

CLINICIAN'S PRACTICAL GUIDE TO CULTURALLY COMPETENT CARE: NEON Primer

US Department of Health and Human Services (HHS) Office of Minority Health (OMH)

THEME 1: CULTURALLY COMPETENT CARE

MODULE 1.1: Overview of Culturally Competent Care

Key Learning Points Module 1.1

1. Cultural competence is a national health concern. Many governmental organizations have recognized the existence of health disparities and have developed plans to address them.
2. Barriers in access to health care are economic, geographic, social, and cultural. Sources of disparities and barriers include patients, the health care system, providers, and patients' responses.
3. Culturally competent care can benefit providers as well as patients.
4. The 14 CLAS (Culturally and Linguistically Appropriate Services) standards were developed to improve access to health care for minorities, reduce disparities, and improve quality of care.
5. The CLAS standards are a part of a body of legislation and policy about cultural and linguistic acceptance adopted over recent decades in the United States, including the Civil Rights Act of 1964.

Cultural and linguistic competence is a set of congruent behaviors, attitudes, and policies that come together in a system, in an agency, or among professionals that enables effective work in cross-cultural situations.

The word "Culture" refers to integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.

The word "Competence" implies having the capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities (based on Cross, Bazron, Dennis, & Issacs, 1989).

Rationale for Cultural Competence

Growing concerns about racial and ethnic disparities in health and about the need for health care systems to accommodate increasingly diverse patient populations have positioned **cultural competence as a national health concern**.

1. Health disparities and minority and foreign-born populations are increasing across the United States. The U.S. Census Bureau predicts that within the next 50 years, nearly one-half (48 percent) of the nation's population will be from cultures other than White, non-Hispanic.
2. Despite improvement in overall health for the majority of Americans, the burden of health disparities continues to affect minority populations disproportionately.
3. Providing CLAS (Culturally and Linguistically Appropriate Services) to culturally and linguistically diverse patients has the potential to improve access to care, improve quality of care, and reduce health disparities.
4. For this curriculum, cultural competency encompasses the social groups influencing a person's culture and self-identity, not only race, ethnicity, and religion, but also gender, sexual orientation, age, disability, and socioeconomic status.
5. Linguistic minorities include not only people with limited English proficiency (LEP), but also people with low literacy skills and people who are hearing impaired.

6. Many governmental organizations have recognized the existence of health disparities and have developed plans to address them.
7. The U.S. Department of Health and Human Services (HHS) established a public health agenda, Healthy People 2010, with a focus on eliminating health disparities and improving health.
8. The HHS Office of Minority Health (OMH) has identified health disparities and four cross-cutting areas for attention, including access to health care, improved data collection/analysis, health professions development, and cultural competence.
9. The Institute of Medicine's (IOM's) report on racial and ethnic disparities in health care (IOM, 2002) provided evidence of health disparities, and indicated that "racial and ethnic minorities tend to receive a lower quality of health care than non-minorities, even when access-related factors, such as patients' insurance status and income, are controlled."

Barriers in access to health care are economic, geographic, social, and cultural (Office on Women's Health, 2000):

1. Data on health insurance coverage indicate that every major minority group has significantly less access to health care insurance than Whites do (Brown et al., 2000). "The ongoing gap in the proportion of uninsured Latino, Black, and White Americans essentially remained unchanged between 2001 and 2003, with one in three Latinos, one in five Blacks, and one in 10 Whites under age 65 lacking health insurance in 2003." (Hargraves, 2004)
2. An individual's level of acculturation—which depends on citizenship and refugee status, the circumstances of immigration, and the length of time a person has lived in the United States—affects individual health practices and the ability to navigate the American health system.
3. Fear may be a powerful barrier for groups who are illegal immigrants.
4. Patients are less likely to comply with treatment if they do not understand it (Coleman-Miller, 2000; Woloshin et al., 1995) or if they have conflicting health beliefs (Coleman-Miller, 2000; Vermeire et al., 2001).

The IOM report (2002) suggests that potential sources of disparities and barriers fall into four areas: (1) patients, (2) health care system, (3) providers, and (4) patients' responses.

1. Minority patients are more likely to refuse recommended services, adhere poorly to treatment regimens, and delay seeking care.
2. Time pressures placed on clinicians hamper their ability to assess symptoms, particularly when there are cultural or linguistic barriers.
3. Time pressure increases the likelihood of relying on shortcuts, such as stereotyping or prejudice, because clinicians are forced to make quick judgments often without enough information.
4. Minorities perceive higher levels of discrimination in health care; this perception can lead to patient mistrust, which causes provider disengagement and results in less vigorous treatment.

The 2003 National Healthcare Disparities Report, prepared by the Agency for Healthcare Research and Quality, articulates the complexity of examining the contributing factors of health care disparities and states that knowledge of why disparities exist is limited. The report lists factors that may contribute to differences in health care, these include:

- Different underlying rates of illness due to genetic predisposition
- Local environmental conditions

- Lifestyle choices
- Care-seeking behavior of patients, which vary due to differing cultural beliefs
- Linguistic barriers
- Degree of trust of health care providers
- Variations in the predisposition to seek timely care
- Ability to pay for care (directly or through insurance coverage)
- Location, management and delivery of health care services
- Clinical uncertainty
- Health care practitioner beliefs

Benefits of cultural competence accrue to both providers and patients.

- Decreasing cultural and language barriers to health care has the potential to reduce health disparities greatly.
- Clinicians and health care organizations that provide more culturally competent care can realize administrative and operational efficiencies, improved patient care and increased satisfaction, reduced malpractice costs, compliance with legal requirements, and a more positive image in the community.

CLAS (Culturally and Linguistically Appropriate Services) Standards

The HHS/OMH CLAS standards were developed as a means to improve access to health care for minorities, reduce disparities, and improve quality of care.

The 14 CLAS standards are organized into three themes:

- “Culturally Competent Care” (standards 1—3)
- “Language Access Services” (standards 4—7)
- “Organizational Supports for Cultural Competence” (standards 8—14)

The standards are of two types with varying stringency, **as defined below:**

- **Guidelines** are activities recommended by Office of Minority Health (OMH) for adoption as mandates by Federal, State, and national accrediting agencies.
- **Recommendations** are suggested by OMH for voluntary adoption by health care organizations.

The CLAS standards are a part of a body of legislation and policy about cultural and linguistic acceptance adopted over recent decades in the United States, including the Civil Rights Act of 1964. Medical accrediting and professional organizations also continue to develop policies, guidelines, and resources that encourage their memberships to provide effective culturally competent health care.

1. Source: Federal Register 65(247), 80865–80879.

In 2003, HHS revised its guidance on providing services for people with limited English proficiency (LEP) (OCR/HHS, 2003). Essentially, the guidance states that “the failure of a recipient of federal financial assistance from HHS to take reasonable steps to provide LEP persons with meaningful opportunity to participate in HHS-funded programs may constitute a violation of Title VI [of the Civil Rights Act of 1964] and HHS’s implementing regulations.”

Practical Guide to Culturally Competent Care: NEON Primer for Theme 1

Information quoted and summarized from the guidance about whom it covers, and the extent of obligations to provide services to LEP patients is below. **Reading the guidance in its entirety is important for healthcare providers who serve LEP patients and receive federal financial assistance.**

All recipients of federal financial assistance from HHS (recipients) are required to provide to LEP persons meaningful access to their programs and activities.

1. Recipients of federal financial assistance include those who receive grants, training, use of equipment, donations or surplus property, and other assistance. Sub-recipients, when federal funds are passed through one recipient to another, are also covered under the guidance.
2. Healthcare providers who only receive Medicare Part B payments are specifically excluded from the guidance.
3. Coverage extends to a recipient's entire program or activity, even if only one part of the recipient's program or activity is receiving the federal financial assistance.

To determine their obligation to provide LEP services, recipients must make an individual assessment that balances four factors:

1.	the number or proportion of LEP persons eligible to be served or likely to be encountered;
2.	the frequency with which LEP individuals come in contact with the program;
3.	the nature and importance of the recipient's program, activity, or service to people's lives; and
4.	the resources available to the recipient and costs.

The correct mix for providing language services "should be based on what is both necessary and reasonable in light of the four-factor analysis." See the Language Access Services modules in this curriculum for additional information.

CLAS standards and notes their associated themes and types are tabulated below

Culturally Competent Care

1.	Health care organizations should ensure that patients/consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language. (Guideline)
2.	Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area. (Guideline)
3.	Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in CLAS delivery. (Guideline)

Language Access Services

4.	Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with LEP at all points of contact and in a timely manner during all hours of operation. (Guideline)
5.	Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services. (Guideline)
6.	Health care organizations must ensure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer). (Guideline)
7	Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area. (Guideline)

Organizational Supports

8.	Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide CLAS. (Guideline)
9.	Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations. (Guideline)
10.	Health care organizations should ensure that data on the individual patient's/ consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated. (Guideline)
11.	Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area. (Guideline)
12.	Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities. (Guideline)
13.	Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers. (Guideline)
14.	Health care organizations are encouraged to make available regularly to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information. (Recommendation)

The following statement provides a summary of the importance of developing cultural competence.²

As clinicians, we need to “check our own pulse” and become aware of personal attitudes, beliefs, biases, and behaviors that may influence (consciously or unconsciously) our care of patients as well as our interactions with professional colleagues and staff from diverse racial, ethnic, and socio-cultural backgrounds.

Every clinical encounter is cross-cultural. Developing partnerships with our patients and maintaining “cultural humility” can help us to learn and better understand the historical, familial, community, occupational, and environmental contexts in which our patients live.

It should be understood that there is no one way to treat any racial and ethnic group, given the great socio-cultural diversity within these broad classifications. We need instead to have a framework of interventions that can be individualized and applied in a patient- and family-centered fashion.

Clinical and preventive care needs to be evidence-based, flexible, authentic, and ethical. We need to appropriately tailor our interventions to patients, families, and communities.

Cookbook approaches about working with patients from diverse socio-cultural backgrounds are not useful and instead risk potentially dangerous stereotyping and overgeneralization. Important intergenerational differences exist, and diversity is often greater within groups than between them.

It is important to understand not only patient and community barriers to care, but also clinician and health care system barriers to care. To eliminate racial and ethnic disparity, health care providers and organizations need to become more culturally and linguistically competent.

We need to challenge and confront racism, sexism, classism, and other forms of prejudice and discrimination that occur in clinical encounters as well as in the society at large.

Through collaboration and achieving a better understanding and appreciation of our commonalities and differences, patients and clinicians can become empowered to work together with others to help eliminate racial and ethnic disparities in health care.

One of the key findings of the 2003 National Healthcare Disparities Report is that improvement is possible. The report provides the following examples of exceptions to health care disparities which may result from targeted improvement efforts for certain conditions and communities:

- While Blacks and poor patients are more likely to present with later stage cancers with higher death rates, Black women have higher screening rates for cervical cancer and no evidence of later stage cervical cancer presentation. While it would not be possible to demonstrate a causal link, the significant investment in community-based cancer screening and outreach programs for cervical cancer may be responsible for the lack of disparity.
- Black patients are more likely to receive blood pressure monitoring without any disparity in blood pressure management. A greater perceived risk for significant cardiovascular disease among Blacks may result in appropriately increased screening rates and treatment for risk factors. Directed public education campaigns about cardiac risk factors and the importance of an activated patient may play an important role in the lower observed rate of cardiac disparities among Blacks.

Fast fact

Although diabetes can affect any segment of the population, the disease is especially burdensome among certain groups, particularly African Americans, Hispanic Americans, Native Americans, the elderly, those of the lower socioeconomic classes, and women . . . For women in particular, diabetes can have devastating effects on health. Diabetes effectively eliminates the protection that women generally experience against coronary heart disease, because hyperglycemia and hyperinsulinemia undermine the positive effects of estrogen.

The highest rates of diagnosed diabetes are experienced by Native American tribes in the Southwest, with an estimated prevalence of more than 37 percent. Indeed, the highest prevalence of diabetes in the world (50 percent) is experienced by the Pima Indians of Arizona.

The prevalence of undiagnosed diabetes has been estimated to be as high as 15 percent for Native Americans. These large percentages of undiagnosed diabetes [among ethnic minorities] show not only that the burden of diabetes is much greater than is indicated by the statistics for diagnosed disease, but also that the unrecognized burden is greatest among the non-White culturally diverse groups.

It is significant that non-White populations not only experience higher prevalence of type 2 diabetes, but also suffer from more frequent complications and greater disease severity.

The New Mexico Diabetes Prevention and Control Program analyzed data from the Hospital Inpatient Discharge Database and the Santa Fe Indian Hospital from 2000 by linking hospital discharges to persons to create "episodes" of Lower extremity amputations. The age-adjusted rate of lower extremity amputation by episode was approximately 3.5 times higher for American Indians (11.4 per 1,000 persons with diabetes) than for non-Hispanic whites

MODULE 1.2: Cultural Competency Development

Key Learning Points Module 1.2

1. Developing cultural competence helps to ensure effective, understandable, and respectful care for all patients.
2. A goal of cultural competency development should be to balance knowing specific cultural facts and information with acquiring sound skills and general knowledge of effective clinician-patient interaction in all encounters.
3. The fact-centered approach teaches cultural information about specific ethnic groups. The attitude/skill-centered approach enhances communication skills and emphasizes the socio-cultural context of individuals. Fact-centered and attitude/skill-centered approaches should be balanced.
4. Two important paths to cultural competency development are self-reflection about one's cultural identity and beliefs, and experiences with cross-cultural encounters.
5. Cultural competence is a series of succeeding levels or stages of development, rather than a specific achievement.

Fast fact

A solely fact-centered approach risks presenting patients as racial stereotypes. However, culture-specific knowledge—such as an ethnic group’s historical context, cultural concepts of illness and disease, health-seeking behaviors, health-oriented data and disease patterns, and so on—may be helpful in certain situations.


Cultural Competency Development

The CLAS standards state that healthcare providers should ensure effective, understandable, and respectful care for all patients.

- Effective health care restores the patient to the desired health status and protects future health **by incorporating health promotion, disease prevention, and wellness interventions.**
- Understandable care focuses on the need for patients to fully comprehend questions, instructions, and explanations **from clinical, administrative, and other staff.**
- Respectful care includes considering the patient’s values and preferences and creates an environment in which patients from diverse backgrounds feel comfortable **discussing their specific needs with any member of an organizational staff.**

Fact-Centered and Attitude/Skill-Centered Approaches

A goal of cultural competency development should be to balance knowing specific cultural facts and information with acquiring sound skills and general knowledge of effective clinician-patient interaction **in all encounters. Approaches to developing cultural competence fall into two categories: fact-centered and attitude/skill-centered (Bobo et al., 1991; Scott, 1997).**

Balance fact-centered and attitude/skill-centered approaches.		
The fact-centered approach teaches cultural information about specific ethnic groups		The attitude/skill centered approach enhances communication skills and emphasizes the socio-cultural context of individuals

Examples of Fact-Centered Information

The list below illustrates the types of cultural understandings and beliefs that clinicians should try to identify and accommodate while treating diverse patients. Remember that diversity exists within groups as well as between them and it is important not to over-generalize; clinical care should remain individualized.

- Some communities, African-American and Hispanic for example, have solid religious traditions that help to form beliefs about causes of illness and treatment decisions. Some see prayer as a method of healing and believe that prayer may serve as an alternative to medical care. Some may interpret illness as the result of sinful behavior or the work of the Devil or may see healing as intervention by God or the saints. Or they may hold beliefs that health is God’s to give or take from an individual (Kaiser Permanente, African American Population, 1999).
- Some beliefs envision illness as divided into natural and supernatural. Some Haitians, for example, believe that supernatural illnesses appear suddenly and are caused by evil spirits; in such cases, a voodoo priest would be sought, rather than a clinician (Kaiser Permanente, African American Population, 1999). Mediterranean and other cultures believe in the mal de ojo, or the evil eye, which can cause fitful sleep and sickness (DSM IV TR, 2000).

- The *Diagnostic and Statistical Manual of Mental Disorders* (2000) presents a series of culture-bound syndromes that include, for example, *susto*, an illness in Hispanic and Caribbean groups in the United States in which a frightening event is believed to cause the soul to leave the body. Other culture-bound syndromes include various types of attacks of uncontrollable or aggressive actions, trances, or behavior believed to result from possession by spirits or ghosts.
- Especially in people who are socioeconomically poor, beliefs about fate, or the “will of God,” have significant impacts on decisions to seek health care and adhere to preventive health care guidelines. For example, a study of African- American women in Chicago found that the personal stress of caring for families took precedence over testing for diseases that the women believed they were unable to control (Kaiser Permanente, African American Population, 1999).
- Those who have lived with a historical context of discrimination may be particularly sensitive to impersonal or hasty treatment and may interpret it as racism (Kaiser Permanente, African American Population, 1999).
- In many communities, it is expected that family members, including extended family, will have an important role in treatment decisions. For example, Somalians, Ethiopians, and Eritreans may consider it uncaring for a clinician to tell a terminally ill patient about his or her condition; they prefer that the clinician tell the family about the illness (Kaiser Permanente, African American Population, 1999).
- Hispanic and Haitian cultures respect parental authority even into adulthood.
- Parents or other family members may be highly involved in health-care decision-making.
- In some cultures, blood plays a central role in beliefs about health and healing. African-Americans, for example, may hold beliefs about the importance of the proper balance of blood in the body, and may consume special foods, such as pork, beets, and carrots, to build the blood. Haitian individuals may believe that losing blood through a blood test might make them weak or may be used for voodoo purposes (Kaiser Permanente, African American Population, 1999).
- In some cultures, especially Asian and Pacific Island communities, health beliefs are integrated with worldviews. Those influenced by Buddhist beliefs may see illness as a punishment for transgressions. Confucian beliefs hold that bodily harmony is important, that the body links to ancestors and future generations, and that the body should not be abused. Taoism focuses on the balance of two forces, yin and yang, in the body. Each force dominates half the vital organs and must be balanced, or it will block energy, or chi. Acupuncture, a traditional Taoist treatment, is believed to help chi to flow correctly (Kaiser Permanente, Asian and Pacific Island American Populations, 1999).
- Some cultures believe that the intake of certain types of food may cause illness. For example, in Ayurvedic beliefs, optimal health comes from nutrition based on foods that balance the bile (fire), phlegm (water), and breath (wind) components of the body. Taoism also includes beliefs about the imbalance of various types of foods as a cause of specific types of disease (Kaiser Permanente, Asian and Pacific Island American Populations, 1999).
- Environmental forces are seen to cause illness in some cultures, such as Vietnamese, Laotian, Hmong, Cambodian, and Filipino. High winds and rain are believed to cause rheumatism and respiratory disease, and overheating is seen as a source of fever (Kaiser Permanente, Asian and Pacific Island American Populations, 1999).
- Some American Indian cultures, the Navaho for example, believe that the mention of an illness will cause the illness. So, for example, a discussion of cancer would, in this belief, cause the onset of cancer.

Attitude/Skill-Centered Approaches

Two important paths to cultural competency development are self-reflection about one's cultural identity and beliefs, and experiences with cross-cultural encounters. In general, the road to cultural competency includes making progress toward adopting the principles listed below:

- Understanding self in terms of culture
- Reflecting personal beliefs about cultural competence
- Understanding how race, ethnicity, gender, spirituality, and other issues play a role both in delivery and in perceptions of health care.
- Understanding the community served and the different cultures within the community
- Examining family beliefs, roles, and constructs in the community
- **Developing cultural humility**
- Practicing cultural etiquette

Cultural Competency Development Frameworks

Cultural competency should be considered a series of succeeding levels or stages of development, rather than a specific achievement.

The four frameworks illustrated on the next several pages illustrate the development and characteristics of culturally competent care. Studying the frameworks can help clinicians begin to assess their cultural competency development.

Learning Objectives for Cross-cultural Training of Family Medicine Residents (Bobo, Womeodu, & Knox, 1991) focuses on four areas important for cultural competency development: intercultural concepts, intercultural knowledge, intercultural skills, and intercultural attitudes. The framework balances the importance of understanding cultural facts and developing cultural knowledge about the health beliefs of specific cultures with sharpening skills and knowledge of general patient-clinician interactions that apply to all patient encounters.

¹ Source: U.S. Department of Health and Human Services. *Teaching cultural competence in health care: A review of current concepts, policies, and practices* [Contract # 282-98-0029.]

Intercultural Concepts <ul style="list-style-type: none">• Culture is important in every patient's identity.• Communication of cultural understanding and respect is essential for establishing rapport and confidence.• Culture-related stresses and tensions can induce illness.• Culture-related behaviors (e.g., religion, diet) affect a patient's acceptance of and compliance with prescribed therapy.• Nonverbal and verbal communication may differ from culture to culture.	Knowledge <ul style="list-style-type: none">• (Should be specific for each culture represented and include the following)• Common dietary habits, foods, and their nutritional components• Predominant cultural values, health practices, traditional health beliefs• Family structure—patriarchal vs. matriarchal; nuclear vs. extended; role of individual members• Effect of religion on health beliefs and practices• Customs and attitudes surrounding death• Significance of common verbal and nonverbal communication• Awareness of the culture shock experienced by the very poor and immigrants on entering modern health centers• Awareness of prevailing cross-cultural tensions and psychosocial issues
Intercultural Skills (Should be specific for each culture represented and include the following) <ul style="list-style-type: none">• Communicate an understanding of patient's culture.• Elicit patient's understanding of patient's culture.• Recognize culture related health problems.• Negotiate a culturally relevant care plan with patient as partner.• Interpret verbal and non-verbal behavior in a culturally relevant manner.• Have basic or essential language proficiency.• Apply principles of clinical epidemiology to common illnesses.	
Intercultural Attitudes <ul style="list-style-type: none">• Recognize the importance of the patient's cultural background and environment when constructing an approach to an illness.• Acknowledge the patient's role as an active participant in his or her care.• Accept responsibility for the patient who has few support systems; avoid the "what can I do?" attitude when facing a patient in abject poverty or with language barriers.	

Seven Stages of a Developmental Model of Ethnosensitivity for Family Practice Training (Borkan & Neher, 1991) lays out a progressive model of cultural competency development, from “fear” to “integration.” The framework includes, for example, “denial” or “cultural blindness,” followed by “superiority” or negative stereotyping. The final stage is integration, in which a practitioner “stands both inside and outside a culture, having both deep understanding and a critical viewpoint.”

Stage 7: Integration. The culturally integrated practitioner “stands both inside and outside a culture, having both deep understanding and critical viewpoint.” The integrated clinician is able to make ethical decisions through a contextual evaluation of critical cultural and individual factors. The refinement of cultural integration can continue through fostering integrative skills and multiculturalism.

Stage 6: Empathy. This stage involves a framework shift to be able to experience events as a patient might. Trainees exhibit “pluralism” when they are able to move outside their worldview to come to an understanding of the patient’s value system and worldview. However, ethical decision-making requires more than empathy; it requires an enrichment of cultural experiences.

Stage 5: Relativism. This stage is characterized by the acceptance of ethnic and cultural differences, but a naiveté regarding knowledge of specific differences and their implications on providing care remains. The goals for this stage are to gain experience through cultural exploration and education and to foster empathy.

Stage 4: Minimization. The clinician or student acknowledges that cultural differences exist, but views them as unimportant compared with similarities. The characteristics of this stage are “reductionism” and “universalism.” Reductionism, which most medical training promotes, stresses “biochemistry and pathophysiology models while de-emphasizing the medical effects of personality, family structure, and socio-cultural factors.” Universalism is the idea that universal laws and principles of human behavior exist that transcend human differences. At this stage, it is important to stress individual and group differences by stressing biopsychosocial awareness and by debunking the belief that “common sense” is all that is needed to establish good therapeutic relationships.

Stage 3: Superiority. This stage is characterized by negative stereotyping, which results from “ranking” cultural differences according to one’s culture, or “reversal,” which results in denigrating one’s culture as a result of identifying with another group’s attitudes, beliefs, and practices to the point of seeing their culture as superior. The goal at this stage is to promote the recognition of similarities between cultural groups.

Stage 2: Denial. In this stage, “culture blindness” or “over-generalization” is displayed. A clinician or student may have little understanding of cultural variation and behave as if cultural differences do not exist. The goal at this stage is to “promote recognition of ethnicities” through fostering the simple awareness of cultural differences. The medical trainee must learn that “everyone has an ethnicity.”

Stage 1: Fear. Family clinicians may fear a specific group and idea or have a general mistrust of differences. Fear is an incredibly problematic response because it is a powerful motivator. The goal is to decrease or eradicate fear by using basic approaches and understandings.

A Culturally Competent Model of Care (Campinha-Bacote, 2003) defines cultural competence as “the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client” (family, individual, or community). The model has five constructs of cultural competence.

1.	Cultural awareness is “the process of conducting a self-examination of one’s own biases towards other cultures and the in-depth exploration of one’s cultural and professional background. Cultural awareness also involves being aware of the existence of documented racism in healthcare delivery.”
2.	Cultural knowledge is “the process in which the healthcare professional seeks and obtains a sound information base regarding the worldviews of different cultural and ethnic groups as well as biological variations, diseases and health conditions and variations in drug metabolism found among ethnic groups (biocultural ecology).”
3.	Cultural skill is “the ability to conduct a cultural assessment to collect relevant cultural data regarding the client’s presenting problem as well as accurately conducting a culturally-based physical assessment.”
4.	Cultural encounter is “the process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other encounters with clients from culturally diverse backgrounds in order to modify existing beliefs about a cultural group and to prevent possible stereotyping.”
5.	Cultural desire is “the motivation of the healthcare professional to ‘ want to ’ engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful and seeking cultural encounters; not the ‘have to.’ ”

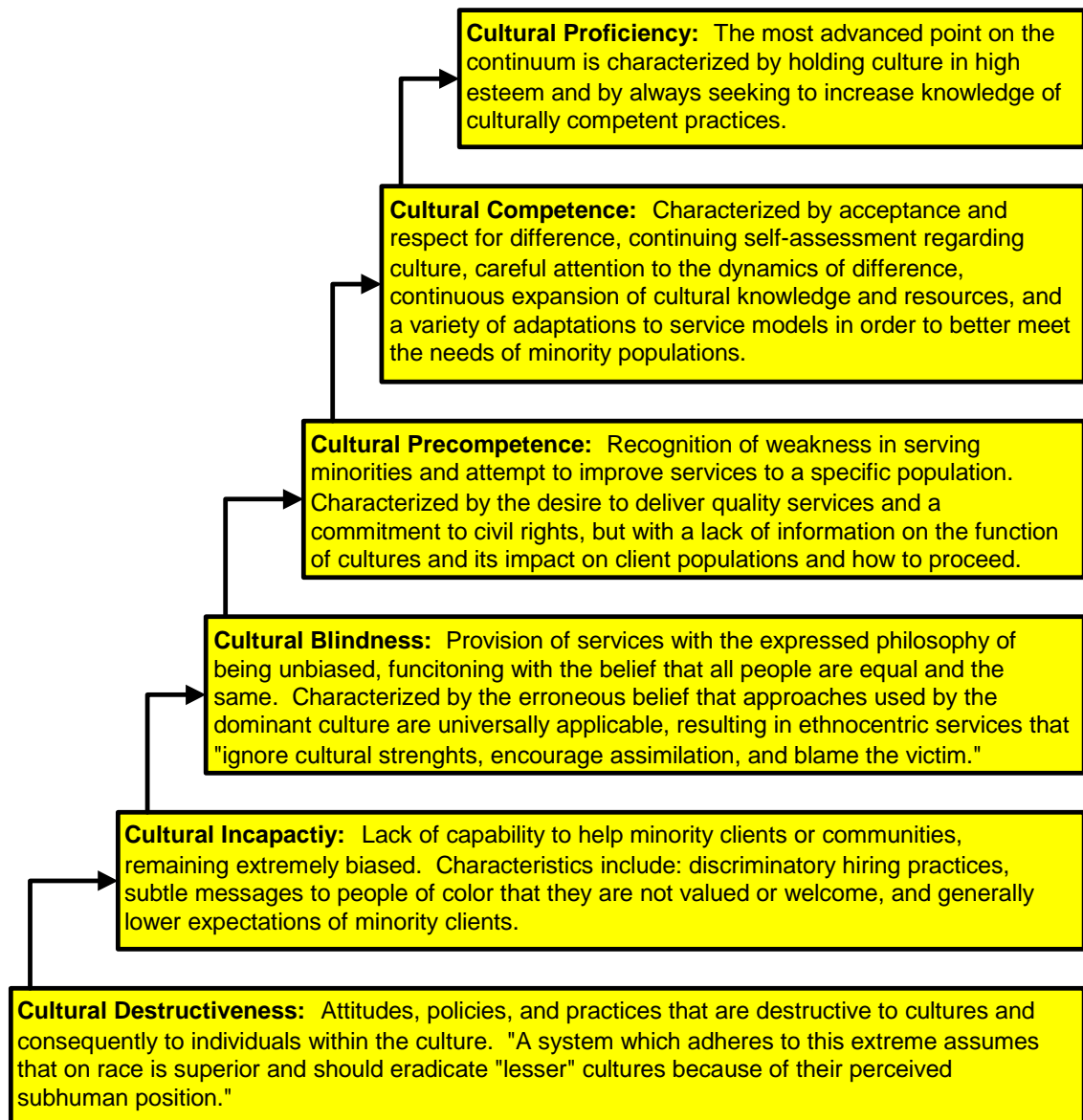
Campinha-Bacote framework depicts cultural competence as a volcano, “which symbolically represents that it is cultural desire that stimulates the process of cultural competence. When cultural desire erupts, it gives forth the desire to enter into the process of becoming culturally competent by genuinely seeking cultural encounters, obtaining cultural knowledge, conducting culturally-sensitive assessments and being humble to the process of cultural awareness.”

The **ASKED** mnemonic—“Have you ‘ASKED’ the right questions?”—(Campinha-Bacote, 2003) assists health care professionals in informally assessing their level of cultural competence.

- **Awareness:** Are you aware of your biases and the presence of racism?
- **Skill:** Do you know how to conduct a cultural assessment in a sensitive manner?
- **Knowledge:** Do you know about different cultures’ worldview and the field of biocultural ecology?
- **Encounters:** How many face-to-face interactions and other encounters have you had with people from cultures different than yours?
- **Desire:** Do you “want to” become culturally competent?



The Developmental 6-Point Continuum Ranging From “Cultural Destructiveness” to “Cultural Proficiency” (Cross et al., 1989) includes the progression from attitudes, policies, and practices that are destructive to cultures, through the recognition of weakness in serving minorities, to holding culture in high esteem and seeking to increase knowledge of culturally competent practice.



SUMMARY

As clinicians work to enhance their cultural competency, it is important that they learn facts about diverse population groups. It is, however, more important to examine individual beliefs and behaviors to continually enhance awareness, knowledge, and skills related to cultural differences.

Module 1.3: Patient-Centered Care and Effective Communication

Key Points

1. A culturally competent clinician must be adept at patient-centered care. Patient-centered care involves being (1) aware of the role of culture in health-seeking behavior and (2) able to **negotiate** appropriate and culturally sensitive treatment options.
2. The word “**disease**” refers to physiological and psychological processes; the word “**illness**” refers to the patient’s meaning and experience of the perceived disease. **A culturally competent clinician must address both a patient’s disease and illness.**
3. Although a clinician might know the scientific way, or “truth” about how to treat a specific disease or condition, learning a patient’s “truth” as formed by culture, language, experience, history, power differentials, alternative sources of care, and other factors is a key to providing culturally competent care.
4. Culturally competent care requires **integrating or coordinating traditional care with conventional evidence-based medicine.**
5. Effective medical interviewing elicits the patient’s explanatory model for his or her illness.

Fast Fact

Patient-centered care “establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs and preferences and solicit patients’ input on the education and support they need to make decisions and participate in their own care” (IOM, 2000).

Patient-Centered Care

A culturally competent clinician must be adept at patient-centered care, including being aware of the role of cultural health beliefs and practices in a person’s health-seeking behavior and being able to negotiate treatment options appropriately and in a culturally sensitive way.

- Every encounter is a cross-cultural encounter in health care. **Principles of patient-centered care should be applied with every patient, not just those belonging to minority groups.**
- Patient centeredness tends to take a holistic approach and emphasizes the cultural and social influences on a person’s health and health beliefs.
- The principles of patient-centered care (Modern Maturity, 2001) include the following:
 1. Treat everyone with dignity.
 2. Share unbiased information with patients and their families.
 3. Strengthen patients’ sense of control.
 4. Collaborate with patients, families, and the broader community in deciding how the [health care organization] looks and functions.
- Patient centeredness is furthered when: (Hurtado et al., 2001)
 1. Patients receive information in their language
 2. Clinicians have greater awareness of potential communication difficulties

3. Care is provided by taking into account the context of the patient's cultural beliefs and practices
- **Patient-centered care empowers the patient as an "expert" of his or her unique illness experience** (Tervalon & Murray-Garcia, 1998).

Interpreting Illness and Understanding Experience

The distinction between the words "disease" and "illness" is important in providing culturally competent care.

- The word **"disease"** refers to physiological and psychological processes; the word **"illness"** refers to the psychosocial meaning and experience of the perceived disease for the individual, the family, and those associated with the individual (Kleinman, Eisenberg, & Good, 1978).
- Individuals seek health care because of their experience of illness. Clinicians, however, are trained to treat disease. The resulting disconnect between a doctor's treatment of disease and a patient's need for treatment of illness (that is, individual interpretation and experience of the disease) is especially significant in cross-cultural encounters.
- **A culturally competent clinician must address both a patient's disease and his or her illness.**

Although a clinician might know the scientific way, or "truth" about how to treat a specific disease or condition, **learning a patient's "truth" as formed by culture, language, experience, history, power differentials, alternative sources of care, and other factors is a key to providing culturally competent care.**

- Examples of cultural and social factors that may influence a patient's experience of illness include socioeconomic standing, immigration status, language, religious traditions, worldview, family relationships, belief about the supernatural world, fatalism, environmental impacts, food intake, understanding of causation of illness, among others.
- Minority patients' backgrounds may include discrimination, lack of quality care in health care organizations, success in treatment with traditional medical approaches, or any number of other experiences that their clinicians may not share.
- Power differences, of some form or another, often define personal experience and, thus, have an impact on beliefs and approaches, including those related to health care.
- **Clinicians have an especially important role in the power differential in health care encounters;** they hold knowledge, ability, and access permissions (e.g., through prescriptions and referrals) to determine whether a patient receives necessary treatment in a timely manner.
- Past experience of power differences, coupled with a perception that clinicians have power over their patient's current condition, has an impact on how both clinicians and patients communicate with one another.
- Recognizing the power differences that patients may perceive (or that clinicians believe they hold) is important to improving communication.
- It is especially important for clinicians to examine their beliefs and behaviors as the "party with power" in clinical encounters.

Understanding a patient's interpretation of illness is closely related to recognizing a patient's understanding of alternative sources of care. For many minorities, traditional or folk models of care and treatment explain illness. **Traditional health beliefs should not be confused with the increasingly popular movement toward "alternative medicine"** (Spector, 2000). Traditional health care methods are based on beliefs and practices integral to a person's culture. Some examples of traditional health care methods (Kaiser Permanente, 1999) include the following:

- Healing rituals
- Herbal medicine
- Managing the balance of hot and cold foods (defined either by a food's temperature or by its perceived characteristics)
- Acupuncture
- Various forms of massage (including massage with special balms and/or hot objects)
- Pinching
- Cupping (placing a heated cup on the body until it cools, creating a vacuum that draws "bad wind" out of the body)
- Ingesting nonfood materials (such as dirt or clay)
- Wearing objects to prevent illness (such as tight belts to keep gas from entering the body)

Those who want to provide culturally competent care should attempt to integrate or coordinate traditional care approaches with conventional evidence-based medical approaches. Pachter (1994) provides guidelines for addressing clinical issues surrounding folk beliefs in a culturally sensitive way, including:

- Becoming aware of the commonly held medical beliefs and behaviors in the patients' community
- Assessing the likelihood of a particular patient or family acting on these beliefs during a specific illness episode
- Arriving at a way of successfully negotiating between the two belief systems

Models of Effective Clinician-Patient Communication

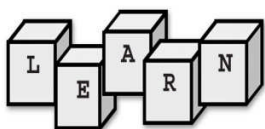
A patient forms an explanatory model that encompasses his or her beliefs about the course of sickness, including its origin, severity, treatment, and expected recovery (Kleinman, 1980). **Effective medical interviewing elicits the patient's explanatory model for his or her sickness.**

Kleinman (1980) suggests the following questions as a tool to elicit health beliefs, or explanatory models, in clinical encounters.

- What do you call your problem? What name does it have?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? Will it have a short or long course?
- What do you fear most about your disorder?
- What are the chief problems that your sickness has caused for you?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from the treatment?

Source: <http://www.diversityrx.org/HTML/MOCPT3.htm>

There are many other models to provide more effective clinician-patient communication in cross-cultural encounters. Five commonly used models are presented below.



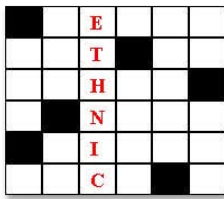
The **LEARN** model suggests a framework of listening, explaining, acknowledging, recommending, and negotiating (Berlin & Fowkes, 1983).

- **Listen** with sympathy and understanding to the patient's perception of the problem.
- **Explain** your perceptions of the problem.
- **Acknowledge** and discuss the differences and similarities.
- **Recommend** treatment.
- **Negotiate** agreement. Becoming aware of the commonly held medical beliefs and behaviors in the patients' community

The **BATHE** model provides a useful mnemonic for eliciting the psychosocial context through asking simple questions about background, affect, trouble, handling, and empathy (Stuart & Lieberman, 2002).

- **Background:** The simple question "What is going on in your life?" elicits the context of the patient's visit.
- **Affect:** Asking "How do you feel about what is going on?" or "What is your mood?" allows the patient to report and label the current feeling state.
- **Trouble:** "What about the situation troubles you the most?" helps the clinician and patient focus and may bring out the symbolic significance of the illness or event.
- **Handling:** "How are you handling that?" gives an assessment of functioning and provides direction for an intervention.
- **Empathy:** "That must be very difficult for you" legitimizes the patient's feelings and provides psychological support.





ETHNIC, a framework for culturally competent clinical practice, includes questions to elicit information about a patient's explanation of illness, treatment, and healers, along with negotiation, intervention, and collaboration about treatment (Levin, Like, & Gottlieb, 2000).

Explanation

- What do you think may be the reason that you have these symptoms?
- What do friends, family, or others say about these symptoms?
- Do you know anyone else who has had this kind of problem?
- Have you heard about, read about, or seen it on television, radio, or newspaper? (If patients cannot offer explanations, ask what most concerns them about their problems.)

Treatment

- What kinds of medicines, home remedies, or other treatments have you tried for this illness?
- Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it.
- What kind of treatment are you seeking from me?

Healers

- Have you sought any advice from alternative/folk healers, friends, or other people (non doctors) for help with your problems? Tell me about it.

Negotiation

- Negotiate options that will be mutually acceptable to you and your patient and that do not contradict but rather incorporate your patient's beliefs.
- Ask what are the most important results that your patient hopes to achieve from this intervention.

Intervention

- Determine an intervention with your patient. This intervention may include the incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g., foods eaten or avoided in general and when sick).

Collaboration

- Collaborate with the patient, his or her family members, other health care team members, healers, and community resources.

Practical Guide to Culturally Competent Care: NEON Primer for Theme 1

The **ESFT** model guides clinicians in understanding a patient's explanatory model, social and environmental factors, fears, and concerns and in contracting for therapeutic approaches (**Carrillo, Green, & Betancourt, 1999**).

- An explanatory model is a patient's conception of his or her illness.
- In the case of a patient not taking prescribed medication, Dr. Betancourt presented some sample questions to apply the ESFT model (www.amc.edu/patient/HIV/pdf/betancourt_Jan2001.pdf).

Explanatory model:

- What do you think caused your problem?
- Why do you think it started when it did?
- How does it affect you?
- What worries you most?
- What kind of treatment do you think you should receive?

Social and environmental factors:

- How do you get your medications?
- Are they difficult to afford?
- Do you have time to pick them up?
- How quickly do you get them?
- Do you have help getting them if you need it?

Fears and concerns:

- Does this medication sound okay to you?
- Are you concerned about the dosage?
- Have you heard anything about this medication?
- Are you worried about the side effects?

Therapeutic contracting (treatment):

- Do you understand how to take the medication?
- Can you tell me how you'll take it?

The holistic "sunrise model" presents nine main domains that influence the care and health status of individuals, families, groups, and socio-cultural institutions (Leininger, 1978):

1.	Patterns of lifestyle
2.	Specific cultural values and norms
3.	Cultural taboos and myths
4.	Worldview and ethnocentric tendencies
5.	General features that the client perceives as different from or similar to those of other cultures
6.	Caring behaviors
7.	Health and life care rituals and rites of passage to maintain health
8.	Folk and professional health-illness systems used
9.	Degree of cultural change

Practical Guide to Culturally Competent Care: NEON Primer for Theme 1

Below is a communications model summary checklist. It would be appropriate to use one or more of the models depending on the clinical situation and patient's responses. Use one or more of the models depending on the clinical situation and patient's responses.

LEARN		ESFT	
<input type="checkbox"/>	Listen	<input type="checkbox"/>	Explanatory model of health and illness
<input type="checkbox"/>	Explain	<input type="checkbox"/>	Social and environmental factors
<input type="checkbox"/>	Acknowledge	<input type="checkbox"/>	Fears and concerns
<input type="checkbox"/>	Recommend	<input type="checkbox"/>	Therapeutic contracting
<input type="checkbox"/>	Negotiate		
BATHE		Sunrise	
<input type="checkbox"/>	Background	<input type="checkbox"/>	Patterns of lifestyle
<input type="checkbox"/>	Affect	<input type="checkbox"/>	Specific cultural values and norms
<input type="checkbox"/>	Trouble	<input type="checkbox"/>	Cultural taboos and myths
<input type="checkbox"/>	Handling	<input type="checkbox"/>	Worldview and ethnocentric tendencies
<input type="checkbox"/>	Empathy	<input type="checkbox"/>	Caring behaviors
ETHNIC		<input type="checkbox"/>	General features that the client perceives as different from or similar to those of other cultures
<input type="checkbox"/>	Explanation	<input type="checkbox"/>	Health and life care rituals and rites of passage to maintain health
<input type="checkbox"/>	Treatment	<input type="checkbox"/>	Folk and professional health-illness systems used
<input type="checkbox"/>	Healers	<input type="checkbox"/>	Degree of cultural change
<input type="checkbox"/>	Negotiation	<input type="checkbox"/>	General features that the client perceives as different from or similar to those of other cultures
<input type="checkbox"/>	Intervention		
<input type="checkbox"/>	Collaboration		

SUMMARY

Providing culturally competent care includes patient centeredness. Understanding a patient's interpretation of illness and the factors that contribute to the interpretation is critical. Several frameworks for effective clinician-patient communication help clinicians to understand a patient's "truth" about his or her illness, in light of social, cultural, historical, and other factors that contribute to a patient's experience.