness is shaped by cultural factors that govern perception, labeling, explanation, and valuation of the experience. To truly take care of patients requires that health professionals take into account not only the manifestations and treatment of disease but also the patient’s experience of illness in a social and cultural context.

We generally think of health as referring to the absence of disease, a state of complete wellness. But in reality, this is not exactly the case: health is relative. Most people, in fact, experience mild symptoms of one sort or another fairly frequently-this is according to national surveys of “healthy” people. The anthropologist Catherine Bateson points out that health is essentially an artifact of culture, that is to say the relatively long life expectancy and good health that most of us enjoy in modern societies is a relatively new phenomenon and is an artifact of our cultural practices and technologies.

It is also important to understand the difference in healthcare between acute illness and chronic illness. With an acute illness most of us expect that our symptoms will be short-lived and that eventually we will be restored to our previous “normal” health. Examples are things like a common cold, a mild infection, or a simple fracture. On the other hand, with chronic conditions such as high blood pressure or diabetes we expect the condition will last indefinitely. In these situations the goal cannot be to restore “normal” health, rather the goal of patient and clinician alike is to maintain the highest level of function and the lowest degree of symptoms that can be obtained. Problems can arise when we confuse these, for example when a person with a chronic illness thinks of it as an acute illness and expects to be cured and restored back to their normal state. Part of the management process in these situations is to help a person change their thinking and revise their expectations. For many people with chronic conditions such as diabetes or high blood pressure or asthma, health means things are pretty stable, symptoms are not too troublesome, and the person is able to get on with their life and function normally, even if this requires medication.

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Now that we understand a little more about health, disease, and illness, we can think about what we mean by healthcare. When we look at health in the broadest sense, it is a product of broader social and environmental factors, rather than just the healthcare system. Think of the effect of food, sanitation, and housing and how these have impacted our life expectancy and quality of life in the last century. So health is not just the result of healthcare or healthcare system but rather health is the product of broader cultural and social factors.

Furthermore, if we think of healthcare as actions which are principally and explicitly directed at maintaining or restoring health, then it’s still true that most healthcare happened outside the health care system: actions taken by the patient by family members by caregivers constitute between 70 and 90% of the healthcare that people receive [Kleinman 1978]. Hence, most illness episodes never enter the professional or folk domains. For health informatics professionals one implication of this fact is that health information technologies need to reach beyond the conventional healthcare system and health professionals to patients and families if they are to reach their full potential.

Finally we can think of the healthcare system as a collection of structures and actions directed at delivering healthcare.

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This slide illustrates what we've been talking about. The chart shows United States mortality data for the period 1900 to 1963 for diseases including measles, scarlet fever, typhoid, whooping cough, and diphtheria. In modern times these are all illnesses for which we have specific vaccines or medications to prevent or treat them. However if you look at the graph most of the improvement in mortality for these diseases happened before our modern treatments were available. Consider typhoid fever, it appears as a very dark blue line in the chart: today we treat this disease with antibiotics and can prevent it with an oral vaccine, but antibiotics only became available in the mid-20th century and as you can see from the chart typhoid fever mortality declined about tenfold before antibiotics were ever available. The improvements were mainly due to improvements in sanitation, water supply, and housing. Even today most of the deaths in persons who get treated are in those who are malnourished or otherwise in a weakened state. Similarly mortality from measles had fallen substantially before measles vaccine became available in the 1960s, mortality from scarlet fever had fallen dramatically before antibiotics became available in midcentury.

The point is, broad social and cultural factors such as improved sanitation, improved nutrition, reduced overcrowding, were the major contributors to reducing mortality due to these serious infectious diseases. Modern treatments delivered through the health care system have continued to improve things, most of what we call “health” in terms of our longer life expectancy and better quality of life is the result of other factors.

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This graphic makes a somewhat similar point about the care of chronic conditions. There is no question that the care of chronic conditions depends on the existence of modern healthcare technologies: insulin and other medications for diabetes, antihypertensive medications for blood pressure, surgical or other interventions for hardening of the arteries. However our contemporary understanding of how persons with chronic conditions can achieve the best social and clinical outcomes is based on some variant of the chronic care model articulated by Wagner in 1998. In this model the existence of treatments is important, but to take best advantage of them requires coordinated action that incorporates community-based resources and policies, organized and accessible healthcare services, support for individual self-management, information systems and decision support to assist clinicians and patients-all of these working together to produce productive interactions between an informed and active patient in a prepared and proactive practice team. You can see that this chronic care model requires much much more than a simple prescription or treatment based on an individual clinician-patient interaction. The graphic helps us remember once again that health is not solely the product of the healthcare system but the result of broader community and social factors brought to bear on individual conditions. It also reminds us that health information technology can facilitate many actions and interactions in the management of chronic diseases, not simply office-based episodes between clinician and patient.

: Adapted from Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? *Effect Clin Pract.1998;1:2-4. Available at: www.improvingchroniccare.org/change/ model/components.html. Used with permission.*

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Finally we need to come up with some kind of definition of “culture.” We will refine our thinking about the concept of culture in a subsequent lecture, but for now we can use the definition provided by the office of minority health in the Department of Health and Human Services. According to their definition “culture refers to integrated patterns of human behavior that include the language, thought, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.” This is pretty much the conventional and historic definition that until recently most people have worked with.

Office of Minority Health, U.S. Department of Health and Human Services. Teaching Cultural Competence in Health Care: A Review of Current Concepts, Policies, and Practices. Washington, DC: U.S. Department of Health and Human Services; 2002.

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Another useful definition is this one from the Medical Subject Headings index of the National Library of Medicine. According to this definition “culture” is “a collective expression for all behavior patterns acquired and socially transmitted through symbols. Culture includes customs, traditions, and language.” Both these definitions help us think about what we must pay attention to if we are to study and understand “healthcare culture.”

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So if we adopt those definitions to the healthcare system we come up with these definitions of “the culture of healthcare”.

Using the Department of Health and Human Services definition, it would be “patterns of human behavior that include that language thoughts communications actions customs believes values and institutions of the healthcare system”

Using the National Library of Medicine definition, it would be “behavior patterns in the healthcare system which are acquired and socially transmitted including customs traditions and language.”

So this would mean not only the customs traditions and language of doctors, nurses, and therapists but also those of patients, and families, and the many other individuals who work within the many settings of our health care system.

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Here are some photographs which illustrate what we’re talking about. All of these were taken by researchers studying the information behavior of healthcare professionals in typical healthcare settings.

At top left is a critical care nurse working with a three ring binder paper based medical chart, a labeled bottle of some kind of IV medication, a large spreadsheet like flow sheet of patient data, and a small yellow blank sheet of paper for personal notes. She appears to be using all these information objects at the same time.

At top right is a primary care doctor using a mouse to navigate an electronic medical record on an exam room computer while in her lap is a partly unfolded paper-based medical record-you can see that her fingers are inserted at various places in the paper record acting as some kind of bookmarks perhaps to help her keep her place.

At bottom right are 3 stacks of patients’ records in old paper-based format: one stack is about 6 inches high another about 12 inches high and the third could be 18 inches high. Large rubber bands hold together the green folders full of patient information. You can tell at a glance simply by the thickness of these records that the patients are likely to have a large and complex medical history.

Finally at bottom left is a photograph from an intensive care unit: in the foreground are two physicians and in the background are several nurses, all of them looking down toward some kind of record on the counter while around them are numerous computers. What you can’t tell from the still photograph is the significant level of background noise and the constant motion of the people working in this setting.

These are just some simple examples of the sorts of observations we can make in the field and then inquire about to learn more about the language, behaviors, traditions, and customs of people who work in the health care system.

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A brief survey of what is retrieved when searching Google, Google Scholar, and the National Library of Medicine's MEDLINE database using the search terms “culture of healthcare” returns mainly four basic themes.First Is the culture of patients. There is a great deal of discussion having to do with the cultural diversity of patients cared for in the healthcare system, and the need to take into account the ethnic, national, racial, and religious considerations when providing their healthcare.Second Is the culture of the healthcare workforce. There is discussion of workplace diversity and the need to collaborate effectively with others of diverse national, ethnic, and religious backgrounds.Third is the culture of organizations, including discussion of safety culture, organizational culture, a culture of innovation, measuring culture, and the like.Fourth is the culture of professions, including the professional culture of nurses, physicians, surgeons, traditional and alternative healers, and the like

Google "culture of health care" 75,300,000

Google Scholar "culture of health care" 2,740,000

Medline "culture [MeSH] + allied health [MeSHs] , + nurses [MeSH], + Physicians [MeSH]

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When we talk about the culture of patients, most of the contemporary literature discusses either problems with the inequities in health care that is received by persons of other cultures or the need to understand and adjust to the beliefs and values of specific cultures who encounter the health care system.

Inequities in healthcare are the result not only of social economic factors which make healthcare less accessible, but also the result of differences in language, and the concepts and models of illness. Individuals dealing with our health care system who come from another culture and speak another language have a potential problem of understanding that reaches deeper than just language. In many cases their concepts of illness and the cause of diseases are fundamentally different, so the translation of language alone is not sufficient. These differences can mean that clinicians may not understand the patient and the patient may not understand the clinician, with the result that the appropriateness or effectiveness of care may be threatened.

Much is being written of late about cultural competence and the need for culturally sensitive care. Large organizations such as healthcare systems must train their workforce in order to deliver appropriate and culturally sensitive care to all who present themselves. Modern urban hospitals with great cultural diversity of cities are not the only institutions that must address these issues-many small or critical access hospitals and small clinics in rural areas are similarly likely to encounter significant cultural diversity in their patient populations and workforce populations, although the resources available to address these may be much less.

There are many categories of these differences and cultural variation that can lead to problems of effective communication and appropriate care: some are based on geography, such as Southeast Asia and or African-American; some are based on religious differences such as the Hmong or Islam; on differences of language such as Spanish speaking (including geographic variations in Spanish), or Telegu; make or cultural differences such as the Romany (Gypsy) people; and there are other special groups whose beliefs and values must be considered, such as “ street culture,” adolescent culture, and the like.

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Each of the groups that we have mentioned may have specific beliefs, values, or practices that must be understood when they encounter our healthcare system if we are to deliver effective healthcare. We refer to this as “cultural competence.” This refers to an awareness of and respect for cultural differences. It's especially important in this regard to avoid cultural stereotypes that may or may not apply to a given individual and not to assume that because a person belongs to a particular cultural group that they uniformly share and adhere to some stereotype about that groups beliefs. The bottom line is each person has to be approached as an individual: there is no cookie-cutter approach. Some of the issues that need to be considered include things like traditional beliefs about transfusions or vaccines, modesty issues when conducting a physical exam.

We can adopt this same notion of cultural competence to our dealings with other groups in the healthcare system. When we think about the healthcare workforce it is easy to bring with us stereotypes about different health professionals and their behaviors.

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A third team one finds in surveying healthcare deals with the culture of the healthcare workforce. This includes issues such as cultural diversity of work groups such as nursing, issues relating to be culture of physicians, especially gender, race and ethnicity, the cultural diversity arises increasing numbers of international medical graduates trained elsewhere in the world who come to the United States to practice, and the impact of the culture of these health professionals on patient care. In this brief survey there is not time to discuss all of these issues though many of them may become apparent or important as our study of the culture of healthcare continues in other units.

One area that is receiving increasing attention with the current emphasis on medical errors and patient safety is the concept of “just culture”.

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This concept of “just culture” is more easily understood when contrasted with the “blame culture” that sometimes exists in organizations and can interfere with organizational learning and improvement. What we refer to as the blame culture is characterized by high degree of organizational rigidity, by an emphasis on strict compliance with existing practices. A blame culture can easily fall unintentionally into an organization is overly rigid and rule oriented and when there is a focus on assigning blame to individuals for system failures. The result for members of such organizations is fear of punishment, a tendency to avoid risk and to distrust. The predominant response to error or near misses becomes silence, because workers are afraid to come forward.

Contrast this with the so-called “just culture”. This is characterized by organizational learning, by an environment in which members believe it is okay to question existing practices, where management expresses an openness to worker input. Such environments have an overall commitment to quality. Ideally this will lead to uninhibited reporting of problems, to extensive information sharing about problems, and to organizational response that follow up with remediation directed not at removing offending individuals but rather improving processes or execution through staff training and the like.

In healthcare a “just culture” means that healthcare workers believe they are safe to report problems in question practices, then they are invested in quality improvement.

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A third common theme in the literature on culture and healthcare is concerned with the culture of organizations. Much is being written about desirable properties in organizations such as a culture of innovation or a culture of health, as an employee wellness. In health-care settings organizational culture is often concerned with maintaining a culture of privacy with regard to patient health information, a culture of cost-effectiveness, and a culture of safety. This interest in organizational culture has led to a great deal of research on understanding and measuring culture in particular measuring for the presence of a safety culture and understanding the process of culture change, which has obvious relevance to the introduction of major disruptive changes such as new health information technology.

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Safety culture has received a great deal of attention, as it relates so strongly to not only work force safety (such as fewer needle sticks and other on-the-job injuries), but also because it is so important for patient safety. This slide lists some features of a safety culture in an organization. First safety culture is a concept defined at the group level, referring to shared values among all members of the group. Second safety culture is concerned with formal safety issues in the organization, including its management and supervisory systems. Third safety culture emphasizes the contribution from everyone at every level of the organization. Fourth safety culture has an impact on members' behavior at work, and it is usually reflected in a relationship between reward systems and safety performance. Safety culture, as we discussed in a previous slide is reflected in an organization's willingness to develop and learn from errors, incidents, and accidents. Finally safety culture when present should be relatively enduring, stable, and resistant to change.

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In healthcare evidence suggests that a climate of safety exists when many elements are working together: first a management commitment to safety. Second explicit safety practices and behaviors in the organization. Third safety knowledge and training programs among the membership. Fourth safety communication. Fifth safety equipment and supplies. These factors are indicators that the climate of safety exists, and working together can improve patient safety.

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We now turn to the fourth major theme in literature on culture of healthcare, health professional culture. This refers to the beliefs, values and practices of the professions themselves. Much of this literature discusses comparisons of western biomedicine or allopathic medicine to other traditions such as osteopathic medicine, as well as to complementary and alternative medicines such as traditional Chinese medicine and acupuncture, naturopathic , or homeopathic practice. These healthcare practice traditions differ not only in the treatments and interventions they provide, but in the underlying belief systems about the causes and consequences of illness on which those treatments are based. Also prominent in the literature on healthcare culture are discussions of the cultures which are specific to individual professions such as nursing culture or physician culture. Nursing may be characterized, for example, as a holistic and caring profession. Physicians may be characterized as being focused on diseases, expressing a benign paternalism, and placing great importance on autonomy. Closer examination reveals that the culture of health professionals is often more fine-grained than that, with differences between the culture of surgical practice compared to medical practice or differences among the distinct cultures of critical care units, operating rooms, and emergency rooms. The closer we look at the “culture of healthcare” the more cultures we find are operative.

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In fact, of course, the culture of biomedicine includes more than just professional cultures of nurses, physicians, and other health professionals. Modern healthcare settings also include the relatively distinct cultures of management, business, IT, and so forth. We can get some sense that differences exist between these interacting cultures from their language. For example, consider the words used to refer to the individuals that these groups serve: from the business point of view they are “customers,” from the IT point of view they are “users,” from the librarian's point of view they are “patrons,” to counselors and therapists they may be considered “clients,” while to most doctors and many nurses they are referred to as “patients.” Each of these terms may be used for the same individual when interacting with different parts of the healthcare system, and the terms imply differences in underlying assumptions about their relationship

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To summarize, based on this brief survey of contemporary literature about the culture of healthcare, we can make the following observations:

First most of this literature is about “other” cultures, that is, one culture describing another. Less often is it about any particular culture describing itself. This is consistent with the notion that one’s culture is transparent, that is the culture you don’t notice is your own. We’ll talk more about that in the second lecture of his unit.

Second, this brief survey shows us that there are an enormous number of resources available to learn more about these various cultures of healthcare which are easily found on the Internet.

Third, these discussions bring up the question of acculturation. We usually think about acculturation with respect to an individual moving from one culture to another and adopting or adapting to the language, believes, and practices of that culture. This happens for example when a person moves from the United States to another country or vice versa. We can also think about acculturation with respect to individuals who move from outside the health care system into the health care system and must adopt or adapt to the beliefs and practices and language of the healthcare system. This happens of course when IT professionals or others move from outside the health care system and must become acculturated to it.

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To summarize the main points of this lecture:

First culture as it is used in relation to health care has many meanings that are relevant to health care and health information technology.

Second health care takes place in a complex mix of cultures: professional, organizational, and so forth.

Third culture is not apparent from within-it is taken for granted by its members, though differences may be obvious to outsiders.

Fourth we can work more effectively when we are aware of these differences. Cultural competence can be applied not only to the interaction of health professionals with their patients, but also to the interactions between IT professionals and the healthcare system.

It becomes evident that that one job of biomedical informatics professionals is to bridge these cultures and translate across the boundaries. We can do this by learning more about the healthcare culture, which is the subject of the second lecture in this introduction to the healthcare culture.