



Cultural Pointers for Healthcare Providers



Introduction

This point-of-care tool contains easily accessible, practice-oriented, basic information geared at assisting healthcare providers involved in direct patient care to better understand their culturally diverse patients and to effectively manage cross-cultural communication issues that commonly arise during the clinical encounter. The tool will enhance providers' skills to deliver quality care to culturally diverse populations. Since this resource provides only key pointers, providers may want to seek other resources for more comprehensive information on this topic.

Table of Contents

1	Important Information	2
2	Implications for Healthcare Providers	5
3	Examining Personal Stereotypes, Biases, and Assumptions	9
4	Providing Care to Members of Diverse Populations: Key Issues	13
5	Cultural Values Across Cultural Groups	16
6	Key Cultural Norms of Selected Diverse Groups	18
7	Communicating With Culturally Diverse Patients	20
8	Difficult Cross-Cultural Communication Situations	22
9	Avoiding Cultural Conflict in the Clinical Setting	24
10	End-of-Life Concerns	26
11	Toward Achieving Effective Cross-Cultural Communication.....	30
12	References	33

Useful Definitions and Implications

Culture	<p><i>Definition:</i> Cultures are systems of beliefs, values, and lifestyles that are developed within geographic areas. As systems, they are dynamic, responsive, and coherent.¹</p> <p><i>Implication:</i> Culture impacts patients' responses to medical and preventive interventions as well as how physicians deliver services.²</p>
Provider Cultural Competence	<p><i>Definition:</i> Having knowledge, awareness, and respect for other cultures; the ability of professionals to establish effective interpersonal relationships that overcome cultural differences.^{3,4}</p> <p><i>Implication:</i> Providers who integrate their culture, patients' cultures, and the healthcare organization's culture into the clinical encounter create effective cross-cultural interactions. Such interactions are culturally competent encounters.¹</p>
Racial and Ethnic Healthcare Disparities	<p><i>Definition:</i> Differences in the quality of care received by minorities and non-minorities even though they have equal access to care. That is, they have similar health insurance and the same access to a provider, and there are no differences between the 2 groups regarding their preferences and need for treatment.⁵</p> <p><i>Implication:</i> Research shows that racial and ethnic minorities tend to receive lower quality of healthcare than whites, even when individuals have the same health insurance and access to care as non-minority individuals.⁵</p>
Stereotyping	<p><i>Definition:</i> Mistakenly assuming that all members of a given culture are alike.⁴</p> <p><i>Implication:</i> Providers may unconsciously use stereotypes when trying to understand their patients.⁶</p>
Generalizations	<p><i>Definition:</i> Awareness of cultural norms shared by many members of given groups.⁴</p> <p><i>Implication:</i> Generalizations can enhance provider cultural awareness; they do not preclude considering the patient's individual characteristics such as education, nationality, faith, and acculturation.⁴</p>

Selected Relevant Demographic Data

Ethnic/racial composition of US population	Based on 2005 census data: Latinos: 42.7 million Blacks: 39.7 million Asians: 14.4 million American Indians and Alaskan Natives: 4.5 million Native Hawaiians and other Pacific Islanders: 990,000 Non-Latino whites: 198.4 million ⁷
US minority population	98 million or one third of the nation's total 296.4 million (for 2005) ⁷
Foreign-born population	11.7% of US population (March 2003) ⁸
Projected minority population by 2050	49.9% of US population (2004 projection to 2050) ⁹
Individuals living in the US who speak a language other than English at home	47 million in 2000 ¹⁰
Persons with disabilities	An estimated 18% of the US population (51.2 million individuals) have some level of disability (2002 report) ¹¹
Lesbian, Gay, Bisexual, Transgendered (LGBT) population	594,000 households had partners of the same sex, according to the 2000 census ¹²
US physicians by race and ethnicity (2004)	47.8% white, 2.3% black, 3.2% Latino, 8.3% Asian, 0.06% American Native/Alaskan Native, 2.3% other, 36% unknown ¹³
US nurses by race and ethnicity (2004)	88.4% white, non-Latino; 4.6% black/African American, non-Latino; 3.3% Asian or Pacific Islander, non-Latino; 1.8% Latino; 0.4% American Indian/Alaskan Native; 1.5% two or more racial backgrounds ¹⁴
PharmD degrees conferred (2003–2004)	60.9% white; 8.7% black; 4.4% Latino; 0.6% American Indian; 20.4% Asian American; 2.4% foreign nonpermanent residents ¹⁵

Reported Ethnic and Racial Healthcare Disparities

Compared with white patients, members of ethnic minorities have been reported to be less likely to receive needed services, such as clinically necessary procedures, even after correcting for access-related factors such as insurance status.⁵

African Americans and Latinos have been reported to receive lower quality of care across a range of disease areas and clinical services.⁵

Compared with whites, African Americans are reported to be more likely to receive less desirable services, such as amputation of all or part of a limb.⁵

Healthcare disparities are associated with higher mortality rates among minorities who fail to receive the same services as white patients.⁵

According to data from 2000, death rates of African American, American Indian, and Puerto Rican infants are higher than the death rates of white infants.¹⁶

African American women are:

- More than twice as likely to die of cervical cancer than white women
- More likely to die of breast cancer than women of any other racial or ethnic group¹⁶

In 2000, the leading causes of death for all US racial and ethnic groups are heart disease and stroke. Among African Americans, mortality rates related to heart disease were 29% higher and stroke-related mortality rates were 40% higher than those of whites.¹⁶

In 2000, compared with non-Latino whites, the likelihood of being diagnosed with diabetes was:

- 2.6 times more likely among American Indians and Alaskan Natives
- 2.0 times more likely among African Americans
- 1.9 times more likely among Latinos¹⁶

Although African Americans and Latinos represented only 26% of the US population in 2001, they accounted for 66% of adult AIDS cases and 82% of pediatric AIDS cases reported in the first half of that year.¹⁶

Latinos and African Americans aged 65 and older were less likely than non-Latino whites to report having received an influenza vaccine in 2001.¹⁶

Self-Assessment

During a clinical encounter, I take into consideration that:	Yes	No	Sometimes
1. Healthcare providers incorporate their own cultural values into the clinical encounter.			
2. Western medical training may influence diagnosis and treatment and can conflict with health beliefs of patients who have non-Western or different explanatory models of disease.			
3. Even in language-concordant situations, patients and providers may have different cultural values.			
4. The patient's culture influences how he or she perceives and explains symptoms and illnesses.			
5. Members of some cultural groups may not feel comfortable asking questions of providers.			
6. Communicating bad news or undesirable diagnoses in the Western world may be different from the way it is done in the non-Western world.			
7. Health-related decisions have a cultural context.			
8. Cultural values should be incorporated into the healthcare communication process.			
9. Sociocultural differences between providers and patients may pose communication obstacles.			
10. An interpreter may be necessary to assist in communicating with patients who have limited English proficiency.			

The Self-Assessment covers 3 areas: cultural awareness, cultural knowledge, and communication skills.

Please assess your perspective regarding the statements listed as they relate to your practice. There are no right or wrong answers.

2

Implications for Healthcare Providers

Consider your response to the self-assessment on the previous page. *No* and *Sometimes* responses suggest opportunities for cultural competency development.

Cultural Awareness

1. Healthcare providers incorporate their own cultural values into the clinical encounter.	The majority of physicians and healthcare professionals have the cultural values of the mainstream culture and the values of the medical culture. ¹⁷ Providers' cultural backgrounds can affect their communication when they deliver care without recognizing differences between themselves and their patients. ¹⁸
2. Western medical training may influence diagnosis and treatment and can conflict with health beliefs of patients who have non-Western or different explanatory models of disease.	The explanatory models of illness of provider and patient may be different. Each one may be influenced by racial/ethnic culture, sociocultural values, education, profession, faith, and personality. ¹⁹ In Western medical training, diseases have no spiritual or metaphysical basis. Diseases are natural errors that can be corrected by repairing organs or manipulating chemical pathways. ²⁰ Some ethnic groups believe that health exists when there is equilibrium and illness occurs when there are excesses or deficiencies. ²¹
3. Even in language-concordant situations, patients and providers may have different cultural values.	Cultural differences may exist even with language concordance. It has been reported that, although African Americans share the same language with providers, some individuals perceive unfairness and disrespect from the healthcare system as a consequence of the way they speak English. ³

Cultural Knowledge

<p>4. The patient's culture influences how he or she perceives and explains symptoms and illnesses.</p>	<p>Cultural factors influence the manner in which a patient identifies, interprets, and expresses symptoms. It also affects the expression of pain or discomfort, the perception of a chronic condition as one that is stigmatized or acceptable, as well as whether the dependency created by a chronic disease is part of the normal cycle of life or is disvalued.²¹</p> <p>The severity of an illness is often rated by Native Americans based on the amount of pain, disability, and discomfort that it produces.²¹</p> <p>In order to elicit information, providers may use their knowledge regarding patients' health beliefs and practices while evaluating the degree to which the patients' cultural backgrounds influence these.¹</p>
<p>5. Members of some cultural groups may not feel comfortable asking questions of providers.</p>	<p>In some cultures, it is not appropriate to question the provider. Patients who are members of these groups may feel uncomfortable asking for clarification.¹⁸</p>
<p>6. Communicating bad news or undesirable diagnoses in the Western world may be different from the way it is done in the non-Western world.</p>	<p>In the United States, the standard practice is to inform the patient before family members of a diagnosis.⁴</p> <p>It has been reported that physicians in Japan, China, and the United Arab Emirates tend to avoid communicating information about terminal diagnoses to patients. Patients from these cultures were also more likely to prefer physicians to withhold information related to terminal diagnoses.²²</p>
<p>7. Health-related decisions have a cultural context.</p>	<p>Effective clinical encounters depend on understanding the cultural context related to making decisions about health issues. It is important to consider the norms, health practices, and role of family members when making health-related decisions.²³</p>

2

Implications for Healthcare Providers

Communication Skills

<p>8. Cultural values should be incorporated into the healthcare communication process.</p>	<p>Patients and providers hold different health beliefs and explanatory models of illness. Providers should incorporate the patients' explanatory model of illness when communicating with patients about their illness.²⁴</p>
<p>9. Sociocultural differences between providers and patients may pose communication obstacles.</p>	<p>Sociocultural differences between patients and providers may pose communication barriers that can impact the relationship.²⁴</p> <p>Bias may exist on the part of the provider based on the patient's skin color, gender, perceived social class, and education.¹⁹</p> <p>Racial and socioeconomic characteristics can influence physicians' beliefs regarding patients' intelligence, willingness to comply, and likelihood to engage in risky behaviors. Decisions regarding treatment options may also be affected.²⁵</p>
<p>10. An interpreter may be necessary to assist in communicating with patients who have limited English proficiency.</p>	<p>Providers should consider having trained interpreters available for patients who do not speak or understand English or are limited English proficient.²¹</p> <p>Research has shown that there is a higher quality of patient-provider communication when trained interpreters are used.²⁶</p> <p>Family members may not be appropriate interpreters because issues of confidentiality and cultural norms may prohibit discussion of certain topics.²¹</p>

- 1 Patients' race and/or ethnicity
- 2 White, English-speaking mainstream patients
- 3 Limited English proficient (LEP) patients
- 4 African American patients
- 5 Asian patients
- 6 Latino patients
- 7 Sexual orientation of patients
- 8 Patients with disabilities
- 9 Role of providers' cultures in patient-provider interactions
- 10 Role of patients' cultures in patient-provider interactions

Please consider your experiences and reflect on what comes to mind when you think about the items listed.

3

Examining Personal Stereotypes, Biases, and Assumptions

Implications for Healthcare Providers

<p>1. Patients' race and/or ethnicity</p>	<p>Racial and cultural factors may influence the patient-provider relationship.²⁷</p> <p>Evidence suggests that patients' race or ethnicity influences providers' diagnostic decisions and their feelings about patients.²⁸</p> <p>Race concordance can improve the patient-provider relationship. It has been reported that patients are more satisfied with race-concordant providers.²⁹</p>
<p>2. White, English-speaking mainstream patients</p>	<p>White patients report higher levels of satisfaction with care, compared with non-White patients.³⁰</p> <p>In one study, white patients reported having better patient-practitioner relationships than Latinos or Blacks. During office visits, white patients reported having to wait less time and were more likely to be seen by the same clinician.³¹</p>
<p>3. Limited English proficient (LEP) patients</p>	<p>Compared with English-speaking patients, LEP patients may have less access to care and give poorer ratings of their care.²⁰</p> <p>Patients who are in language-discordant encounters have reported better experiences with care in interpreted encounters than in non-interpreted encounters.²⁰</p> <p>In emergency department settings, non-English speakers reported dissatisfaction with overall care, courtesy, respect, and discharge instructions.³²</p>
<p>4. African American patients</p>	<p>African Americans may be concerned about trust in the provider and the system and may need to feel respected by healthcare professionals.³³</p> <p>Less positive affective tone has been observed between African American patients and their physicians compared with white patients and their physicians.³⁴</p>
<p>5. Asian patients</p>	<p>Asian Americans have been found to report dissatisfaction with their usual source of care and to be more likely than whites to state that they would not go to their main provider for new health problems or for preventive care.³⁵</p>

Implications for Healthcare Providers

6. Latino patients	<p>Latinos are a very diverse group with marked demographic and socioeconomic differences whose origins trace back to many countries.³⁵</p> <p>Studies have found that Spanish-speaking Latinos are more dissatisfied with the care they received than English-speaking and white patients.³⁷</p>
7. Sexual orientation of patients	<p>Elucidating sexual orientation and family structure was more likely to occur for medical students with greater exposure to lesbian, gay, bisexual, and transgendered (LGBT) patients.³⁸</p> <p>LGBT individuals may have distinct behaviors, choices, and practices. Education of health professionals is important to effectively assess and manage their health issues.³⁸</p>
8. Patients with disabilities	<p>Factors that influence the health outcomes of people with disabilities include the environment, behavioral practices, and access to routine preventive services.³⁸</p>
9. Role of providers' cultures in patient-provider interactions	<p>The backgrounds of healthcare practitioners mold their own attitudes and beliefs.³⁹</p> <p>Healthcare professionals who wish to understand the culture of the patient need to recognize their own culture.³</p> <p>Communication with patients may be negatively affected when providers fail to recognize that differences exist between their values and their patients' values.¹⁸</p>
10. Role of patients' cultures in patient-provider interactions	<p>Patients' culture, language, lifestyle, and disease greatly impact the manner in which they access and respond to healthcare services.⁴⁰</p>

3

Examining Personal Stereotypes, Biases, and Assumptions

The majority of physicians and healthcare professionals have the cultural values of the mainstream culture and the values of the medical culture. Both cultures have values, biases, and assumptions.¹⁷

Why is it important to consider healthcare professionals' cultural values?

Stereotyping	<p>Stereotypes are labels given to individuals on the basis of their presumed membership in particular groups. Unfortunately, stereotypes are often biased or unfair and they can be negatively or positively judgmental.⁵</p> <p>Stereotyping is mistakenly assuming that all members of a given culture are alike.⁴</p> <p>Individuals use stereotyping because it creates social categories to acquire, organize, and remember information about others.⁵</p>
Conscious or Unconscious Bias	<p>Bias occurs when stereotypes are projected onto individual patients, impacting decision-making in the clinical setting.¹⁷</p> <p>Researchers suggest that most doctors try to stay free of bias in their clinical practice.¹⁹</p> <p>Providers' conscious or unconscious beliefs regarding patients are influenced by patient race. Such beliefs may influence providers' decision-making.⁴¹</p> <p>It has been reported that members of ethnic and racial minority groups are more likely to perceive bias and a lack of cultural competence in the healthcare system relative to whites.³</p>
Prejudice	<p>Prejudice consists of an unjustified negative attitude based on an individual's group membership. It is often revealed through explicitly biased stereotypes and can impact the quality of care that minorities receive.⁵</p> <p>Reports indicate that race and ethnicity influence providers' feelings about patients and also their diagnostic decisions.²⁸</p>

Health Beliefs

Folk Medicine	<p>It is important to find out which patients define health issues as folk illnesses, which patients may use folk healers, and what reasons determine whether patients will use the folk system instead of Western clinical care.⁴²</p> <p>While some Latinos may use folk healers as the first option for treatment, others may seek simultaneous treatment from folk healers and physicians.⁴³</p> <p>Black Americans who reject the medical system or whose health problems have not been resolved by Western medicine have been reported to use folk healers in conjunction with or instead of biomedicine.⁴⁴</p>
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Health Practices

Complementary and Alternative Medicine (CAM)	<p>CAM is the use of practices and products not considered to be part of conventional medicine.⁴⁵</p> <p>CAM is used mostly to treat head, joint, or back pain or stiffness; head or chest colds; and anxiety or depression.⁴⁵</p> <p>In 2002, about 62% of US adults used some form of CAM. If megavitamins and prayers are included, white adults and Asian adults use CAM less frequently than black adults. Its use is more prevalent among women and people with higher educational levels.⁴⁵</p>
Coining, Cupping, and Acupuncture Combined With Moxibustion	<p>These are common practices among some Asians. Some of these treatments may leave burns or bruises.⁴</p>

4

Providing Care to Members of Diverse Populations: Key Issues

Other Issues

Language	<p>Limited English proficient (LEP) patients whose providers did not speak their language were more likely to report problems understanding the medical situation, problems understanding medication labels, and confusion about their medication, compared with LEP patients whose providers spoke their language.⁴⁶</p> <p>LEP patients are likely to be older, female, less educated, low income, and underinsured.⁴⁶</p>
Level of Acculturation	<p>Higher levels of acculturation are associated with greater alcohol consumption and greater frequency of alcohol use among Latinos.⁴⁷</p> <p>US-born Mexican Americans exercise more during leisure time than Mexican-born individuals.⁴⁸</p>
Disabilities	<p>When addressing a person who uses a wheelchair, the provider should consider sitting down. When giving information, the provider should consider whether she/he should address the patient, rather than a friend or relative. If the patient has a hearing loss, it is useful to enunciate clearly. Patients with a physical disability may require more time to get up and down from the examination table and patients who have a sensory disability may need more time to receive information. Thus, providers should consider allowing extra time for such appointments.⁴⁹</p>

Other Issues (cont)

Sexual Orientation	<p>Lesbian, gay, bisexual, and transgendered (LGBT) individuals may appreciate the acknowledgement of intimate partners and family members as caregivers.⁵⁰</p> <p>Providers taking a patient's history should consider gathering information about same-sex intimate partners, household dependents, and other LGBT health issues.⁵⁰</p>
Gender Issues	<p>Asking about a patient's preference for physician gender, instead of making assumptions, may help physicians prevent uncomfortable situations.²⁴</p> <p>It has been reported that women receive better preventive care and care for chronic health issues but less acute care than men.⁵¹</p> <p>Having a female physician has been reported to be positively associated with women's satisfaction with care. Male physicians should be sensitive to this possible gender preference among female patients.⁵²</p>
Socioeconomic Status and Education	<p>Provider-patient sociocultural differences relating to authority, physical contact, communication styles, gender, sexuality, and family issues can potentially lead to misunderstandings.²⁴</p> <p>Socioeconomic status, education, and occupation as well as family values and belief systems help define individuals' cultures.⁵³</p>

5

Cultural Values Across Cultural Groups

Cultural Values Impact on the Clinical Encounter

Time Orientation	It has been reported that people from some cultures, such as Latinos and African Americans, may be more relaxed about time management because they consider personal relationships more important than schedules. In these cultures, if the issue of punctuality needs to be explained, it should be approached with tact. ⁴
Individualism vs Collectivism	Differences exist in the way members of cultural groups view themselves and their relationships with other members of their groups. ⁵⁴ While members of most Western cultures view themselves as individuals and separate themselves from others, members of Eastern cultures define themselves based on interdependence in their groups. ⁵⁴
Familism	Some cultures have a more family-centered approach to making decisions related to healthcare. ²²
Personal Space	The perception of appropriate interpersonal distance varies with cultures. Anglo, mainstream-culture individuals often prefer more interpersonal distance than Latinos. ⁴
Health-Related Decisions	Among Latinos, general dynamics have been identified. For example, the mother often decides whether a family member should seek medical attention and when this should happen and the male head of the family grants permission to do it. ⁴³ In addition, while the head of the family is the one who makes decisions, the entire family often participates in making important decisions. ⁴³

Cultural Values	Impact on the Clinical Encounter
Religion/Spirituality/ Faith Issues	<p>When dealing with serious illnesses, religion may provide support to patients and their families. In such cases, providers should understand patients' religious and spiritual connections and beliefs.⁵⁵</p> <p>Religiosity has an effect on the rituals used to cope with signs and symptoms of illnesses. In particular, religiosity and spirituality have been identified as important factors in dealing with health issues among women of color.⁵⁶</p> <p>Mexican American patients with diabetes have been reported to believe that God can help control their diabetes by working through clinicians and medications.⁵⁷</p> <p>Among African Americans, spirituality and prayer have been noted as important in decision-making.³³</p> <p>Issues related to religion and spirituality should be acknowledged and respected. When necessary, physicians and patients must attempt to reach an acceptable agreement.⁵³</p> <p>As an important aspect of culture, religion often determines food patterns.²¹</p>
Food Patterns and Fasting	<p>Food restrictions, especially those based on religion, are important considerations. For example, pork is not acceptable food for some Jewish or Muslim individuals, Hindus do not consume beef, and adherents of Islam engage in fasting from sunrise to sunset during Ramadan.²¹</p>
Fatalism	<p>Fatalism is the belief in an external locus of control. It contrasts with the mainstream culture's belief in internal locus of control.⁵³</p> <p>Some patients may not adhere to treatment because they believe that their fate is predetermined and that medical intervention will not affect their health outcome.⁴</p>
Illness and Disease	<p>Many ethnic groups share the belief that health is a state of equilibrium and illness is a consequence of excesses or deficiencies.²¹</p>

6

Key Cultural Norms of Selected Diverse Groups

Some cultural norms and issues shared by members of specific communities are presented in this section. However, due to intracultural variations, not all individuals of the same cultures may share these values. To avoid stereotyping, it is best to keep in mind that each patient is a unique individual.

Cultural Groups	Norms	Impact on the Clinical Encounter
African Americans	Religious healing	Faith and prayer can be a powerful influence and can often be the first resort to improve health for devout black Christians. ⁴
	Mental health issues	African Americans are reported to have a more favorable attitude toward seeking mental health services for depression than whites. ⁵⁸
Asians	Traditional Chinese medicine	Chinese medicine is based on maintaining the balance between the body's cold (yin) and hot (yang) energies through diet, lifestyle, acupuncture, and herbal remedies. ⁴ For Chinese people, cold water and cold air are considered unhealthy. Thus, patients may prefer to drink hot tea or hot water instead of ice water. ⁴
	Mental health issues	Many Asians consider mental health issues shameful and are less likely to seek care. ⁴
Latinos	Personal space	Latinos prefer less interpersonal space than Anglos. ⁴
	Explanatory model of illness	Illness is sometimes conceptualized as an imbalance between hot and cold or natural and supernatural and may be believed to be caused by God or other external forces. ⁴³
	Folk diseases and folk healers	Latinos often select folk healers as a first option for treatment. Folk diseases, such as evil eye (<i>mal de ojo</i>) and indigestion (<i>empacho</i>), coexist as sources of explanation for disease. ⁴³
Native Americans	Illness	Native Americans may perceive illness as a loss of harmony with the forces of life. They also may more readily accept illness and prefer for nature to take its course. ⁵⁰
	Traditional remedies	Native Americans may use traditional remedies, which they guard as secrets. ⁵⁰
	Sick elders	The Sioux may prefer to accompany sick elders who are hospitalized. ⁵⁰
	Expression of pain	Native Americans may appear stoic regarding pain because they have been taught to avoid expressing pain. ⁵⁰

Key Cultural Norms of Selected Diverse Groups

6

Cultural Groups	Norms	Impact on the Clinical Encounter
Mainstream Whites	<p>Internal locus of control</p> <p>Individualism</p> <p>Communication</p>	<p>Persons control their environment and also their destiny. Thus, fate is not a factor.⁵⁹</p> <p>Emphasis is on the person's individual issues, not on group members' concerns.⁵⁹</p> <p>Sharing the truth directly and openly is part of the culture. This includes making eye contact.⁵⁹</p>
Lesbian, Gay, Bisexual, Transgendered (LGBT) Individuals	<p>Health-seeking behaviors</p> <p>Family structure</p>	<p>Health-seeking behaviors, preventive health measures, and disease risk are influenced by shared social behaviors and choices.³⁸</p> <p>Understanding that LGBT individuals maintain their own family structure can help in identifying the patient's caregivers and dependents.³⁸</p> <p>It is important to remember that the family structure may include children.³⁸</p> <p>Knowledge of the family structure can be important because it may have important implications related to healthcare decisions and health insurance.³⁸</p>
Persons With Disabilities	<p>Daily-life issues</p> <p>Health issues</p>	<p>Persons with disabilities often face isolation and reduced activities of daily living.⁴⁹</p> <p>Factors in the environment may act as barriers in the daily lives of persons with disabilities.³⁹</p> <p>Persons with disabilities have been identified as having higher smoking rates and being more sedentary than people who do not have disabilities.³⁹</p> <p>Persons with disabilities have been reported to receive insufficient routine preventive care.³⁹</p>

7

Communicating With Culturally Diverse Patients

Verbal Communication Styles Impact on the Clinical Encounter

Instructions	Assessing the patient's beliefs and practices regarding a condition can provide invaluable information. It can help identify the best ways to design and provide patient education. ²¹ Providers should consider giving instructions in writing if the patient is literate. ⁴
Information	Cultures with strong oral traditions may welcome health information provided through pictures or storytelling. ²¹ Patients' health beliefs, preferred learning styles, lifestyles, and community context should be incorporated into patient education programs. ²¹
Healthcare Communication Process	Treatment discussions should acknowledge that differences exist in belief systems between patients and providers. ²⁴ Providers should consider asking the patient if the plan is acceptable. ⁴
Direct vs Indirect Communication	US mainstream-culture individuals tend to be more direct and open than members of other cultural groups. ⁵⁹
Silence	Among Latinos, silence may indicate a lack of understanding or disagreement. ⁴³

Nonverbal Communication Styles

Impact on the Clinical Encounter

Body Language	Many Asians believe that exposing the sole of the foot, pointing with the foot, or touching the head are repugnant actions. ⁴
Gestures	Gestures are not universal. ⁵³ For example, some Latinos may consider the “OK” sign (ie, circle made with thumb and forefinger) to be obscene. ⁴
Touching	Asians are generally low-touch groups. It is recommended that providers explain examinations prior to executing them. ⁴ Opposite-sex touching may not be allowed among Orthodox Jews and individuals who are members of some Islamic sects. This includes shaking hands. ⁴
Using the Left Hand	Among many non-Western cultures, the left hand is considered to be unclean because it is used for personal hygiene. Thus, it should not be used to offer anything to members of these cultural groups. ⁴
Eye Contact	In mainstream culture, not making eye contact may lead to the assumption that the person is either not truthful or is depressed. ⁵³ However, in some cultures, avoiding eye contact may be a sign of respect. Patients, especially when they are of a different gender or social status, may avoid eye contact with providers. ⁴ Latinos avoid making eye contact with providers out of respect. For some Latinos, making eye contact may be related to evil spirits. ⁴³

8

Difficult Cross-Cultural Communication Situations

Causes of Miscommunication

Impact on the Clinical Encounter

<p>Language Issues</p>	<p>Language barriers represent obstacles for access to care in the absence of interpretation and translation services.³⁹</p> <p>A basic understanding of the English language is not sufficient to understand healthcare information. A trained interpreter should be available to overcome language barriers and avoid miscommunication and inappropriate treatment plans. Bilingual family members should not be used due to issues of confidentiality and possible cultural norms that preclude discussing certain health topics.²¹</p> <p>When using an interpreter, the provider should speak slowly, using short sentences and a normal tone of voice, speaking directly to the patient, rather than to the interpreter.⁴</p>
<p>Different Explanatory Models of Illness</p>	<p>Miscommunication can occur when providers view the biomedical model as the right way and disregard the patient's perspective of illness.²⁰</p> <p>Providers and patients (to the extent permitted in the discussion by the patient) should focus the conversation on an open discussion about cultural meanings, considering the critical implications on the delivery of care.⁶⁰</p> <p>Providers must acknowledge that patients may have different views based on their explanatory models. If the patient does not accept the biomedical explanation of an illness, the provider should seek a compromise by presenting the problem in a way that reflects the patient's explanatory model.²⁴</p>
<p>Patient-Provider Interaction Issues</p>	<p>Since providers are in a position to guide the course of the encounter, achieving effective communication is their responsibility. This involves understanding how patients' beliefs and values relate to their illness.²²</p> <p>The key to effective patient-provider interaction lies in communicating across cultural differences.²³</p> <p>It has been reported that the quality of patient-physician interaction is lower among Latinos and Asians due to lack of physicians' cultural sensitivity and patients' health literacy levels.³⁰</p> <p>Lack of mutual trust and respect may reduce clinicians' ability to provide care and patients' willingness to follow advice.²⁰</p>

Causes of Miscommunication

Impact on the Clinical Encounter

Healthcare System Factors	Time pressures may have a negative effect on healthcare providers' ability to evaluate symptoms of minority patients, especially if there are linguistic and cultural barriers. ⁵
Racial/Ethnic Issues	<p>The race and ethnicity of provider and patient can impact their ability to communicate and negotiate a shared model. This may be due to language issues as well as communication styles.¹⁹</p> <p>Compared to whites, Latinos and African Americans are reported to use health services at lower rates.¹⁹</p>

9

Avoiding Cultural Conflict in the Clinical Setting

Causes of Conflict

Patients' Perceptions of Healthcare

<p>Language Issues</p>	<p>Spanish-speaking Latinos have been reported to be more dissatisfied with provider communication than English-speaking Latinos and whites.³⁷</p> <p>African Americans report unfair and disrespectful treatment in the healthcare system on the basis of the way they speak English, despite being language concordant with providers.³</p> <p>Limited English proficient (LEP) Asian patients perceive the quality of care with interpreters to be similar to the care that they receive when providers speak their language.⁶¹</p> <p>Spanish-speaking patients who used telephone interpreter services reported the same satisfaction rates as patients in language-concordant encounters. In contrast, patients who used family members or ad hoc interpreters reported being less satisfied.⁶²</p>
<p>Delivery of Care Issues</p>	<p>According to African American, Asian, and Latino patients, the most important factor in cross-cultural communication is the provider's display of concern, courtesy, and respect.⁶³</p> <p>African Americans are reported to value providers who listen, allow participatory decision-making, and exhibit respectful attitudes.²⁹</p> <p>According to a report, while Latinos and whites rate their satisfaction with care very similarly, Asians have lower satisfaction rates and are less likely to recommend their provider to a family member.⁶³</p> <p>Reports show that Latinos value the time spent by the physician and prefer friendly and polite, rather than distant and therapeutic, relationships with providers.^{29,43}</p> <p>Asians have been identified as valuing time and respect.²⁹</p> <p>White patients value listening, time spent, respect, and patient-physician race-concordance.²⁹</p> <p>White patients report having better patient-practitioner relationships than Latinos or blacks.³¹</p> <p>White patients often have less wait time during office visits and are more likely to see the same provider during visits.³¹</p>

Causes of Conflict Patients' Perceptions of Healthcare

Shared Decision-Making

Important differences may exist between patients' and providers' perspectives even when they share similar sociocultural backgrounds.²⁴

Patients' desire to be involved in decision-making regarding their care is affected by their backgrounds and by the specific clinical circumstance.⁶⁴

Providers may wish to ask their patients to what extent they want to engage in sharing decisions regarding their treatment plans.⁶⁴

In shared decision-making, providers help patients translate their values into decisions related to their treatment.²⁰

Patients in race-concordant visits have been reported to have more positive views of providers' participatory attitudes in their decision-making style.⁶⁵

End-of-Life Issues

<p>Main dimensions of end-of-life issues impacted by culture</p>	<p>Through research and case studies, 3 basic dimensions that may be affected by culture have been identified:</p> <ol style="list-style-type: none"> (1) Communicating bad news (2) Locus of decision-making (3) Attitudes of patients and family members toward advanced directives and end-of-life care⁶⁶
<p>Communicating bad news</p>	<p>In the United States, the norm is to tell the truth to patients. This includes the good and the bad news.^{53,66}</p> <p>In Chinese, Latino, and Pakistani cultures, family members protect patients who are terminally ill from knowing about their condition.⁶⁶</p> <p>Navajos believe that negative words and thoughts related to health issues may become self-fulfilling.⁶⁶</p> <p>Some cultures believe that discussing serious illness and death is disrespectful or impolite. The desire is to prevent depression or anxiety in the patient and not eliminate hope. Some cultures believe that speaking about the condition may make death or terminal illness real.⁶⁶</p> <p>In dealing with members of cultural groups who believe that the family should be informed first regarding a negative prognosis, physicians' conduct should be to explain to patients and family members that the standard practice in the United States is to inform the patient first. Next, they should ask the patients about their preferred approach.⁴</p> <p>Latinos prefer to protect the patient from receiving bad news regarding an illness. Family members may prefer to hear the news first and to designate a family member who will share the information with the patient.⁴³</p>

End-of-Life Issues (*cont*)

<p>Locus of decision-making</p>	<p>The mainstream norm is for individuals to make their own decisions regarding medical care. In dealing with people from cultural groups who believe that the family should be involved in healthcare decisions, providers should explain to the patient and family that the standard practice in the United States is to provide information to the patient and that family members will only be involved in discussions to the extent requested by and with explicit consent from the patient.⁶⁶</p> <p>Differences between providers' medical practices and patients' cultural backgrounds may lead to misunderstandings.⁶⁷</p> <p>People from other cultures may be unfamiliar with the mainstream concept of patient autonomy and informed consent.⁶⁷</p> <p>Members of some ethnic and racial groups include family members in decision-making. Asians and Latinos often consider family involvement as a way to relieve the patient from making decisions about treatment. African Americans may accept trusted family members' participation because it helps carry out the patient's wishes.⁶⁸</p> <p>In some cultures, the family member who holds the highest rank, often the eldest male, is in charge of making decisions regarding end-of-life issues.⁵³</p> <p>Some cultures prefer not to disclose a terminal diagnosis to the patient because it may precipitate death. It has been suggested that providers ask patients how much they wish to know about their illness or whether they would prefer to have the provider discuss the illness with them and their families.⁵³</p>
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End-of-Life Issues (*cont*)

Attitudes of patients and family members toward advance directives and end-of-life care

It has been reported that white individuals are more likely to have advance directives than African Americans. Unless they are enrolled in special health services, older Latino, Asian, or Native American individuals have lower rates of advance directives.⁶⁸

Non-Latino white patients tend to be more exclusive in the selection of family member involvement, are more interested in consultations from specialists, and are less interested in involving spiritual representatives. In addition, they prefer to have more information regarding the condition, treatment options, and effects on quality of life.³³

Euro-American patients trust that the healthcare system will serve them well and wish to have some control over their care including life support and other terminal care.⁶⁹

African Americans may feel that treatment is controlled by the system and prefer to share their wishes with family members only after they are very ill. Providers may want to be respectful toward their reluctance to discuss care issues.⁶⁹

Mexican Americans are not generally receptive to advance directives. They feel the system controls treatment so there is no point in expressing their wishes.⁶⁹

Death and dying

Among terminally ill cancer patients, those who live in minority communities are less likely to receive hospice care than those who live in white neighborhoods.⁷⁰

Asian Americans and Pacific Islanders with cancer are less accepting of hospice care than white patients. Foreign-born Asian patients are particularly unlikely to enroll in hospice care.⁷¹

Some Chinese immigrants prefer not to die at home because of the traditional belief that ghosts inhabit houses where an individual has died. In some Chinese neighborhoods, a recent death may have a negative impact on the market value of real estate.⁷²

An Islamic family may request that the patient's body be turned to face the East after the patient's death.⁷²

End-of-Life Issues (*cont*)

Emotional expression of grief	<p>Showing grief is patterned by individuals' cultural values.⁷²</p> <p>Expressing grief may vary among cultures. Among some Middle Eastern cultures, loud wailing at the death of a dear one is common.⁵³</p> <p>Often, during the mourning period in Bali, an individual will keep a strict separation between inner and outer feelings. Thus, the person may remain calm and cheerful.⁷²</p>
Autopsy	<p>According to a study, most ethnic minorities understand that the purpose of the autopsy is to identify the cause of death. However, Mexican American women were the only ones among those interviewed who favored the procedure. They believed it would help physicians to learn more or that it might help somebody else.⁷³</p> <p>In one study, almost half of the Mexican American men and African American women interviewed believed there was no need to perform an autopsy if the cause of death is known.⁷³</p>

Providers with appropriate knowledge, attitudes, skills, and behaviors are better prepared to engage in quality interpersonal communication and meaningful dialogue and to form effective relationships.⁷³

Cultural Pointers

<p>1. View every patient as a unique individual.</p>	<p>Viewing patients as individuals who have unique experiences and perspectives, rather than as members of cultural groups, can help avoid stereotyping patients and making inappropriate assumptions about them.⁷⁴</p> <p>It is helpful to have a basic knowledge of different cultures. However, providers must explore issues with the individual patient.²²</p> <p>The situation of each patient is unique and is influenced by the patient's culture and personal and social factors. Providers may want to explore the different problems that are likely to arise during cross-cultural medical encounters and learn to identify and manage them.²⁴</p>
<p>2. Assess the need for a trained interpreter if language is a barrier to effective communication.</p>	<p>If the provider and patient do not speak the same language fluently, an interpreter may be necessary.⁴</p> <p>The use of trained interpreters has been reported to be associated with improved care for limited English proficient patients. Trained interpreters help diminish communication errors and improve patient satisfaction and clinical outcomes.⁷⁵</p> <p>One study identified a drawback to using interpreters. In that study, the use of interpreters was shown to prevent Asian patients from asking questions about their healthcare issues, especially regarding mental health concerns.⁶¹</p>
<p>3. Enhance cross-cultural communication skills.</p>	<p>Focusing on building rapport is beneficial to all patients, particularly racial and ethnic minority patients.³⁴</p> <p>Key communication skills include social introduction, showing respect, and not being in a hurry. Also, using direct vs indirect communication, silence, personal space, and touch in a culturally appropriate manner is important.²¹</p> <p>Communication during medical interactions with minority patients can be improved by using openings and prompts that help the patient provide a health narrative (explanatory model of illness), ask questions, express concerns, and be assertive.¹⁹</p> <p>A good approach is to have a balance between knowledge of cultural norms of specific groups and communication skills not specific to any particular group.⁷⁴</p>

Cultural Pointers (cont)

4. Understand the patient's explanatory model of illness and health.	Ask what the meaning of the illness is to the patient. This may help when explaining treatment options and finding a treatment plan that is acceptable. ⁴
5. Promote patient-centered communication.	<p>The goal of delivering patient-centered care is to provide individualized care and focus on personal relationships.⁷⁴</p> <p>During the clinical encounter, patient-centered communication involves a balance between searching for a diagnosis and therapeutic plan and understanding patients' needs and engaging them in their own care.⁷⁶</p> <p>Patient-centered communication has been reported to be associated with fewer diagnostic tests.⁷⁶</p>
6. Develop patient trust.	<p>Provider sensitivity toward patient perception of trust in the system and understanding of the impact of distrust on healthcare decisions may help improve healthcare outcomes for racial and ethnic minorities.⁷⁷</p> <p>In a population-based study, although patients reported having a high level of trust in providers and hospitals and less trust in health insurance plans, the responses varied according to racial group.⁷⁷</p> <p>Non-Latino black patients are less trusting of the system than non-Latino white patients.⁷⁷</p> <p>Compared with white patients, black patients have more concerns about personal privacy and hospitals conducting harmful experiments.⁷⁷</p>
7. Incorporate culture into all patient evaluation routines.	<p>By including culture as a regular part of patient evaluations, providers have the opportunity to examine personal values associated with culture and ways in which these impact health and healthcare.⁷⁸</p> <p>Being more culturally responsive to patients calls for an exploration of personal cultural perspectives, respect for patient autonomy, willingness to accept patient decision-making, and partnering with patients to improve their health outcomes.⁷⁸</p> <p>Providers must confront personal prejudices and biases and also explore how these impact their interactions with patients.²²</p>

Cultural Pointers (*cont*)

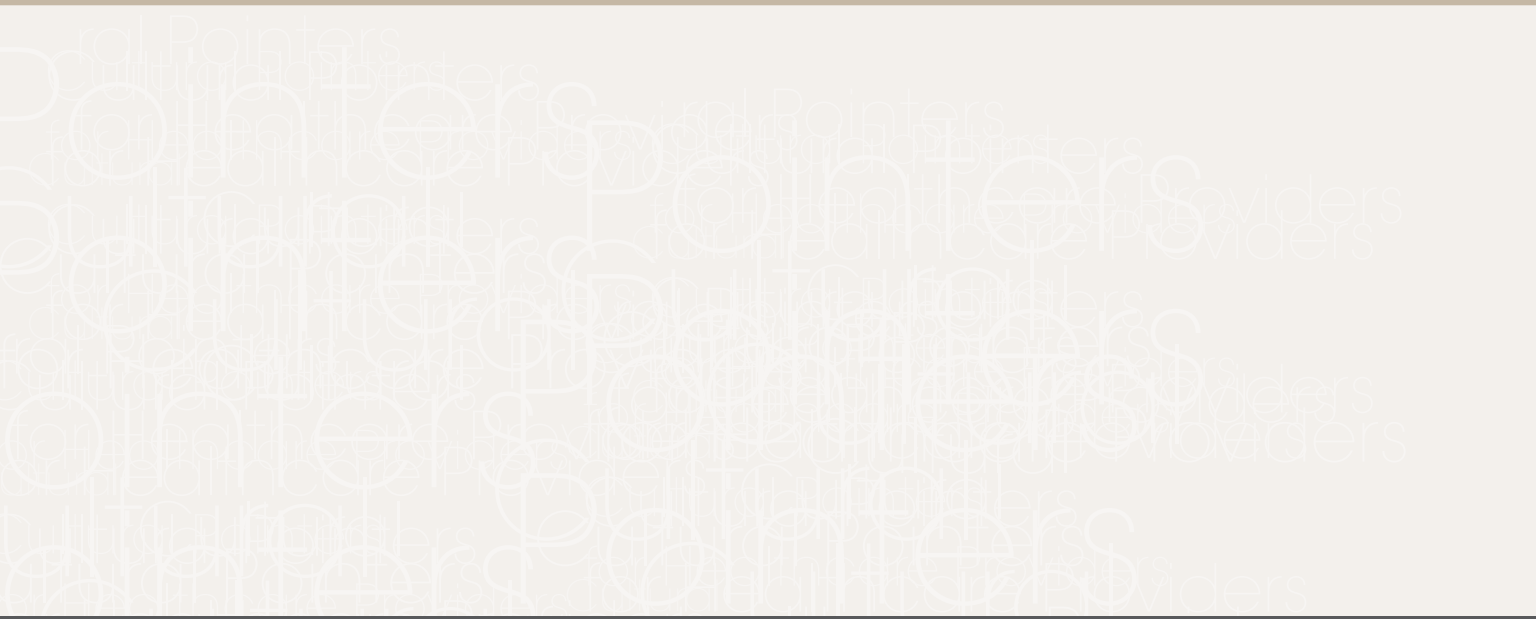
8. Embark on a lifetime journey of increased cultural awareness.	A common cultural barrier to quality care for practitioners is the belief that biomedicine is right, inherent in the beliefs and values of the biomedical culture. Such beliefs and an undeveloped skill set may lead to inadequate care. ²¹
9. Respect cultural values.	Clinicians can deliver care that is responsive to the patient's experiences with the illness and try to view the illness as the patient sees it. ⁶⁰ Emphasis on respect for members of all cultural groups and on client dignity and incorporating rituals, such as sharing food, starting a project with a prayer, or sharing symbolic gifts, can contribute to effective cross-cultural communication. ²¹
10. Value diversity.	View cultural differences in backgrounds and viewpoints as strengths. This is a step beyond being tolerant of differences. ² Showing interest in patients' cultural heritage can be very useful in developing rapport. ⁶⁶

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