University of Colorado

Department of Pediatrics

Cross-Cultural Health Care Curriculum

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Cross-cultural Health Care Curriculum (Syllabus)
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Program Objectives and Overview

Background
- Over one-third of the children in the seven Metro Denver counties are from a culture other than their healthcare provider's: Hispanic, African-American, Native-American or Asian-American.
- By 2020, approx 40% of US school-age children will be members of minority group
- By 2020, expected that 1:5 children in US will be Hispanic origin
- Health outcomes for Hispanic, African-American, Native-American, Asian-American and children recently emigrated from most other countries have health outcomes that are poorer than American-born, White non-Hispanic children.
- There are many potential reasons for these poor health outcomes.
- This curriculum discusses what health care providers can do to improve those health outcomes for these child

Objectives
- Understand local demographics
- Understand health disparities in Colorado’s children
- Understand the causes of these health disparities and what providers can do to reduce them
- Understand the concept of culture
- Begin to think about personal cultural beliefs and values and develop self awareness of personal biases
- Understand the dimensions of culture
- Demonstrate ability to take culturally sensitive history
- Recognize cultural values, not perpetuate stereotypes
- Learn how to integrate families’ cultural beliefs into medical plan
- Demonstrate ability to use appropriate medical interpreters
- Recognize pitfalls in LEP encounters
- Be able to recognize families at risk for limited health literacy and effectively help them
- Ensure our residents fulfill RRC requirements
- Incorporate this enhanced knowledge and skills into everyday patient care and regular conferences and teaching.
Demographics of Colorado’s Children

99% of private practice pediatricians in Colorado are white, non-Hispanic

96% of UCHSC pediatric residents are white, non-Hispanic

33% of children in Colorado are raised in a family from culture other than their healthcare provider’s

40% of newborns are born into a family from a culture that is different from their provider’s

34% of Colorado children (nearly 400,000) live in poverty or near-poverty…and 65% of these children are identified as belonging to a minority (i.e., minorities were twice as likely as white, non-Hispanic children to be poor).

The Children’s Hospital clientele:
  Hispanic – 35%
  African American – 15%
  Asian – 3%
  White, non-Hispanic – 45%
Health Disparities among Colorado’s Children

Health disparities are differences that occur by gender, race and ethnicity, education level, income level, disability, or geographic location. Low income children and children from ethnic and racial minorities do not enjoy the same health outcomes that white, non-Hispanic children do. The 2005 National Healthcare Disparities Report, prepared by the U.S. Department of Health and Human Services, tracks scores of health quality parameters (like HEDIS measures) and access indicators. For 85% of the quality parameters that DHHS tracks for these families, the trends were significantly worse in the past 5 years for low income families, Hispanics, African American, Native Americans.

African American children make up around 15% of the children in the US
- Lower immunization rates than white, non-Hispanic children
- Infant mortality rates are 2.5 times greater than for European Americans.
- Higher incidences of obesity and type II diabetes
- Higher rate of dental caries
- They have higher rates of disabling conditions
- Among African American asthmatics, 40% more rate their asthma control as poor compared to white, non-Hispanic
- Higher death rates at all ages
- Higher rates of injuries
- More likely to have a limitation of activity
- More than twice as likely to have elevated blood lead levels.
- Less likely to have a medical home and less likely to receive preventive health education

Native American / Alaskan Natives
- Lower immunization rates than white, non-Hispanic children
- Infant mortality rate is 1.5 times higher for than for European Americans.
- Higher incidences of obesity and type II diabetes
- Higher rate of dental caries
- Higher incidence of disabling conditions
- Less likely to have a medical home
- Less likely to receive preventive health education

Hispanic / Latino Americans
- Lower immunization rates than white, non-Hispanic children
- Higher incidences of obesity and type II diabetes
- Two times higher rate of dental caries than white, non-Hispanic
- Two times as high a rate of asthma as white, non-Hispanic (but it differs by geographic origins: 2 times higher in Puerto Ricans than Mexicans)
- Less likely to have a medical home
- Less likely to receive preventive health education

Pacific Islanders
- Two times as high a rate of type II diabetes as white, non-Hispanic
- Twice as high a rate of previous Hepatitis B acute infection
- Two times as high a rate of asthma as white, non-Hispanic
- Infant mortality is 2/3 higher
Preventive Care

These groups have poorer outcomes compared to White, non-Hispanic

<table>
<thead>
<tr>
<th></th>
<th>African American</th>
<th>Latino</th>
<th>Asian/ PI</th>
<th>NA/AN</th>
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<tbody>
<tr>
<td>Higher percentage do not have a medical home</td>
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<tr>
<td>Low rates of immunization</td>
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<tr>
<td>Low rates of Preventive care</td>
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<tr>
<td>Receive less health education</td>
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</table>

PI – Pacific Islander
NA – Native American
AN – Alaskan Native

Medical Conditions

These groups have poorer outcomes compared to White, non-Hispanic

<table>
<thead>
<tr>
<th></th>
<th>African American</th>
<th>Latino</th>
<th>Asian/ PI</th>
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<tbody>
<tr>
<td>Higher incidence of asthma</td>
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<td></td>
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<tr>
<td>Poorly controlled asthma</td>
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<td>Higher hospitalization rates for asthma</td>
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<td>Higher death rates from asthma</td>
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<td>Higher rates of dental caries</td>
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<tr>
<td>Higher incidence of obesity</td>
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<tr>
<td>Higher incidence of type II diabetes</td>
<td>√</td>
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<td></td>
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<tr>
<td>Hepatitis C rate</td>
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<tr>
<td>Higher injury rates</td>
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</table>
These groups have poorer outcomes compared to White, non-Hispanic

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<tr>
<th></th>
<th>African American</th>
<th>Latino</th>
<th>Asian/ PI</th>
<th>NA/AN</th>
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</thead>
<tbody>
<tr>
<td>Poorer outcomes for chronic disease</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>Higher incidence of disabling conditions</td>
<td>✓</td>
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<td></td>
<td></td>
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<tr>
<td>Higher infant mortality rates</td>
<td>✓</td>
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<td>✓</td>
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<tr>
<td>Higher death rates</td>
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Health Disparities – Contributing Factors

The potential causes of these health disparities are, of course, very complex. And they differ from one family to another and form one condition to another. However, there is good research to support the contribution of the following causes to health disparities in children.

**Poverty** – most influential cause, but not the only cause.…  
Contributes to reduced access to health care, poor nutrition, inadequate housing, barriers to health behaviors and greater exposure to environmental threats.

**Environmental exposures** – Blacks have twice the incidence of lead poisoning. Asian immigrants have a higher incidence of Hepatitis C.

**Life style behaviors** – reduced access to everything needed for healthy behaviors.

**Genetics** – health conditions associated with geographic origins.

**Provider’s ability to understand and accommodate to the patient’s / parent’s culture**

Provider’s skill in **cross-cultural communication**

Patient’s / parents' **limited English proficiency**

Patient’s / parent’s **limited health literacy**

**Discrimination** - In some cases, there is individual conscious discrimination (a belief that a certain ethnic or racial group is less likely to follow medical advice). More commonly, there is inadvertent institutionalized discrimination (i.e., minorities and low income families have significantly reduced access to a medical home, continuity of care, specialists). Another example of inadvertent institutional discrimination is the lack of ability to provide care that the family can understand when they don’t speak English or they have limited understanding of what their health care provider says to them.
Poverty

Poverty is clearly the most influential factor and explains most of health discrepancies.

African American, Hispanics and Native Americans are at least twice as likely to be poor as white, non-Hispanics.

Poverty = 100% of the Federal Poverty Level
Near-poverty = 200% of the Federal Poverty Level

To be able to afford health insurance on your own, you need to be above 400% of the FPL.

Children in poverty (100% FPL) or near poverty (200% FPL)
- Less likely to have a medical home
- Lower immunization rates than children in higher income families
- Higher incidences of obesity and type II diabetes (2 times higher)
- Higher rate of dental caries
- Higher rates of asthma and higher rates of acute episodes
- Higher rates of obesity (3 times the rate of higher income children)
- Higher death rates at all ages (1.67 times higher)
- Higher rates of complications of illness (1.67 times higher)
- More likely to have multiple health problems
- Higher rates of hospitalization (1.73 times higher)
- Higher rates of vaccine-preventable disease (2.11 times higher)
- Higher rates of disability
- Lower compliance rates
- Lower rates of continuity of care
- Much lower rates of receiving preventive care visits (more than 2 times lower)
- Higher absentee rates at school
- Higher cost of health care as adults

Poor children compared to other children

<table>
<thead>
<tr>
<th>Preventive Care</th>
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</thead>
<tbody>
<tr>
<td>Do not have a medical home</td>
<td>✓</td>
</tr>
<tr>
<td>Low rates of immunization</td>
<td>✓</td>
</tr>
<tr>
<td>Low rates of preventive care</td>
<td>✓</td>
</tr>
<tr>
<td>Receive less health education</td>
<td>✓</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical Conditions</th>
<th></th>
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<tbody>
<tr>
<td>Higher incidence of asthma</td>
<td>✓</td>
</tr>
<tr>
<td>Poorly controlled asthma</td>
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<td>✓</td>
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<tr>
<td>Higher death rates from asthma</td>
<td>✓</td>
</tr>
<tr>
<td>Higher rates of dental caries</td>
<td>✓</td>
</tr>
<tr>
<td>Higher incidence of obesity</td>
<td>✓</td>
</tr>
<tr>
<td>Higher incidence of type II diabetes</td>
<td>✓</td>
</tr>
</tbody>
</table>

**Outcomes**

| Poorer outcomes for chronic disease                | ✓ |
| Higher incidence of disabling conditions           | ✓ |
| Higher infant mortality rates                      | ✓ |
| Higher death rates                                 | ✓ |

**Children with Cystic Fibrosis**

- Worse outcomes for minorities
- All of the poor outcomes go away when control for socio-economic status
Poverty Status Of Children, 2001

Non-Poor
(200% + FPL)

Near Poor
(100% + 199% FPL)

Poor
(<100% FPL)

% of Children 0-17 Who are Uninsured or Have Periods of No Insurance Coverage by Race/Ethnicity - 2003

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>14%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>42%</td>
</tr>
<tr>
<td>African American</td>
<td>48%</td>
</tr>
<tr>
<td>Asian Only</td>
<td>68%</td>
</tr>
<tr>
<td>American Indian/Alaska Native</td>
<td>46%</td>
</tr>
</tbody>
</table>
Percentage of children who do not have access to a medical home

- White NL
- Black NL
- Latinos
Children in poverty or near poverty are less likely to have a medical home, as are minority children.

The percent of children who have a medical home:

- White, non-Hispanic - 73%
- Black – 39%
- Hispanic - 30%
- Poor children (100% of the FPL) – 31%
- Asthmatics with a consistent medical home dramatically improve their health outcomes
Current Asthma Prevalence by Poverty Status: United States, 2004

Source: National Health Interview Survey; National Center for Health Statistics
Genetics

It appears that African Americans may actually have a higher incidence and higher degree of severity of asthma to a degree not explained by poverty and the other factors.

Interestingly, Puerto Rican Hispanics have a higher incidence of asthma than White, non-Hispanics and Hispanic children from Mexico have a lower incidence than either of the above.

Hispanics in general (even those from Mexico) have poorer health outcomes. The poorer outcome for Mexican immigrants suggests poverty has influenced outcomes.
Environmental exposures
Life style behaviors

Environmental exposures
• Closely tied to poverty
• Substandard housing
• Dust, mold, pollution, ventilation, lead, etc.

Life style behaviors
• Certainly influences health outcomes
• Poor families have reduced access to food, facilities and supports needed to promote healthy behaviors
Provider’s ability to understand and accommodate to the patient’s / parent’s culture and to communicate well with families

Patient’s / parents' limited English proficiency

Patient’s / parent’s limited health literacy

Review of research

This table summarizes the medical literature regarding poor outcomes resulting from these three factors

<table>
<thead>
<tr>
<th>Provder Poor Understanding of Patient’s Culture</th>
<th>Limited English Proficiency</th>
<th>Limited Health Literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health outcomes poorer</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Compliance poorer</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Higher complication rates</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Higher rates of medical errors</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>High rates of unneeded testing</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>High hospitalization rates</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Higher rate of missed appointments</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Family satisfaction rates lower</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Higher cost of care</td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

When the health care provider does not understand or effectively respond to the culture, expectations, values, beliefs or culture-based behavior of the patient and their family

- Health outcomes are poorer
- Compliance (adherence) s poorer
- Higher rate of complications
- Patient understanding of illness is poorer
- More likely to receive unneeded testing.
- Less likely than others to return for follow-up appointments
- Higher rates of hospitalization
- Higher rate of missed appointments
- Patient / parent satisfaction with care is lower
When the patient / parent has limited English Proficiency

- Less access to health care. Less likely to have a medical home
- Poorer quality of care
- Increased risk of adverse health outcomes
- Lower adherence to medication or treatment plans
- More likely to miss appointments
- More likely to defer needed medical care
- Less likely to receive preventive care
- More likely to experience medication complications
- More likely to receive unneeded testing.
- Less likely than others to return for follow-up appointments
- Higher rates of hospitalization
- Higher rates of drug complications
- More expensive care for acute illness
- Lower levels of patient/parent satisfaction.

When the patient / parent has limited health literacy

- Asthmatic children’s use of medication and control of asthma was directly related to the literacy of their parents
- Poorer health outcomes
- Increased risk of adverse health outcomes
- Lower adherence to medication or treatment plans
- More likely to miss appointments
- More likely to defer needed medical care
- More likely to experience medication complications
- More likely to receive unneeded testing.
- Less likely than others to return for follow-up appointments
- Higher rates of hospitalization
- Higher rates of drug complications
**Institutionalized Biases**

**Individual discrimination**
When an individual treats someone unfairly based on their group membership. Or could be simply a bias (assumption) about a certain group that influences how people in the group are treated.

**Institutionalized discrimination**
When regular operations of social institutions result in unequal opportunities or treatment

**Disparity in management**
Blacks and Hispanics are less likely to be on appropriate medications to control asthma
7 percent of Black children are prescribed routine medications to prevent future asthma-related hospitalizations
2 percent of Hispanic children
21 percent of white children
Blacks and Hispanics are less likely to be referred to specialists for asthma care
How Can We Help Reduce Health Disparities?

What interventions have been shown to improve health outcomes for children?

- Improvement in family’s socio-economic status
- Coverage in a health plan
- Having a medical home and continuity of care
- Case managers, resource coordinators, social workers
- Outreach: health navigators, Promotoras, outreach workers
- Training for providers and staff in **cross-cultural communication skills**
- **Increased attention to health education, prevention and early intervention**
- Attention to **linguistic needs of the family**
- Attention to **health literacy** (understanding) of the family

<table>
<thead>
<tr>
<th>Causes</th>
<th>What can we do?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetics</td>
<td>Recognize at-risk patients, Screening, Early Detection and Intervention.</td>
</tr>
<tr>
<td></td>
<td>Advise families about prevention</td>
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<tr>
<td>Poverty</td>
<td>Assist families in accessing community resources. Provide a medical home for</td>
</tr>
<tr>
<td></td>
<td>low-income families. Advocate for health coverage for children. Provide</td>
</tr>
<tr>
<td></td>
<td>outreach for low-income families.</td>
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<tr>
<td>Environmental exposures</td>
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<tr>
<td>Life style</td>
<td>Health Education</td>
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<tr>
<td>Provider’s ability to understand and</td>
<td>Cross-cultural Communication Skills</td>
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<tr>
<td>accommodate to the patient’s /</td>
<td>Cultural sensitivity/responsiveness training for staff and providers</td>
</tr>
<tr>
<td>parent’s culture</td>
<td></td>
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<tr>
<td>Patient’s / parent’s limited English</td>
<td>Appropriate interpretation</td>
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<tr>
<td>proficiency</td>
<td></td>
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<tr>
<td>Patient’s / parent’s limited health</td>
<td>Recognition and accommodation to literacy/understanding level</td>
</tr>
<tr>
<td>literacy</td>
<td></td>
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<tr>
<td>Discrimination (BIASES)</td>
<td>Self Awareness and Personal Growth</td>
</tr>
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</table>
What can a pediatric provider do?

- **Self awareness** for the individual and the practice regarding biases
- Recognize higher risk
- Advise families on prevention practices and education
- Ensure adequate screening and good surveillance for early recognition
- Provide early treatment and detailed education
- Provide culturally sensitive care (cross-cultural communication training for everyone in the practice), including:
  - Provide linguistically appropriate care
  - Provide care that addresses health literacy issues
- Accept Medicaid, CHP+ and uninsured children into the practice
- Make administrative changes to improve the practice’s ability to provide effective care for all cultures.
- Be an advocate in behalf of low-income families

Race is a socio-political construct that categorizes people who are considered to share distinct characteristics like skin color, facial features, hair texture, body shape and size. Very, very few pure races any more. 99.9% of genes in any two unrelated people on the planet are alike. And the majority of genetic variation (85%) within a group (racial, ethnic, religious) can be found in any two members of the group. The American Anthropological Association passed a resolution in 1997 that “differentiating species into biologically defined ‘races’ has proven meaningless and unscientific.” Its usefulness is just in drawing attention to issues like health disparities.

Genetic conditions relate more to geographic origins than “race.” “The information about genetic group membership captured by race is less than that obtained by making inferences of ancestry from geographic origins or from family history.” Bamshad, JAMA, 2005. So, rather than asking about the race of parents and grandparents, providers are being taught to ask about what countries (regions) their ancestors came from and to ask about specific conditions in the family history.

A minority group is a category of people who have unequal access to power, socioeconomic status, privileges, wealth, and opportunities. It is not defined by absolute numbers, but by access. This has a socio-political use, but not a medical use.

Ethnicity refers to shared cultural heritage or nationality. Ethnic groups can be distinguished on the basis of language, beliefs, values, dietary customs, certain social behaviors, etc.

"Culture" is defined as a shared system of values, beliefs, and learned patterns of behavior among a group. It is the “lens” through which people view the world. And culture includes the social factors that influence the way individuals think about health and illness and how they relate to health care professional.

Culture is not equivalent to just race or ethnicity. We all belong to multiple cultures, including the “medical culture”. Culture is dynamic and it evolves over time, as geographic, historical, social, economical, political, educational conditions change. There are obviously many different cultures in the US. The same is true in Mexico. There is no one culture, but many different ones: farmers in northern Mexico….wealthy residents of Mexico City….people descended from Native Americans…..people recently immigrated from Spain, etc.
What is Culture?

By Marcia Carteret

The meaning of “culture” has been widely debated and it can be defined in many ways. For our purposes in the medical field the following definition is useful:

*Culture can be seen as an integrated pattern of learned beliefs and behaviors that can be shared among groups and includes thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs. (Robins et al., 1998b)... Culture should not be considered “exotic” or about “others.” We all are influenced by and belong to multiple cultures that include, but go beyond, race and ethnicity. (IOM)*

| The culture a person learns early in life becomes a set of hard-wired mental and emotional “operating instructions” for how to go about getting basic needs met. |

As humans, we develop our self-esteem and identity within a particular cultural context. Without a clear cultural identity, we would experience confusion and isolation. Our resistance to cultural difference is natural. It is important to recognize the resistance we feel, to see it as part of being human and avoid turning it into something negative. Resistance to cultural difference is a phase we pass through on the way to becoming more cross-culturally aware and skillful.

To begin moving beyond resistance, we first have to ask some basic questions. Do we see our own culture as the “one” that is central to reality? Do we assume our way of operating in the world is better, thereby trivializing difference automatically? In the field of intercultural communications, the terms ethnocentric and ethnorelative are often used. Ethnocentric means that we view our own culture as being central to reality. Ethnorelative means we can indeed experience our own culture within the context of other cultures. Moving through resistance means moving towards a place of comfort in the ethnorelative stage.

You might be thinking at this point, “OK, I understand the concepts here, but what can I DO to become more cross-culturally skillful. The answer may surprise you. The first step is learning more about your own culture – American culture. Are you thinking, “We Americans don’t really have a culture because we are a melting pot of other cultures.” If so, you are in good company; many of your fellow Americans feel the same way. But you
do have a culture, and it is a very specific one. Your culture is something people around the world are keenly aware of, so it’s a good idea to learn how others see you. Further, as a healthcare provider to increasingly multi-cultural populations right here in Colorado, it is vital that you understand your culture as a baseline for comparing other cultures. Hopefully this feels like good news because an imbalance has been addressed. Instead of feeling charged with responsibility for learning about everyone else, you realize that you too are part of the culture game. You have something to learn about yourself first, and then, hopefully, learning about others will be more meaningful and more pleasurable. You’ll be able to replace the paralysis of political correctness with an intercultural playfulness. One day, you’ll even be able to laugh at yourself for behaving so darned American in a situation.

It’s worth addressing what we mean by “American” before we start exploring specific cultural dimensions in other cultures, like time and its control, individualism and language use. Just what constitutes being an American? It’s a tricky question. There are Asian Americans, African Americans, Native Americans, etc. All of these “groups” are absolutely Americans. But for our purposes here, being very specific, we are addressing the styles of communicating, ways of interacting, values and beliefs that are rooted in what interculturalists often refer to as Americans of Northern European descent. In other words, historically speaking, white middle and upper class citizens of the US.

Based on the definition we are using here, if you think of yourself as an “American,” ponder the following questions. Go beyond a quick “yes, no” response – feel your answers as they arise in you. This is very important.

- Do you feel as if there’s enough time in your life to do all the things you want and need to do?
  
  Americans think of time as a very important commodity. For many, time dictates much of their day. Much more than other cultures.

- When you ask someone a question, do you expect a straight answer? If she gives a long story as an answer or “beats around the bush,” does it frustrate you?
  Americans are very linear thinkers who value efficiency in most things, including conversation. “Get to the point.”

- How important is a person’s being direct? Do you depend on others to “say what they mean, and mean what they say”?
  Americans are direct in their style of communication. They depend on the words they speak to convey the message they intend. Non-verbal cues are given less emphasis than in other cultures.
• Do you believe that hard work and determination will enable you to achieve your goals?
  *Americans believe in their ability to create the future they want for themselves. Americans place far less emphasis on the role of fate in life.*

• Do you respect a person who knows his own mind and can think for himself and doesn’t need several other people to help?
  *Americans value the individual over the group and this is very evident in decision making.*

• Do you believe in the ideal that everyone should be treated equally?
  *Americans tend to be very informal and believe everyone should be treated the same. In many other cultures, status plays a greater role in social interactions.*

• Do you believe that technology and science should be trusted to provide new solutions to replace the old solutions to common problems?
  *Americans (especially medical people) believe in science providing new solutions that are better than old solutions. Most other cultures do not believe this as strongly as we do.*
Cross-cultural Communication

By Marcia Carteret

Have you ever wondered why people from some cultures talk so loud and seem aggressive? Why do they stand so close to you when they speak? Or maybe you’ve wondered why some patients seem reluctant to speak or maintain eye contact? Could that be cultural? Why do people from some cultures make it difficult to get a straight answer to a simple question? Why do some people from some cultures seem not to follow our advice? And why is it that some patients never show up on time – don’t they own a clock? Is a lax attitude towards time a cultural or individual behavior? Neither? Both?

Intercultural communication in its most basic form refers to understanding how people from different countries and cultures behave, communicate and perceive the world around them. Given the growing multicultural population in the US, intercultural communication research is actively being applied in healthcare settings so that doctors and their staffs can relate effectively to their patients from diverse cultural backgrounds. We will share that research and specific tips with you.

One of the most important skills needed for intercultural communication is the ability to recognize, in any given interaction with someone from another culture, which of their behaviors are universal human behaviors and which are peculiar to a cultural group(s) and which are specific to that individual. We will provide tips on how to distinguish these behaviors.

The most effective communication skills are the same in an intercultural setting as those we use to communicate within our own culture: listen without judging, repeat what you understand, confirm meanings, give suggestions and acknowledge a mutual understanding. However, when we are communicating with a different culture, we need to add to these basic skills. We need to build some understanding of how, even with the best intentions, our misperceptions can cause confusion and create misunderstanding. In patient-doctor interactions, the stakes are high. Confusion over which bus takes you downtown is one thing, but misunderstanding that leads to misdiagnosis is quite another.

At first glance, it might make sense to learn the beliefs, customs, and taboos of each “foreign” culture we interact with regularly. But memorizing lists of dos and don’ts is both impractical and ineffective because every situation is different. It is the context of an intercultural interaction that is key. By way of example, you might be told that in Japan it
is customary to bow when you are greeting someone. True, but you need to understand the status relationships of the people involved to know how to bow. If you don’t bow appropriately, you will surely offend someone more severely than if you don’t bow at all because a Japanese person doesn’t expect a foreigner to understand their custom. In fact, many Japanese will say they prefer that foreigners not bow unless they really understand what the gesture means and the context of the interaction. Obviously, it would be peculiar to bow to a Japanese patient during an office visit here. It would be totally out of context.

If rote learning about beliefs, customs, and taboos is ineffective, then how can we learn to be better intercultural communicators? The answer lies in developing both an intercultural mindset and skill set. We need to learn to recognize cultural differences and also be able to maintain a positive attitude towards those differences. We need to develop a skill set, beginning with a thorough understanding of what culture is and what our own culture looks like. What lens do we look through when judging other cultures? Many Americans can’t say much when asked to describe American culture - just as a fish can’t describe the water it swims in. Our skill set also includes a thorough understanding of the difference between stereotypes and generalizations. Stereotypes are very destructive to good communication, but generalizations, if used mindfully, are necessary to making sense of the human experience.

**Learning About Other Cultures: Is it Effective Use of Cultural Generalizations or Is It Stereotyping?**

By Marica Carteret

In almost every cross-cultural program I deliver, the question comes up about generalizations and stereotypes. It’s an ever-present issue because people are afraid of saying something unacceptable and being viewed by others as insensitive, critical, backwards, or worse. The truth is, that we all do plenty of generalizing and stereotyping, and it’s useful, for starters, to acknowledge that. Only then can we begin to explore the predisposition all humans have for classifying other humans and themselves. It isn’t hard to learn to distinguish between stereotyping, which inhibits cross-cultural communication, and generalizing which can be used to interpret and attribute meaning to what we experience when interacting with other cultures.

To survive in this complicated world, we use our senses every moment to acquire information about the surrounding environment and our immediate situation. This cognitive process is truly miraculous. Without the capabilities of our brains to make sense
of the input that bombards us, we wouldn’t be able to function. Through the perception process, we make sense of what we have observed. We select the information we take in, simplify it, and categorize it using general labels. We even fill in gaps for information we don’t have to piece together an understanding of ourselves and other people based on appearance, roles, interactions, and categories of belonging. A person is male or female, young or old, etc. He or she plays certain roles in life – doctor, student, attorney, wife, and so on. We consider social behavior and personality. Is a particular person friendly, helpful, aloof, nervous? We also decide about a person’s belonging. Is he or she a republican, an immigrant, a Christian, etc.

The final stage of our cognitive processing is attributing meaning to what we have observed and categorized. We rely on socialization and our own recurring experiences to interpret what we’ve put into mental categories.

When someone says in a corrective tone, “you’re generalizing,” it suggests that we are guilty of sloppy thinking. However, considering the complexity of processing all the stimuli in our experience, it is arguably more accurate to think of generalizing as a natural and necessary function of the human brain. In cross-cultural situations, there’s a lot of information to take in, and generalizations help with the sorting. Generalizations are useful in summarizing the shared values, beliefs, and practices of cultural groups. If we use generalizations carefully as a starting point for learning about people from other cultures, we can gain useful understanding. However, if we apply a generalization to every person in a group, if we fail to consider whether or not a statement we make is appropriate to an individual, we have stereotyped. We must always test our generalizations and be aware of those individuals who do not fit the mold, so to speak.

I find that healthcare providers who worry about stereotypes and generalizations are the ones least likely to offend. Their awareness of the negative impact cultural insensitivity can have on provider-patient relationships and health outcomes means they are likely to use generalizations about cultures appropriately, modifying their own behaviors to improve interactions with patients. There’s certainly nothing sloppy in that. Quite the opposite. It’s what being culturally aware is all about. Let’s look at a few examples:

1.) We can generalize about immigrants to the United States being people from lower classes who haven't had the benefit of education in their countries of origin. This is, in fact, often the case. However, there are also immigrants in the US who are highly educated, having given up prestigious careers in their home countries. Perhaps they work
menial jobs in America, but were once university professors or doctors. Individuals with this experience can become extremely frustrated when people talk down to them because their command of English is imperfect and they have joined the low-income class in the US.

2.) We often generalize that Asian women are quiet and submissive. Well, this might be true of women from traditional Asian cultures. The time-honored role of women in many Asian countries emphasized these qualities. To avoid stereotyping, we need to consider the background of the individual. How long has she been in the US? Which Asian country is she from? There are important cultural differences between the Chinese, Japanese, and Koreans, to name a few. How educated is the woman? Many Asian American women are outspoken and assertive. Many are successful entrepreneurs who contribute significantly to their family's income. An introverted individual may appear to fit the traditional stereotype, when in fact her behavior isn't about culture. It's about who she is.

3.) People from countries around the world generalize that white middle-class Americans don't learn to speak foreign languages. While it is true that our schools don't place as great an emphasis on learning foreign languages as schools do in many other countries, plenty of white middle-class Americans are bi-lingual. I've encountered a number of staff in CCHAP pediatric practices who speak Spanish fluently in addition to English. These individuals certainly don't fit the mono-lingual American generalization. How might they react to a person from Spain expressing astonishment that an American actually speaks Spanish?

What Providers and Staff Need To Know About Culture (Dimensions of Culture)

By Marica Carteret

American Culture
Cultural aspects of everyday life are often difficult for people of dominant cultures to discern because their practices, traditions, values, and understandings are taken for granted as the norm. For them, there's no apparent need to examine cultural difference, and thus, no inclination to do so. In the US, middle-class Americans are typically so unaware of their own culture they believe that American culture is a melting pot of other cultures. This misperception is further complicated by confusion over terms - like white, American, the dominant majority, mainstream, middle class, western, European
American. For our purposes here, American means “middle-class European American” and refers specifically to the “cultural ways of the group that in recent decades has held a mainstream position in North America. These are people who are primarily of Western European descent, with a social position that is often characterized as middle class on the basis of having participated in high levels of formal schooling and associated occupations.” (Rogoff 2003)

Now that we’ve established what the term American points to in this article, let’s begin to look at some specific dimensions of American culture. A dimension of culture is a recognizable point of comparison used to explain how different cultures prefer to approach and solve a universal problem. There are more cultural dimensions than we can possibly address here, so we will focus on a few that seem especially relevant to patient/provider interactions.

Time and Its Control
For Americans, time is a critical factor that is battled on a daily basis. We’re in an adversarial relationship to time. We talk about saving or wasting time, managing time and beating the clock. Americans invented day-timers and added the term multi-tasking to the English language. We invented fast food and made it even faster by adding the drive-thru. Now even our pharmacies offer drive-thru pick-up.

Many of the other cultures in the world have a more relaxed view of time. In a healthcare setting, busy practitioners may not realize that patients from different cultures often experience the rushed pace of an office visit as disturbingly impersonal. It is important to slow down enough to exchange a few words of personal conversation with patients. Ask how their family is doing. This gesture only takes a few moments. It puts patients more at ease so they can respond more openly to medical questions. If the doctor is in a big hurry, patients won’t ask for clarification about treatment and medications. Establishing a conversational style also helps providers introduce conversation about cultural beliefs around illness which can be very important in diagnosing and achieving patient compliance. Physicians will succeed best with patients from different cultures when the care and the cure are experienced as inseparable.

Comfort with Change
Americans are fundamentally optimistic and place faith in the future. As a young culture with few traditions tying us to ways of the past, our identity and inspiration are projected forward in time. Americans link change to progress, development, and growth. We like things that are “New and Improved!” Older traditional cultures consider change to be
disruptive and unpredictable. In other words - *negative*. When a new medical procedure or miracle drug becomes available, Americans are likely to respond with optimism while patients from risk-adverse cultures will show pessimism. Doctors who demonstrate balance in this area will gain the most patient confidence. Clearly risk-avoidance varies from person to person within a culture, and plenty of Americans prefer what’s safe and predictable too. But as a generalization, we in the US do tend to take chances and embrace change.

**Personal Control Over Destiny**

Americans tend to believe that every individual has primary control over his or her destiny. There isn’t typically a strong belief in the power of fate or karma. In many cultures there is a belief that things, including illnesses, happen for a reason and may be beyond our control. People may show a tendency to resign themselves to bad things in a way that Americans never would. “It’s God’s will.” This doesn’t mean patients/families won’t put faith in an American doctor’s medicine, but there may be surprising belief systems operating around what has caused illness or how much control they can exert on the outcome. A Hispanic mother may believe that her child has *Mal d’ojo*, or has been cursed with the “evil eye.” Members of the traditional Hmong culture believe a baby’s soul can be detained by a malevolent spirit called a *dab* causing a number of serious illnesses including epilepsy.

**Self-Sufficiency**

Closely related to the American emphasis on individual control over destiny is the value of being self-sufficient. To succeed without depending on others shows supreme self-determination, self-reliance, and self-confidence. The concept of being self-sufficient, however, doesn’t translate into all languages and the trait is not valued in many other cultures. People from Hispanic and Asian cultures, who have strong attachment to families and communities, emphasize a skillful use of the bonds between families and friends when making decisions and getting things done. Interdependency is a more helpful cultural adaptation in many cultures around the world. The US healthcare system presents all of us with a unique set of challenges, but those who are from different cultures will really struggle to demonstrate the kind of self-sufficiency we respect in America. The very nature of working together to find solutions means everyone – provider, staffs, patients, and their extended families - relinquishes self-sufficiency to some degree.

**Language**

Language use as a cultural dimension deserves a whole separate article, but the basics can
be touched on here.

Americans are low context communicators, so the words we speak are expected to deliver everything that’s important during verbal interaction. We pay far less attention to factors such as body language and the context of what is being said. In high context cultures, gesture, body language, eye contact, pitch, intonation, word stress, and the use of silence are as important as the actual words being spoken in conversation. High context cultures tend to communicate in a less direct fashion. Americans, being low context, are comfortable with very direct speech and sometimes seem abrupt to people from high context cultures. We miss the nuances of conversation. Americans appreciate communication that gets straight to the point and tend to interrupt when conversation isn’t moving along. People from many other cultures do not feel they have had a chance to adequately explain their concerns until they have told “the whole story.” This is important to keep in mind when communicating with people from different cultures, especially those who are relatively new to the US. Interactions with Americans who are highly verbal and direct can be challenging for someone who is accustomed to telling a story as a way of answering a question. Americans aren’t the only direct/high context communicators in the world, but we certainly rank among them.

Individualism
Cross-cultural research shows US Americans score higher on this cultural value than any other culture in the world. All the values we’ve addressed up to this point are closely related to this one aspect of American culture. Individualism is the belief that each individual’s interests should take precedence over those of the social group. Collectivist cultures, by comparison, assign value based on the role a person plays within a group. If people were stars in the sky, being one of the seven brightest stars forming the Big Dipper would be more important to someone from a collectivist culture than being the single brightest star. In American culture, where the individual is paramount, everyone wants to be the North Star.

Individualism versus collectivism is an important dimension of culture because it affects the way people live together – for example in nuclear families or extended families – and it has many implications for values and behavior. Childrearing as a whole is handled differently in collectivist cultures. The child in a collectivist culture is seldom alone, either during the day or night. Children are reared by an extended kin group that may or may not include family like ties with persons who are not biological relatives. Important health decisions are not made solely by an individual – parent or otherwise. In many collectivist cultures, the term “family” doctor points to a medical relationship that is
indeed more like family. Several generations visit the same physician, establish rapport and hold certain expectations for interaction with their doctor. Compare this to searching for doctors on the internet in the United States, or having to choose from an approved list of physicians in a managed care network. Feeling like an isolated stranger visiting a doctor’s office can cause great anxiety for a recent immigrant. There’s much uncertainty about how the medical system works, about insurance, about how an American doctor will relate to cultural and language barriers. All of these worries are an added burden to the actual illness that requires medical attention in the first place. So, a mother from a collectivist culture will likely bring a grandmother, aunt, or family friend for support when she visits a pediatrician. Big decisions about procedures, such as surgery, may take hours as wives ask husbands, husbands consult elder brothers, elder brothers consult the father or perhaps even a community healer. This can create confusion and frustration for western doctors, but collectivism is a deeply rooted value. The classic American individualist who stays aware of how collectivist cultures operate will be much more skillful in cross-cultural interactions. Being group-oriented isn’t better or worse than being more individualistic. Both ways of approaching life have advantages. As with all the dimensions of cultures, awareness of difference without judgment is the path leading to happier healthier patients and successful providers.

Summary
This article has introduced six dimensions of American culture. Learning about our own cultural patterns provides us with a baseline for comparing cultures that are different. As we develop self-awareness around cultural experience, we are able to observe without leaping to judgment. We realize there’s a difference between what we actually observe and how we label our observations based on our own cultural programming. In the process of becoming more aware of interactions with culturally diverse patients, providers hone communications skills that benefit all patients. Increased patient satisfaction and health outcomes lead to happier providers and more successful practices. Certainly within the medical culture, that’s seen as a win-win situation of great value.

Basics of Cross-Cultural Communication

Often, people attending cross-cultural communication trainings expect to learn a lot about cultural do’s and don’ts that can be applied reliably in interactions with patients. They are disappointed when I say that such lists are impractical if not downright problematic. There are three reasons I point to when explaining why lists of dos and don’ts won’t work. First, even if it were possible to assemble a comprehensive list of facts for each culture, the challenge of memorizing such information and keeping it straight would be enormous – and people don’t use lists, anyway. Second, people are varied in every
culture and no simple list would be capable of capturing the variations within each culture. Third, and perhaps most important, interactions between people happen within a given context and it is the context that should dictate behavior more than memorized lists of ritual greetings, cultural rules of etiquette and so on.

In Thailand, it is considered rude to touch someone’s head - even a child’s. Also, inferiors generally keep their heads at a lower level than those they consider their superiors. Knowing these two things, would you need to adjust your behavior with a Thai family during an office visit in Denver? How would you determine your rank versus theirs? Do these same two rules of behavior apply across Asian cultures?

Clearly, lists of cultural dos and don’ts may actually create more confusion than clarity. In place of culture-specific lists, it proves more useful to build awareness around a set of solid generalizations that apply when conversing with a variety of non-American cultures. First, in order to establish a strong baseline of comparison, it is important to learn about key dimensions of American culture that have practical application in healthcare settings. For a review of these, refer to last month’s article. (www.cchap.org/nl18) Once you are grounded in an understanding of your own cultural norms, keep in mind the following basics for conversing cross-culturally.

Formality in Interactions: Americans tend to be very informal because we value equality among people and will often downplay overt expressions of status. This is related to our strong sense of individualism. We tend to be on a first name basis with a lot of people regardless of social position or rank within organizations. However, many of our patients will come from cultures where there is an element of formality in interactions between people early in relationship. For example, verbal and nonverbal communications with Hispanics are characterized by respecto while Asians focus on the importance of maintaining face/harmony in interactions. This is especially true with older persons and those who come most recently from very traditional societies. Over-familiarity, signaled right off by a casual use of first names, would not be appreciated in these cultures. Mr., Ms., and Mrs. should be used as a rule.

Eye Contact: Americans typically look directly into each other’s eyes when talking, conveying informality, spontaneity, and equality in their exchange of glances. When eyes shift and avoid meeting those of the other person, Americans may sense disinterest or perhaps even deception. However, a lack of consistent and strong eye contact may be a sign of respect or humility in other cultures. In some Asian cultures, eyes may be downcast or sweeping, and this often disturbs Americans. “He wouldn’t look me in the...
eye!” In Hispanic culture, direct eye contact is used far less and direct disagreement with a provider is uncommon.

**Head Nodding:** Nodding of the head may be a sign of acknowledgement rather than agreement in some cultures. The nod may be saying, “Yes, I am listening to you intently” rather than “yes I understand what you are saying and I agree.” The usual response to a decision with which the patient or family disagrees is silence and noncompliance. So, nodding and silence may mean “I am listening…but I am not in agreement.” The only way to know is to ask in a respectful manner what they are going to do (or are willing to do).

**Taking Turns in Conversation & Silence:** The way conversation gets passed between people varies greatly between cultures, and it is the length of sustained eye contact that cues conversational turn taking. Americans tend to make medium-length eye contact before looking away, and they use a longer direct gaze to cue changing speakers. In other cultures, where a direct gaze may be confrontational, lack of eye contact may make it awkward for Americans to pass conversation back and forth. Being generally uncomfortable with any period of silence in conversation, Americans will tend to rush through pauses and quickly complete sentences that dangle. As a result, people from less direct cultures may struggle to participate equally in conversation with Americans, an obvious hindrance in successful patient-provider exchanges. The solution is to practice allowing silence, which necessitates slowing down conversation and more careful listening as well. Being a task-oriented culture, Americans tend to want conversation to get to the point, where other cultures will use it to build relationship. The use of silence suggests really hearing, considering, and valuing what is being said by the other person and is critical in cross-cultural interactions to establish trust.

**Use of Body Language:** Americans tend to be moderately expressive when it comes to body language, gesturing freely compared to most Asians, but seeming constrained when compared to some Latin or Arab cultures. An American might misread an exaggerated use of hands or arms in conversation as an indication of excitability or distress in a person when, in fact, it means nothing of the sort. Keeping this in mind, providers should stay aware of how their own gesturing could be interpreted. Moving hurriedly and gesturing broadly might create discomfort for an Asian patient/parent but go relatively unnoticed by someone from the Middle East.

**Use of Humor, Smiling and Laughter:** A wise interpreter will avoid translating humor for the good reason that jokes and sarcasm don’t translate well across cultures. In some cultures, humor can even be seen as aggression or dominance. Americans, because we are
individualistic and confident, tend to do a lot of put-down humor. We love to poke fun at ourselves and others. This can be confusing for people from other cultures where close attention is paid to preserving the dignity of all people in a given interaction – in Asian cultures this is called saving face. A well-intentioned provider, whose position automatically conveys status, would confuse some families by poking fun at himself. It could easily disrupt the sense of trust vested in him or her, especially for patients from formal cultures.

Finally, in American culture, there’s a big difference between a wry smile and happy smile, just as in many Asian cultures a ‘masking smile,’ with corners of the mouth turned down, is a polite way of letting you know what you are doing is not appropriate. Similarly, in many Asian cultures, especially in Japan, laughter can be a sign of embarrassment rather than a response to humor as it typically is in the US. Healthcare workers interacting with patients from Asian cultures need to remember the difference between high and low context cultures. Reading facial expressions, body language, etc. is second nature to people from Asian cultures, but goes unnoticed by many Americans unless they make a concerted effort to pay closer attention in cross-cultural situations.

Summary: Since lists of dos and don’ts for a culture can prove impractical for many reasons, it is best to work on developing a cross-cultural mindset instead. This means building awareness around what we call culture-general frameworks that call attention to areas of difference that are most important to consider when first encountering someone from another culture. By observing families in light of these generalizations, and by being willing to adjust to what you are hearing and observing, you will develop your own practical style. The most effective and practical approach will be to carefully apply these generalizations but leave room for individual differences and variations.
How to communicate with and help families with Limited English Proficiency


Case: A 10-year-old Latino boy comes to your office with the complaint of dizziness and a headache. The patient, Raul, seems to speak English pretty well and his mother speaks no English. You, as his provider, speak a little Spanish. Your office has one receptionist who speaks Spanish, but this is her day off. So, Raul acts as his own interpreter. His mother described his symptoms: "La semana pasada a el le dio mucho mareo y no tenia fiebre ni nada, y la familia por parte de papá todos padecen de diabetes." (Last week, he had a lot of dizziness, and he didn't have fever or anything, and his dad's family all suffer from diabetes.) The mother goes on. "A mí me da miedo porque el lo que estaba mareado, mareado, mareado y no tenia fiebre ni nada." (I'm scared because he's dizzy, dizzy, dizzy, and he didn't have fever or anything.)

Turning to Raul, you ask, "OK, is she saying you look kind of yellow?"

Raul interprets for his mother: "Es que si me vi amarillo?" (Is it that I looked yellow?)

"Estaba mareado, como pálido" (You were dizzy, like pale), his mother says.

Raul turns back to you and says, "Like I was like paralyzed, something like that."

If Raul receives inappropriate care due to his misinterpretation, he would not be alone. A receptionist in one office mistranslating for a nurse practitioner, told the mother of a seven-year-old girl with otitis media to put (oral) amoxicillin "in the ears." In another case, a Spanish-speaking woman told a resident that her two-year-old had "hit herself" when she fell off her tricycle; the resident misinterpreted two words, understood the fracture to have resulted from abuse, and contacted the Department of Social Services (DSS). DSS sent a worker who, without an interpreter present, had the mother sign over custody of her two children. Another provider misinterpreted “intoxicado” as intoxicated, rather than nauseated and treated the teenager for intoxication for 48 hours, when the patient actually had nausea and vomiting associated with increased intracranial pressure. That resulted in a malpractice suit. Clearly, catastrophes can and do result from such miscommunication.

Nearly 50 million Americans (18.7 percent of U.S. residents) speak a language other than English at home; 22.3 million (8.4 percent) have limited English proficiency, according to self-ratings. Between 1990 and 2000, the number of Americans who spoke a language other than English at home grew by 15.1 million (a 47 percent increase), and the number with limited English proficiency grew by 7.3 million (a 53 percent increase).

Research clearly shows that language barriers impede access to health care, compromise quality of care, and increase the risk of adverse health outcomes among patients with limited English proficiency (LEP). When a parent has LEP, the family is less likely to adhere to medication or treatment plans, is more likely to miss appointments, is more
likely to defer needed medical care, is less likely to have a medical home, receives less preventive care, and is more likely to experience medication complications. Language barriers can lead to inefficient care because clinicians are unable to elicit LEP patients’ symptoms and, thus, use more diagnostic resources or invasive procedures. Children with asthma, whose families have LEP are less likely than others to return for follow-up appointments, have higher rates of hospitalization and drug complications, have more expensive care for acute illness, have an increased risk of intubation, and have lower levels of patient/parent satisfaction. The risk of medical errors and malpractice suits is higher. Many studies document that trained professional interpreters and bilingual providers improve health outcomes, reduce the number of tests and hospitalizations and improve parent and provider satisfaction.

In a busy office practice, ad hoc interpreters, including family members, friends, untrained members of the support staff, and the patient are commonly used as interpreters. Unfortunately, these ad hoc interpreters are considerably more likely than professional interpreters to commit errors that may have adverse clinical consequences. Ad hoc interpreters are also unlikely to have had training and knowledge needed to be effective: medical terminology, confidentiality, proficiency in English as well as the foreign language and the role of the interpreter. Ad hoc interpreters also may have priorities that conflict with those of patients and their presence may inhibit discussions regarding sensitive issues such as domestic violence, substance abuse, psychiatric illness, and sexually transmitted diseases. It is especially risky to have children interpret, since they are unlikely to have a full command of two languages or of medical terminology; they frequently make errors of clinical consequence; and they are particularly likely to avoid sensitive issues. In some cultures (especially Asian cultures), the child is expected to “take care of” the parent who does not speak English well. So, be sure to reassure the child that it is not anything against them personally, but that Federal guidelines require an older person to translate.

The Office for Civil Rights 2003 guidelines seem to allow smaller health care facilities (i.e., practices) to opt out of providing language services for which costs are too burdensome. But, private practices are expected to at least have one of the following for languages often spoken in their patient population: bilingual staff, staff interpreters, volunteer interpreters, contract interpreters, or telephonic interpretation.

**Using Casual Interpreters** (family members or volunteers)

In some instances, you may not have a formal interpreter available or telephonic voice interpreting. In that case, you may have to use a “casual” or an “ad-hoc” interpreter. This might include a co-worker, a family member or community volunteer, but never a child. Some states, like California, are already working on legislation to prohibit using a child as an interpreter.

Be aware that when using ad-hoc interpreters, there is a higher risk for errors than when using trained interpreters. But there are times when it cannot be avoided. You should be much more cautious and double check important issues. Remember that, when using
family or a friend, confidentiality may become an issue and/or embarrassment. If you sense this may be an issue, get a trained translator or use a phone language line.

In some families, the child may be expected to “take care of” the parent who does not speak English well. So, be sure to reassure the family that it is not anything against them personally, but that medical, as well as Federal, guidelines require an older person to translate. Acknowledge the importance of the perspective of the ad hoc interpreter (family member or friend) and talk with him/her enough to understand that perspective. And then emphasize the importance of getting information as directly and precisely as possible from the patient. Trust your senses: if the responses seem inadequately translated, or the history is confusing, insist on getting a trained interpreter or use the AT+T translation line.

And, of course, in the context of domestic violence, spouses or partners should not be used as interpreters.
Effectively Working With a Trained Interpreter in Your Practice

In our last newsletter, we described the literature on health care for children with a parent who has limited English proficiency (LEP). Using untrained family members, volunteers or staff can result in poor clinical outcomes. The most cost-efficient method to address this problem is to have bilingual staff, who are trained in medical Spanish and who use the methods used by professional interpreters. CCHAP now offers this type of training (see announcement in this newsletter). This newsletter describes how providers can most effectively work with trained interpreters in practice.

Clinicians working effectively with interpreters

1. Permission and confidentiality
Be sure to ask for permission from the patient/family to use the interpreter you have selected and, when feasible, inquire about whether there may be things they would not want to discuss in front of this person. If in doubt, trust your instincts and choose to use a phone language line for sensitive issues.

2. Pre-interview
Prior to entering the exam room, briefly discuss with interpreter: the general reason for the visit, known issues, and the goals for the encounter without breaking confidentiality.

3. Role of the interpreter
In the pre-interview, discuss with the interpreter the roles you want her/him to take. Do you want the interpreter to simply interpret the words or do you want the interpreter to assist in better understanding barriers or needs of a cultural nature.

4. Starting
Ask the interpreter how to say an appropriate, professional greeting in the family’s native language and use the greeting to begin the visit. Most of us feel awkward about talking through an interpreter. Feel free to say so and encourage the parent to let you know if it is not working well for any reason.

5. Etiquette
When possible, try to arrange for you to face the patient, with the interpreter on the side. Ask the interpreter about the family’s cultural preferences regarding eye contact, closeness of sitting proximity, touching, etc. Talk directly to the patient and parent, in the first person, as you would normally do.

6. The Dialogue
Try to use single questions and short phrasing. Attend to the interpreters need to interpret what you are saying, and break long statements and questions down to shorter segments. Periodically check whether the parent/patient understands by asking them to repeat their understanding. If you wonder about the meaning or length of response, ask the patient and interpreter to clarify. Be patient, some phrases in English may require longer sentences in other languages to have the same meaning.

7. The Story
In many cultures, there is a tradition of “telling the whole story.” So, the parent may talk for several minutes and the translator may give you a much shorter interpretation. But, it may well be that the parent will want you to know the whole story and the degree to which you hear the whole story may influence their level of trust and compliance later.
So, spend them time up-front. Ask the translator to tell you the story, show interest.

8. **Barriers**
Be sure to ask the interpreter to explore whether there are barriers that might interfere with treatment: monetary, transportation, attitudes, concerns, beliefs or other cultural barriers, as you would with any patient.

9. **Adequate understanding**
In this setting, there is obviously greater chance that the parent will not have a complete understanding. Allow ample time for questions and specifically ask whether they have gotten all of their questions answered. It is particularly encouraging if you learn the word for “question” in the parent’s language.

10. **Debriefing**
Before leaving the room, ask the patient/parent to provide feedback through the translator. Also ask the interpreter for any feedback the interpreter has regarding potential barriers or concerns about the parent’s understanding or ability/willingness to follow through.

[Click here to go to an excellent article on this topic](#)

Ideal positioning allows for maintaining eye-contact and observation of non-verbal communication

Triangle positioning disrupts the primary provider-patient relationship and inhibits the provider from observing closely for visual cues

IDEAL POSITIONING

AVOID THIS POSITIONING
Using the Clearest English Possible: 8 Tips for Communicating with Limited English Proficiency Patients and Families

By Marcia Carteret

Many of the practices I have visited for the purpose of cross-cultural training are lucky to have staff and providers on their team who speak Spanish and other foreign languages. However, some practices are seeing patients from such diverse cultural backgrounds that it is impossible to have staff and providers capable of understanding all the languages of these patients. During cross-cultural trainings, we talk about the fact that patients from different cultures often nod their heads during conversations with healthcare providers, but this does not necessarily mean that they understand what is being said to them. Culturally, a head nod may be a gesture of respect, a way of saying, “Yes I am listening and being attentive. I recognize and appreciate your professional expertise.” The key question that comes out of this particular conversation in trainings is, “What can be done to make sure patients understand what is being said to them?”

The answer is twofold. First, it is absolutely critical in any healthcare situation that open communication take place, so don’t back off from asking questions in a culturally sensitive way. Americans often experience paralyzing anxiety around political correctness, which definitely shuts down vital communication. You have to push yourself to reach beyond your comfort zone in many situations. Secondly, try your hardest to use the clearest English possible when speaking to nonfluent English speakers. Naturally, you don’t want to offend anyone by oversimplifying, but always be prepared to err on the side of simplicity to maximize understanding. The tips that follow can be adapted to a broad range of nonnative speakers.

TIP #1: Keep in mind, English is a difficult language. We take for granted in the US that much effort is made by people around the world trying to learn our language. If English is your first language, you may not realize you were lucky to learn English without much conscious effort and it is hard to appreciate the struggle of those who have to put great effort into speaking and understanding it. Consider this illustration of how difficult English is: If the word through is pronounced “throo” then why is enough pronounced “ee-nuff?” Why isn’t the word cough pronounced “coo?” Why is threw sometimes spelled through, and why do these two words that sound exactly the same mean two completely different things?

It’s also very difficult to learn which syllable gets the accent in English words: beginning (DEN-ver), middle (col-o-RAD-o), or end (cor-TEZ). In many other languages the accents are equal or they are indicated in the spelling of the word like Còmo està. Also consider the strange spelling of English words like science and since not to mention the illogical trio their, there, and they’re.

TIP #2: Keep it Simple. In work settings, we slip into our professional roles, often changing our way of speaking automatically so that we choose words like utilize instead of use. With limited English proficiency patients and families, the 5¢ word is always better than the 75¢ word. Basics such as good, give, take, more, less will be better choices than positive, administer, increase, decrease. Keep word choice simple and keep sentences simple as well. Avoid run-on sentences. Americans tend to be uncomfortable with silence, so we ramble on if there’s a break in conversation. As we ramble, we tend
towards more complex ideas rather than simpler ones. Allow some silence between simple phrases.

**TIP #3: Give and Seek Feedback.** Even if you are using simpler words and shorter sentences, you can’t be certain there has been communication until the receiver acknowledges it with feedback. Remember, head nodding does not count as feedback with people from many different cultures. Even with Americans, and definitely with children, head nodding is often a sign of partial comprehension. So you must ask clarifying questions.

There are two kinds of questions.

1.) **Close ended questions:** These usually begin with do, did, does, is, are, will, or can. These can be answered with a simple yes or no – or a head nod. Avoid the use of close-ended questions with LEP patients because in many cultures people will frequently simply say yes even if they don’t understand you. If a person doesn’t want to contradict the doctor or other healthcare professional, nodding or saying yes is a way of keeping harmony in the interaction. A patient or parent may nod and then leave the doctor’s office with little understanding of what to do next. Or, the person may have no intention whatsoever of complying with the recommendations for treatment that were given for cultural reasons that were never discussed.

2.) **Open-ended questions:** These usually begin with the 5 Ws – who, what, when, where, why (and how or how many). It’s not possible to answer these questions with a nod, shrug, or simple yes/no. For example, you might ask a patient/parent, “What do you think has caused this illness?” Or, “How long have you been seeing these symptoms?” “What are you most worried about?”

**TIP#4: Not Understanding vs. Misunderstanding:** Keep in mind that when people don’t understand you, you are more likely to get some indication of miscommunication than when they misunderstand you. When there’s a lack of understanding, there’s often a break in the conversation. A person may ask you to repeat what you have said or you may read confusion in facial expressions. But when people misunderstand, they may be less likely to indicate this, especially if they come from an indirect and face-saving culture. For example, the English words want and won’t sound very much alike to a nonnative speaker. You may say to a person, “I want to help you,” but she may hear “I won’t help you.” She may be perplexed that this is your response, but she may be very inclined to accept the word of a healthcare professional who is in a position of authority. She may perceive you as being uncaring, but certainly won’t say so. Many misunderstandings go unnoticed by both parties. Asking clarifying questions is crucial.

**TIP#5: Speak Slowly and Clearly – NOT Loudly** Often when people don’t understand our language we treat them as if they are deaf or “slow” without realizing it. Articulate your words in shorter phrases rather than just speaking more loudly.

**TIP #6: Repeat if Necessary** Much of what we gain from a conversation is the context or general content of the discussion. Our brains constantly fill in the missing information. If we don’t actually hear every word, we compensate. For example, if I say, “I left you a message on your _______” you will almost automatically fill in the blank with cell phone, phone, or voicemail. Nonnative speakers will struggle to do
Tip #7: Avoid Acronyms, Idioms, Abbreviations

The medical culture has a language of its own that includes many acronyms such as ED, PO, NPO, etc. Always take the time to say things the long way and avoid terms that will create confusion for nonnative speakers. It’s best when setting appointments to say “eight o’clock in the morning” instead of “8 a.m.” Common expressions and idioms can also block communication. If you say, “I’ll run that past the doctor,” an LEP patient may literally picture you running to the doctor which sounds urgent when you intended a casual tone. Imagine how confusing an expression such as “we can kill two birds with one stone” might sound in the context of a doctor’s appointment. I’ve often been surprised at the language people use in cross-cultural settings with nonnative speakers. Especially when we are rushed, tired or stressed our self-awareness slips.

TIP #8: Write It Down, Demonstrate While Speaking

Providing simple notes about the key points of an office visit and expectations for patient follow up can be very useful to LEP patients and families. Written material with more detailed information about medications and treatments can also be very helpful in conjunction with thorough explanation in the doctor’s office. A really thorough explanation will include checking for understanding via open ended questions, gesturing while speaking, demonstrating the application of topical medications, etc. Even English learners who have had the benefit of formal education were probably exposed largely to workbooks and taped dialogues. They have little practice with actual conversation and can’t understand native speakers. For those persons who have had no formal schooling, written material may be beyond their capacity entirely, but perhaps someone at home can help translate what is written. That way they have a reference point for what was said in conversation with the healthcare provider. Written material can be taken away and read at a leisurely pace without pressure is often greatly appreciated.

Communicating with limited English proficiency patients is one of the greatest challenges for healthcare professionals. Having a fluent speaker on hand who is either a trained interpreter, a staff member, or adult family member is ideal, but not always possible. Hopefully, the eight practical tips covered here will prove helpful, along with adopting a determined mindset about overcoming the fear of making mistakes in conversation with culturally different patients. Being willing and able to ask questions in a culturally sensitive way is vital. For providers, it is also important to be familiar with the LEARN mnemonic: listen, explain, acknowledge, recommend and negotiate.
Limited Health Literacy:
A Very Important Hidden Health Disparity

CASE: You are seeing a new patient for an illness visit. The mother is given a registration form and a medical history form to fill out. Fifteen minutes later, she and her 2 year-old son are directed into a patient room where the nurse reviews the forms and notices that they are incomplete and contain many spelling errors. She helps the mother fill in the blanks. After the history and physical exam and after you discuss the treatment, you ask, “Do you have any questions?” The mother says, “No” and takes a written handout without further comment. When the nurse returns and again asks if she has any questions, the mother again replies, “no” and says she is late for another appointment and asks if she can leave. The nurse discharges her.

Health Literacy
According to the 2003 National Adult Literacy Survey, there are approximately 89 million adults with significant literacy deficits that affect what they understand at a health visit or what they understand from a healthcare handout. The survey estimates that 21% of our population is functionally illiterate with another 27% having marginal health literacy skills.

Health literacy dramatically influences health outcomes. For example: Glycated hemoglobin levels in a diabetic child are directly correlated to how well the parent and child understand the instructions given to them by their healthcare provider. The HgbA1C levels are 1.5 times higher when the patient/parent has low health literacy skills, and the cost for care can be 3 to 4 times higher.

Malpractice case law makes it clear: the responsibility for making sure patients understand their instructions rests with the clinician.

Who is at risk?
African American adults are two times more likely than White non-Hispanics to have difficulty understanding instructions at health care visits or in handouts. Hispanic adults are 3 times more likely and Asian Americans are 1.5 times more likely than White non-Hispanics to have health literacy problems. However, in absolute numbers, more white non-Hispanic adults are considered to be functionally health illiterate than minority populations. And, of course, highly educated, highly literate adults often report that they do not understand instructions given by their healthcare provider.

Key Steps to reduce the effect of limited health literacy
Recognize parent/patients with limited health literacy
Create a “shame-free” environment
Develop a communication style that promotes good understanding in all parents and patients
Confirm the parent’s / patient’s understanding
Use patient-friendly materials
Recognize families with limited health literacy
The majority of parents (patients) with limited health literacy do not tell anyone about their limitations, especially people in the health care system. The group at highest risk for limited health literacy is, of course, families where English is their second language. Other signs that may be a clue for limited health literacy include:
Incomplete or inaccurate forms
Poor adherence (compliance) with treatment
Lack of follow-through on appointments, testing and referrals
Parents who do not ask questions
Parents who ask many more questions than most parents
Parents who cannot name medications or describe how to correctly give them
Parents who say “I forgot my glasses” or “I will read it later.”

How can clinicians ask about health literacy in a way that enables parents to comfortably acknowledge their difficulty in understanding or reading? The four best validated questions are:
“Do you feel I have explained this well enough for you?”
“How often do you need someone to help you when you read instructions?”
“How confident are you filling out medical forms by yourself?”
“How do you best learn new material? By talking or from a handout or by a demonstration (hands on)?”

Create a “Shame-Free” Environment
Ask the staff in your practice to read this article, so that each staff member can see they have an important role in recognizing and assisting parents or patients with limited health literacy. Everyone can be on the look out for potential signs of limited health literacy.

Front desk personnel can routinely offer assistance to families in completing the forms. Everyone in the practice should be willing to stop what they are doing to assist with forms or to answer questions. All staff should be approachable regarding referrals, insurance questions, appointment scheduling and testing. Clinicians can ask if the families have questions, if they feel the instructions have been explained well enough, and whether they can be of more help. All staff should provide help by imagining what a parent would need if they had limited literacy or limited medical understanding.

Helpful Communication Methods
Slow down and speak slowly. Sit rather than stand. Convey with your body language and tone of voice that you will be patient and spend the time needed by the parent/patient.
Use plain and simple language, using lay terms instead of medical terminology. A rule of thumb is to explain it as you would to your grandmother.
Focus on 3 key issues:
  o The main problem(s)
  o What they need to do
  o Why it is important
Summarize the key issues at the end
Draw pictures or write simple lists
Avoid acronyms, initials and medical jargon. Avoid words like “unremarkable”, “may”, “might”, and “suggests”. Be careful with homonyms like “stool”, “gait”, and “dressing”.

**Confirm the Parent’s/Patient’s Understanding**
Use the “Teach Back” method. When you want to confirm their understanding, ask them to say or show you what they are going to do, rather than asking if they understand. “Let me see if I have explained this well enough. When you get home, how are you going to give the medication?” Or ask them to demonstrate how they will do things.
Allow time for questions. Convey with your tone of voice and body language that you will devote enough time to answer their questions.
Enlist the help of other staff. The medical assistant, nurse or check-out staff can ask “do you have any more questions?” “Do you feel you will need any help?”
When a staff member or provider suspects limited understanding, make a follow-up phone call in a day or two.

**Use Patient-Friendly Materials**
- Forms should be simple and collect only essential information. They should also be offered in the families preferred language.
Written materials should be understandable by a 5th grader (10 to 11 year old)
Written materials are more effective if they are read to the parent and patient by the staff or provider. They are even more effective if a staff member or provider underlines or circles the most important points
Limit content to one or two objectives
Use words that non-medical people know
Use one and two syllable words, short paragraphs, large fonts (minimum 12 point). Do not use UPPER CASE FONT – it is difficult to read.
Don’t clutter the page. Have a lot of empty space
Use headings. Bullets are better than paragraphs [click here to see an example]
Most Internet material is too difficult for the average person to understand
CD’s or videos are more effective than audiotapes, because most people learn better by seeing rather than hearing. Neither should be longer than 3-4 minutes

**Health Literacy Websites**
http://www.healthliteracy.com/ The article section is very good
http://healthliteracy.worlded.org/ Some great examples and tools
http://www.hsph.harvard.edu/healthliteracy/asthma/asthma3.pdf Asthma Info. for patients
http://www.hsph.harvard.edu/healthliteracy/doak.html
http://www.cmc-dayton.org/PDF_Files/For_physicians_sitelet/PedClipsForbiJanfinal.pdf
The Cross-cultural Health Care Toolkit

Two Key Points in cross-cultural communication in healthcare:

- You may be saying to yourself, “I don’t need this curriculum. I am not prejudiced. I treat everyone the same.” Of course you do….pediatric healthcare professionals are very special people in that way. But cross-cultural care is not about treating everyone the same…..it is about recognizing how each family is unique in how they think about and understand the illness, their customs and beliefs, hidden meanings, hidden concerns, other remedies or treatments, how they interpret your recommendations, etc. So, what can you do to understand how your patient’s family is unique? Never assume that you know your patient’s and their family’s cultural background.

- It is not what you know…..it is what you ask. Learning about other cultures may be helpful so we can become more aware that there are other ways to view the world. However, attempts to memorize norms or values of the “Latino”, “Asian”, or “African American” cultures and apply them to individual patients may not be effective and may instead contribute to stereotyping. And there are scores and scores of different Latino cultures…you can’t learn them all. Instead, respectfully ask questions to understand how your patient’s/family’s unique culture will influence the child’s health outcomes.

Imagine that you are vacationing in a remote area of Thailand….and……

- You have a chronic disease that suddenly worsens and you become seriously ill
- You go to a local healer
- She does not speak English
- She feels your wrist and the top of your head
- And then mixes up a muddy-looking solution for you to drink and lights a bundle of herbs

- What would you want/need at this moment?

If you were the patient, what would you want?

- You would want to ensure good communication (translator)
- You would want the healer to listen to you re:
  - What you think is going on
  - What you have tried
  - What you expect from a provider…and form the illness
  - What your health care provider would do
  - What you are most worried about
- You would want to know what the healer is thinking and planning
- You would want to be able to ask all of your questions
- But you would want to negotiate a treatment plan that addresses what you are worried about and what you think will help you get better.
- You would be somewhat leery….right?
Develop ONE cross-cultural communication approach that works for all families in all cultures. We suggest an approach that utilizes two components:

1. A mnemonic: LEARN
2. A list of issues and questions: The Cross-cultural Review of Systems

Respectfully ask questions to LEARN more about how their own unique cultural influences will affect your care, using the cross-cultural review of systems

- **Listen** carefully to their answers to questions from your cross-cultural review of systems.
- **Explain** how you view the symptoms, problem or illness.
- **Acknowledge** the differences between their beliefs, concerns, expectations, etc and your views.
- **Recommend** your treatment plan.
- **Negotiate** a compromise plan that respects their decision-making processes and their beliefs, concerns, expectations.

Cross-cultural Review of Systems

The first step is to ask the right questions that will enable you to understand how their culture will affect your care. This facilitates the “L” portion of LEARN, listening carefully to answers to the answers to the cross-cultural review of systems questions. The following three categories of questions and issues will help in caring for all patients, but in particular those from a different social or cultural background than you.

**Core Cross-Cultural Issues**

Please tell me a little about where your family comes from originally.
Who have you asked for help/advice about the problem?
What remedies or treatment have you tried / want to try?
What were you hoping we would be able to do today?
How (and by whom) are decisions made in your family about health care?
Who should be present for support or to help in decision-making?

**Meaning of the Illness**

What do you worry about the most?
What do you think seems to cause the problem / illness?
Why did it start when it did?
What does illness do to your child?
How severe is it?
What problems has the illness/problem caused?
What do the medicines do? Do they help?

**Social Context**

Stress: What is causing the most stress in your life now? What do you do to cope with it?
Social supports: Are there people in your life on whom you can rely for support or help?
Resources: Are there financial problems in the family? Can you afford the basic things your children need? Are you having any trouble getting to appointments, or getting time off for medical appointments?

English proficiency: Do you feel we should have an interpreter join us?

Understanding: Do you feel I have explained things well enough? Do you have any questions?

Acceptance: Do you think you are going to be able to follow the treatment plan?

**After The Cross-cultural Review of Systems, collaborate on a plan.**
This step includes the EARN portions of the LEARN mnemonic.

**Explain** – Present your perception of the illness and its causes. Explain how you see the cause and meaning.

**Acknowledge** - Explain how your view differs from their view. In some cultures, as we have discussed in other newsletters, the patient or parent may be expected to be passive when ill. Educate the child and parent about the importance of taking an active role in his or her recovery.

**Recommendations** - Give your treatment recommendations. Acknowledge how they differ from what the family had expected or wanted, or had done previously.

**Negotiate (Collaborate)** – Find a compromise that is in the best interest of the child and meets the parent’s concerns, needs. [“My treatment plan may be different than what you were expecting (different than what you have been doing….different than what you are used to). How are you feeling about that? Do you have any concerns with what I have suggested? Do you feel you will be able to do what I have recommended?”]

**Remember**

- Treatment adherence is directly proportional to the provider’s understanding of the patient's beliefs, the meaning of the illness to the patient (family) and social context
- What is acceptable is often better than what is optimal
- Ask “Do you have any final questions or concerns?”
  - Wait for it………..
- Remember, your medical culture is powerful, too.

**When we identify cross-cultural issues, it can lead to:**

- Improved health outcomes
- Improved access to care
- Fewer errors in diagnosis and treatment
- Lower malpractice risk
- More successful patient education
- Increase in patients’ health-care-seeking behavior
- More appropriate testing and screening
- Better adherence to treatment plans
- Reduced incidence of drug complications
- Higher level of patient and parent satisfaction
THE CROSS-CULTURAL "REVIEW OF SYSTEMS"
Detailed Version

Step 1: Identify the Core Cross-Cultural Issues

When you see a new patient, or an old patient facing a new issue, consider these core cross-cultural issues that may be important for that individual:

What is their geographic origin? (to help you begin to think about potential health disparities)

“Please tell me a little about where your family comes from originally.”

The most important thing to remember in cross-cultural health care is “NEVER ASSUME…ALWAYS ASK.” It is not what you know, it is what you ask. You don’t need to know about all of the cultures. You just need to ask the right questions to understand how the family you are talking with is influenced by their unique values, beliefs, concern, needs. Each month we will suggest a question for you to try out as part of your routine visits. Adapt it to where you are comfortable. See how it works for you.

This month’s question is:

Decision-making and support:

“Is there anyone else that you would like to be involved with this decision?”

- Different families empower different family members with the decision to seek care and perhaps another for the role of making final decisions. For serious problems (as determined by their view of “serious”) they may need extended family, or members of their community or church members or spiritual leaders.
- Many families are used to having more family members present at the medical encounter than you may be used to. Try to adapt to it, but don’t hesitate to respectfully explain your concerns about how it might affect your patient’s willingness to be open or your patient’s mental or physical well being.

Cultural Healing Traditions, Customs: How do these factors influence the patient?

“What medicines, remedies, or treatments have you tried or would you normally do for this?” “What treatment have family or friends recommended to you? “What other healers, health advisors have you seen?” “What have they recommended?”

- Families may travel to their country of origin and receive over-the-counter medications that require a prescription here.
- They may use herbal remedies or alternative remedies before coming to see you. They may not know the name of what they have been given, so ask if you can see
the medication or the home treatment if your patient cannot identify the substance.

- It is important to be non-judgmental about these remedies, but also to inquire in detail about them. Keep in mind that often the advice from traditional healers and herbal remedies may be quite useful and many times not different than your own advice. As a specific example, many Latino families will use "Te de manzanilla" (chamomille tea) for infants with "colico" (colic). This is a relatively benign intervention, which at least in 1 small controlled trial, showed some significant efficacy. Clearly though, the important point is to avoid free water intoxication of very young infants from giving too much tea. So rather than discrediting the tea's use, you can try to work with the families, and just make sure they are not giving more than 1-2 ounces a day of the tea to the infant. (This is a tip from Simon Hambidge, MD at Denver Health).

- Make sure that nothing harmful is being used (for example, lead-based liquids for gastric upset). For example, greta and azarcon (also known as alarcon, coral, luiga, maria luisa, or rueda) are Latino traditional remedies taken for an upset stomach ("empacho"), constipation, diarrhea, vomiting, and used on teething babies. Greta and Azarcon are both fine orange powders that have a lead content as high as 90%. Ghasard, an Indian folk remedy, has also been found to contain lead. It is a brown powder used as a tonic. Ba-baw-san is a Chinese herbal remedy that contains lead. It is used to treat colic pain or to pacify young children. Other folk remedies that may contain lead are listed at: Centers for Disease Control and Prevention.

- "Is there anything else that you feel we need to do (or to address)?"
  There may be aspects of the medical encounter that may be of importance to the patient/family, either because they are part of the encounter in their country of origin or because traditional healers use them.

- Consider the impact religion will have in your patient’s health care recovery. Regardless of your own beliefs, let them express to you the importance of their religion and assist them in dealing with the fear the patient might be feeling. You may want to engage the help of a clergy member they have identified them as an important influence.

- A mental health referral or diagnosis may not be seen as an illness. It may be seen as a weakness and an embarrassment to family. Or seen as the result of misbehavior or a lack of will on the part of the sufferer. This is one instance when our medical culture can be powerful. Treat these issues with respect. Ask what they think about the referral or diagnosis and respectfully provide your feeling about their concern.

**Trust**

"Have you been happy with your care in the past?" "What has been your experience with doctors in the past?"
Does the patient trust the healthcare system? Many families have experienced forms of prejudice or less than respectful treatment. This may influence their response to your care. You can explore whether the family has experienced prejudice in US (or elsewhere) or has had bad experiences with health care providers before by asking respectfully. Build trust and reassure the family of your intentions.

Expectations for their health care provider and for modern medicine:

“What kind of treatment were you hoping (or expecting) to receive today?”

The provider’s role and the parent’s expectations are influenced by their past experiences with health care in their country of origin and their past experiences with health care in US. Often, non-compliance is the result of the parent receiving advice or treatment that is very different from what they expected. When this difference is recognized and discussed by the provider, compliance is usually improved.

Styles of Communication and interpersonal etiquette: How does the patient relate?

Eye contact

- Many individuals depend on direct eye contact as a sign of active listening and, often, sincerity and honesty. Without such connection they may feel that they are "out of contact" with the other person. However, eye contact can have different meanings depending on the culture and habits. In American culture, a certain amount of eye contact is required, but too much makes many people uncomfortable. In South Asian and many other cultures direct eye contact is generally regarded as aggressive and rude. African, Latino and Native American groups may prefer to avoid eye contact, as a way of showing respect for authority figures. Keep in mind that the degree of eye contact may have a meaning to the family that is different from your initial interpretation.

Physical contact

- All cultures have rules dealing with who, how, why, when, and under what circumstances people may engage in physical contact. Some cultures discourage physical contact between certain people, for example between a male provider and the patient’s mother. Take your cues from the parent’s behavior and if you make a mistake, simply apologize, explain what the touch means in your culture and move on.

Personal space

- All human beings are territorial to some degree and, although personal space is always context-sensitive and variable, group norms exist for all cultures. The “size” of our specific personal “space” is unconsciously acquired in early childhood. Interpersonal space in sitting, standing, and speaking have cultural
meanings and may trigger intense emotional responses when violated. Knowing the general rule-of-thumb about traditional boundaries for a culture is important if you are not to be perceived as "a cold person" by standing too far away, or "threatening" or "romantic," by standing too close. Many cultures prefer being closer to each other than Americans. When providers place themselves two feet or more away, this may be perceived as not only physically distant but also uninterested and detached. Take clues from the family in front of you. You may want to try sitting closer and leaning forward.

**Timing and pace in the encounter**

- All cultures have well-established patterns that they see as important to maintain regarding the pace and flow of verbal exchanges, "turn-taking," and "pauses," "silences," and "interruptions" during conversation. This can be very subtle, but when people are "out of sync," miscommunication can occur. All this hinges on "timing." When they are excited, many individuals are quick to interrupt another speaker, some prefer the relatively direct communication style, others favor the indirect style.
- Many cultures prefer a slow, polite and friendly beginning to the encounter rather than jumping quickly to the problem. Take time to develop relationships and to build trust. Most cultures like the provider to show interest in them as people. "Tell me a little about yourself." "I would like to hear about your family." "Where is your family from? How did they decide to come to Denver?"
- When your patient’s parent nods his or her head, it does not necessarily signify agreement, but that he or she is listening to you. Silence may be a sign of not understanding or disagreement.

**Direct or indirect questions**

- In some cultures, a direct style of communication will be considered brash and insensitive (Latinos and Asians, for example). For others a less assertive or less direct style may seem restrained and even somewhat impersonal (Australians, Germans and Russians). Notice the style of the parent and adapt to it. Be willing to explain your communication style. This takes only few seconds, as you say, for example, "I tend to be very direct, go directly to the issue. I hope that will be OK for you."
- Many cultures prefer that providers indirectly ask personal/private questions about alcohol use, mental problems, violence, stressors, or sexual practices.

**Understanding and Acceptance**

"Have I explained this well enough? Do you feel you understand this well enough?" "I would like to be sure I have explained the plan well enough. Can you please tell me what you have understood and what you will be doing?"

- Most parents do not readily admit when they do not understand, because of embarrassment.
"Please help me understand what you think about what I have recommended...even if you don’t agree.” Out of a sense of respect, parents from many cultures will avoid disagreeing with, or expressing doubts to their health care provider about, the treatment they are receiving. They may avoid expressing negative feelings directly and this may affect patient care by patient's withholding information, not following treatment recommendations, or terminating medical care.

“‘This is complicated. Would you like me to explain it again? Do you have questions or concerns about what I have said?’”

Parents from any culture may be reluctant to ask questions or admit they are confused about instructions or treatment.

Step Two: Explore the Meaning of the Illness

“What do you feel caused this illness/problem?” “What have other family members or friends told you?” “What concerns (worries) you the most?” "Why do you think it started when it did?” “How does it affect you?”

Some cultures have a way of thinking about illness that is different from the way those of us in the medical culture think. These beliefs highly influence the way the patient or parent describes symptoms, how well they understand what we say and how well they adhere to treatment. It may be particularly helpful to assess the patient's conceptualization of illness, or “explanatory model”, when the physician does not feel s/he understands the patient's behavior, especially when there is non-adherence to a treatment, or when there is some sort of conflict.

Some cultures have beliefs that may seem to us to be superstitious. They might believe that the illness is punishment from God for bad behavior. Or they might believe their illness was caused by a spell cast or by someone who is jealous or evil. Feel free to reassure the patient/parent that these were not part of the cause of the problem.

Some cultures have a fatalistic view of illness. They may feel that God’s will has a far greater impact on the outcome of the illness than medication. They may believe that God determines the outcome of illness and they may not actively participate in health care recovery. The family may believe in fate or destiny rather than in medicine. Yet, keep in mind that they sought your advice, so they do recognize its value. If beneficial to the patient, clarify these issues, or try to interpret the medical facts within the context of their beliefs. Remind the patient/parent that they can affect the outcome, by actively participating in the treatment.

Families may have fears about the cause or the inevitable outcome that they are shy about expressing.

Of course, we should always show respect for patient’s concerns and empathize, but respectfully describe our view of the illness, the treatment and the importance of their participation in the treatment process.
Step Three: Determine the Social Context

The “social context” is of equal importance as an area of exploration, given how intertwined social factors are with cultural factors. Certain key areas to consider are:

**Social stress** – “How has your life been recently?” “Have there been problems?” “Has your family had to cope with much change?”

**Social support or isolated** – “Do you have people in your life who can help you?” “Are there people you can turn when things are bad or difficult?”

- Although many cultures highly value family and community support, some families are isolated, especially recent immigrants.
- In a busy office visit, providers often worry that they haven’t been able to help much; but, simply helping a family identify the people or community resources they can call on for support or advice can be of tremendous value.

**Resources** – “Can you afford the medicine(s)?” “Do you have transportation?” “Are there any problems in your family that will make it difficult to follow the treatment plan?”

- Often it is just a lack of resources that restricts treatment adherence.

**English proficiency** - “Are you able to understand what I have said? “Would you like someone to interpret for you?”

**Literacy** – “Will you be able to understand this written information?”

- Up to 40% of immigrants are not able to read the handouts they are given by healthcare providers (even in their language).
- And 50% of Medicaid parents are not able to read the handouts they are given.

Step Four: Collaborate on a plan (the EARN portion of the mnemonic)

This step includes the EARN portions of the LEARN mnemonic.

**Explain** – Present your perception of the illness and its causes. Explain how you see the cause and meaning.

**Acknowledge** - Explain how your view differs from their view. In some cultures, as we have discussed in other newsletters, the patient or parent may be expected to be passive when ill. Educate the child and parent about the importance of taking an active role in his or her recovery.

**Recommendations** - Give your treatment recommendations. Acknowledge how they are different than the family had expected or wanted, or what they had done previously.
Negotiate (Collaborate) -

“My treatment plan may be different than what you were expecting (different than what you have been doing….different than what you are used to). How are you feeling about that? Do you have any concerns with what I have suggested? Do you feel you will be able to do what I have recommended?”

In cross-cultural care, the degree of treatment adherence is directly proportional to how well the provider understands the patient’s cultural influences, the meaning of the illness and the social context, and how well the provider collaborates with the patient/parent in a way that responds to these influences. Incorporating those things from the family’s culture that they would like to do, or have tried, and that aren’t harmful (or perhaps are helpful), dramatically increases the treatment adherence. Sometimes what is acceptable is better than what is optimal, if the risk of trying to secure the optimal means losing the patient's trust or buy-in. Oftentimes, this requires exploring the cross-cultural review of system and then compromising and formulating a mutually acceptable plan.

Indicate that you are willing to collaborate with them. Decide what’s critical and be willing to consider compromise on anything else.

Explore other barriers like expense, transportation, or people in their environment who will not support your recommendations.

Always ask at the very end…. “Do you have any other questions or concerns?” “Is there anything that will make this difficult for you to do?” And be sure to wait sufficiently long after asking these questions for the patient, parent or family members to get up the nerve to ask that last question or bring up that last concern. The last question or concern is often the very most important one in the whole process, so be sure to give it the time and attention it deserves.

“As powerful as the culture of your patient and her family is, the culture of biomedicine is equally powerful.” (Arthur Kleiman). The patient sought your help because (s)he recognizes its value. People are likely to follow your advice if they understand why they need to. If you can make your advice fit within their cultural context (and often they are not mutually exclusive), chances are they will follow it, if they understand it.
You are in your continuity practice at Child Health Clinic at The Children’s Hospital. Your next patient is Holly, a 4-year old Black girl (pictured below), whom you have seen once before for asthma. When you saw her 3 months ago, she was coughing nearly every day with exercise and at bedtime. She was wheezing at least 3 times a week. You started her on inhaled steroids and continued her prescription for her Albuterol inhaler. You asked them to follow up with you in a couple of weeks. You have not seen her until today.

The chart shows that Holly has been to the emergency room for asthma three times in the past 4 weeks. In the ER notes, it says she was not taking her medications. You are frustrated "Why can't these parents give their kids the medicine like they're supposed to?"

When you go in to the room, you can see that Holly has very slight retractions and on auscultation she is wheezing mildly. You ask Holly’s mother if Holly is taking her meds and she says “No.” How would you proceed?
Hint: You recall that her mother had an accent of some kind, but didn’t get a chance to ask many questions, because it was a rushed illness visit.

Here are the answers to the questions the residents are likely to ask based on the ROS

Core Cross-Cultural Issues

Please tell me a little about where your family comes from originally.

Mother’s family emigrated from Somalia 7 years ago. Although she and her child appear to be Black, they have some Middle Eastern heritage, too. Educated in missionary school. Learned English from American missionaries.

Cultural Healing Traditions, Customs

Who have you seen (want to see)?

No one, but asked child’s grandmother for advice.

She thought medicines that you breathe are “dangerous.”

What have you tried (want to try)?

There is a hot tea that is traditionally used.

What were you hoping we would be able to do at the visit today?

You've got to give me something to cure it, doctor; I can't stand to hear Holly suffer so much when she’s trying to breathe.”

“We need a medicine that will make the asthma go away. The medicines you prescribed before did not make the medicines go away.”

How (and by whom) are decisions made? Who should be present for support?

The child’s father was killed during a trip back to Somalia.

Mother listens to grandma and is not likely to go against grandma’s opinion.

Meaning of the Illness

What do you worry about the most?

“I am afraid she is going to die.”

If resident asks for more information – “Cousin who died of asthma in Somalia. Breathed a medicine from local healer and died.”

What do you think seems to cause the problem / illness? Why did it start when it did?

"She was with me at work one day, and I let her play outside. When I went to check on her, her breathing was so bad that I took her right to the emergency room. She's always bad when I clean the Roberts' house. They both smoke like chimneys. Holly seemed a little short of breath when we left, so I thought we should go to the emergency room again, just in case."

What does illness do to your child?

Can’t breathe

How severe is it?
Usually not bad. Only sometimes wheezes. Mother doesn’t understand that coughing with exercise and at bedtime can be occult wheezing.

What problems has the illness/problem caused?
Can’t play without coughing and wheezing. Mother doesn’t let her go outside to play because she wheezes, so she goes to work with mother and stays in the basement of the house that mother is cleaning.

What does the medicine do?
Medicines don’t cure it. It keeps coming back.

Why didn’t you give the medicines?
They gave us some medicine, but I cleaned out my purse and forgot to bring it with us the next week. She's always bad when I clean the Roberts' house. They both smoke like chimneys. Holly seemed a little short of breath when we left, so I thought we should go to the emergency room again, just in case."

Social Context
Typical day
Six days a week, Holly accompanied her mother while Mrs. Ivey cleaned homes in the expensive neighborhoods. While her mother worked, Holly played, quietly hidden in the dark basements of the well-to-do."

Social stress
"I had to leave work early the day I took Holly to the ER, so I didn't get paid, and the car was broke the week before that. I had to spend all my money on the car. If I don't have my car, I can't work. We just didn't have the money to come here. I work hard, but we can't afford insurance, and doctor bills always put me over the top. The emergency room sends us a bill, but I just tell them we don't have any money to pay. It's true."

Social support or isolated
No friends. Always working. Grandmother takes care of Holly. No other family.

Resources
Live in a shack with molds and dust.

English proficiency
Mother understands and speaks well, but Grandmother makes the health care decisions and she does not speak English

Literacy
Does not read well.

Understanding
Doesn’t understand why to give medication everyday even when not wheezing. Can you give medicines at the same time and on the same day?

Acceptance
Grandmother feels not safe to breathe medicine.
Case 2 - Limited English Proficiency, Health Literacy and Patient Communication

Maribel is a 1 month old ex 35 week female infant who is brought to the Child Health Clinic for her first well child visit. She is accompanied by her mother and father, both of whom were originally from Mexico. Upon meeting the parents and asking if they speak English, dad reports that he can speak English. The remainder of the encounter is completed in English.

The first thing you notice at the computer is that the Post-Partum screen available in Spanish/English has not been filled out despite a pen being available, but you just continue with the encounter. After reviewing the records the parents have brought you, the only thing significant is that she was SGA and placed on 24 kcal formula and, but was otherwise discharged after several days of good weight gain in the hospital. The parents’ only question for the visit is what they can do for her congestion.

During the encounter you notice she has not had great weight gain since being discharged from the hospital. POC say that she feeds every 3 hours and is doing well. She has mild congestion at her nose, but is otherwise well appearing with no respiratory distress. The rest of her exam is within normal limits.

During the visit you discuss the possibility of using nasal saline drops and a humidifier. FOC continues to nod in agreement as you discuss the saline and discusses with the MOC in Spanish (for which you don’t understand). FOC asks about using any other medication for which you tell him not to use any cough medicines. You ask dad if the patient’s mom has been doing well and he responds yes, with a nod. You send the family home with the instructions to continue the fortified formula and give return precautions to return if she has a fever or difficulty breathing. You also tell the POC to go to the lab for her second NBS for which she missed at 2 weeks. FOC nods in understanding and leaves the office.

Maribel returns in 2 weeks for a weight check.
At this visit, you notice again that the EPDS is still sitting on the table, blank, but you continue with your encounter. You first look at her weight and notice that she still has not had great weight gain, certainly not having any catch-up growth.

You again ask dad how the feeding is going well- he tells you its going well. You ask if he is fortifying the formula like they showed you in the hospital- again he shakes nod in apparent understanding. You ask how the congestion is going and pulls out a liquid medicine (looks like saline) and tells you it isn’t working when she drinks it. Next you ask why did they not get her lab drawn and he reports- she wasn’t very sick.

Discussion Questions
1. What other information would be useful to this encounter?
   a. Cultural History- positive pertinents:
      i. Who lives at home and takes care of the baby- MOC lives at
         home by herself. FOC is working at a farm living with
         relatives and doesn’t take care of the baby. FOC really not
         aware of feedings or MOC’s state of well-being
      ii. What herbal remedies do they use
   b. Health Literacy
      i. Do they need help filling out the form in either
         English/Spanish? Are they able to understand the form or
         could we assist them? (Can the read the form?)
      ii. Has anyone explained how to mix the formula besides the
         written instructions? Give visual instructions on paper or
         show how to make it in the office
      iii. Provide easy written instructions regarding anything new such
         as the saline drops
2. What other forms of miscommunication are present- how can you prevent
   this?
   a. Use of interpretive services
   b. Use of written instructions/not just verbal instructions
3. Does the “nod” always mean understanding?
   How can the resident verify that the family understands the instructions?
Examining our Own Personal Biases

How I Learned to Treat My Bias

By Manoj Jain

Washington Post
Sunday, April 15, 2007; B07

At our hospital in Tennessee not long ago, I saw my picture on the hallway message board alongside those of other doctors in a display thanking us for our service. My Asian-Indian complexion set me apart -- it's something that I am rarely conscious about in everyday life. It got me thinking: When I walk into the room, do my patients see me as a foreigner?

Then I wondered: When I walk into a room, how do I see my patients?

For the next few days I observed myself whenever I entered a hospital room to see a new patient. To my surprise, I realized that in the initial glance I viewed patients as an "elderly black man" or a "Hispanic worker" -- and all the baggage that comes with their race, gender and ethnicity. My prejudices had kicked in.

Unfortunately, the entire health system sees patients by race, gender and ethnicity, and it has a profound effect on how care is delivered.

The Institute of Medicine in its 2002 report "Unequal Treatment" cited some provocative statistics. Black patients, for example, tend to receive lower-quality care for cancer, heart disease, HIV, diabetes and other illnesses. Black men are 40 percent more likely to die of cancer than white men. These differences often persist even after accounting for age, severity of illness and delays in seeking treatment among different groups.

How can this happen in America in 2007? It's simple. Social psychology shows that stereotyping is a universal human mental function. We use social groups (race, sex and ethnicity) to understand people -- to gather or recall information about people from our minds.

The mental processing goes something like this:

When I enter the room in which a patient is waiting for me, I do four things.

First, in the seconds before our initial greeting, I automatically and often unconsciously activate my stereotype. Thus, I assume a young Hispanic man is likely to be an uninsured construction worker.
Second, even though I believe that I do not judge people based on stereotypes, the data show it is very likely that I do. When I see an elderly black woman I am more likely to ask her about church as a support structure than I am to ask a white man the same question because I assume she is church-going.

Third, after the encounter, my stereotyping affects how I recall and process information. A white man complaining of pain receives more attention than a Hispanic woman with the same complaint because I stereotype white men as being more stoic.

(Remember that stereotyping is different from medical profiling based on disease epidemiology. A young black woman with anemia is more likely to have sickle cell disease than an elderly white man is, based on biology and racial background.)

Fourth, my stereotypes probably guide my expectations and handling of the patient, resulting in a self-fulfilling prophecy. An elderly black man is unlikely to understand the details of a diagnosis, I assume, so I spend less time explaining his disease and its consequences. Ultimately, such a patient is less informed about his illness.

The most glaring result of black-white inequality in health care was found in a 2005 study issued by former Surgeon General David Satcher. He estimated that closing the black-white mortality gap would eliminate more than 83,000 deaths per year among African Americans.

It is painful to write these things. As health-care workers we try to be unbiased in our delivery of care.

Once I became aware of how I thought when I encountered patients, I was able to start changing. Though I initially saw a patient as an elderly black woman, my forced reflection helped reduce the stereotype. As our conversation developed, the stereotype melted away. I began to see my patient rather than his or her social group.

I hope that patients have done the same for me. I hope that they did not see me only as a brown foreigner but recognized me as a doctor keen to be a partner in their health care.

As a society we can overcome prejudices in health care by facing our tendency to stereotype. Medicare and its contractors -- quality improvement organizations -- are training doctors in a "cultural competency" program in which they receive free educational credits and become aware of biases in care delivery and cultural perception of illness. (I am taking the course.)

As for patients, I have another suggestion. The next time you see a worker at a fast-food restaurant, ask yourself: What stereotypes did your mind automatically activate?

Awareness is the first step to change.
8 Steps You Can Take To Enhance Your Skills In Cross-cultural Health Care

Adapted from Doc-for-Tots (www.docsfortots.org)

1. Participate in a free online CME course on effective cross-cultural health care that uses rigorous study designs, well-described interventions and measurable objectives that are linked to process and outcome variables.

   A Physicians Practical Guide to Culturally Competent Care- CME credit
   https://cccm.thinkculturalhealth.org/

   Culture And Health Care: An E-Learning Course- CME Credit
   http://www.doctorsintouch.com/courses_for_CME_credit.htm

2. Learn more about strategies to prevent health disparities, and educate yourself on the different types of disparities that affect your patients.

   Minority Health and Health Disparities -
   http://www.docsfortots.org/MHMJournalArticles.asp

   Provider’s Guide to Quality and Culture -
   http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English

3. Do a self assessment of your awareness around culturally competent care and identify opportunities for improvement.

   Cultural Competence Assessment (.pdf) –

4. Employ enhanced communication strategies during patient / family interactions using the LEARN mnemonic, interviewing techniques that are effective in eliciting cultural beliefs and social influences impacting decision making. These techniques enhance the patient provider relationship. http://www.cchap.org/november-2006/three

   Listen with empathy and understanding of the patient's perception of the problem.

   Explain your perceptions of the problem.

   Acknowledge and discuss the differences and similarities.

   Recommend treatment.

   Negotiate agreement.

5. **Practice your evolving skills** using web-based cases and scenarios by going to The Provider’s Guide to Quality and Culture. 
http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English&mgroup=&mgroup=

6. **Become familiar with CLAS standards** (National Standards on Culturally and Linguistically Appropriate Services) and assess how your practice measures up.

   A listing of the 14 CLAS standards - cchap.org

   The full 139 page report
   [National Standards on Culturally and Linguistically Appropriate Services (.pdf)](http://www.omhrc.gov)

7. **Stay current on policy and community-based strategies** related to children's health and advocacy efforts around eliminating health disparities, and participate in the process. Periodically visit the websites devoted to helping you stay current:

   The federal Office of Minority Health:

   The University of Michigan Program for Multicultural Health:
   [http://www.med.umich.edu/multicultural/index.htm](http://www.med.umich.edu/multicultural/index.htm)

   Docs for Tots:
   [http://www.docsfortots.org/default.asp](http://www.docsfortots.org/default.asp)

   National Health Policy Training Alliance for Communities of Color:

8. **Observe the barriers** families in your practice face in accessing medical care in your community. These could include time constraints and office hours, poverty, and financial difficulties, as well as problems accessing hospitals for non-emergency care. Take time to reflect upon the multiple factors influencing their access to health care and to their well-being. Is there something your practice could do to help?
The IOM’s Cross-cultural Health Care Guidelines - 10 Guiding Principles

1. Elicit the patient’s views on illness and treatment practices to understand his or her health values, particular concerns and expectations for care.
2. Assess the cultural norms, values and customs that influence the patient’s health seeking behaviors, practices and expectations for the physician-patient relationship.
3. Assess the patient’s environmental context to determine what social experiences and resources may be affecting illness behaviors or health-seeking practices.
4. Identify a range of treatment goals for a given medical condition that can be mutually satisfactory and take into account the patient’s cultural health beliefs, practices, norms, customs and traditions.
5. Identify the social, cultural and environmental factors that may potentially interfere with adherence to treatment goals.
6. Work collaboratively with the patient to negotiate treatment plans that incorporate aspects of the biomedical model while integrating cultural concepts for treating illness familiar and important to the patient.

7. **Develop communication skills that are respectful of the patient’s cultural norms, values and language to facilitate empathy in the clinical encounter.**
8. Utilize patient education strategies during the clinical encounter that take into consideration literacy, cultural appropriateness and language concordance.
9. Acknowledge that personal, professional and institutional factors can affect aspects of clinical decision-making which, in turn, may lead to disparities in care.
10. Take proactive steps to adapt institutional and system processes that support clinical practice aimed at delivering clinically appropriate and culturally responsive care.
Organizational Change

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

The CLAS standards are primarily directed at health care organizations; however, individual providers are also encouraged to use the standards to make their practices more culturally and linguistically accessible. The principles and activities of culturally and linguistically appropriate services should be integrated throughout an organization and undertaken in partnership with the communities being served.

The 14 standards are organized by themes: Culturally Competent Care (Standards 1-3), Language Access Services (Standards 4-7), and Organizational Supports for Cultural Competence (Standards 8-14). Within this framework, there are three types of standards of varying stringency: mandates, guidelines, and recommendations as follows:

CLAS mandates are current Federal requirements for all recipients of Federal funds (Standards 4, 5, 6, and 7).

CLAS guidelines are activities recommended by OMH for adoption as mandates by Federal, State, and national accrediting agencies (Standards 1, 2, 3, 8, 9, 10, 11, 12, and 13).

CLAS recommendations are suggested by OMH for voluntary adoption by health care organizations (Standard 14).

Standard 1
Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 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.

Standard 3
Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 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 limited English proficiency at all points of contact, in a timely manner during all hours of operation.
Standard 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.

Standard 6
Health care organizations must assure 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).

Standard 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.

Standard 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 culturally and linguistically appropriate services.

Standard 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.

Standard 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.

Standard 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.

Standard 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.
Standard 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.

Standard 14
Health care organizations are encouraged to regularly make available 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.

For more information, visit: http://www.omhrc.gov/assets/pdf/checked/executive.pdf
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**Limited English Proficiency**

**Bridging language barriers: how to work with an interpreter**

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**Health Literacy**


http://www.health.gov/communication/literacy/quickguide/factsliteracy.pdf - I like this one because it is straight forward and a good beginner article

http://www.health.gov/communication/literacy/quickguide/services.pdf - Good article for explaining the “how can you help” aspect

http://www.healthliteracy.com/article.asp?PageID=7849 – Good real world example of health literacy confusion