Cultural Competency: Providing Quality Care to Diverse Populations

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Objective: The goal of this paper is to define cultural competence and present a practical framework to address cross-cultural challenges that emerge in the clinical encounter, with a particular focus on the issue of nonadherence.
Data source: English-language literature, both primary and reports from various agencies, and the author's personal experiences in clinical practice.
Study Selection and Data Extraction: Relevant literature on patient-centered care and cultural competence.
Data Synthesis: There is a growing literature that delineates the impact of sociocultural factors, race, ethnicity, and limited-English proficiency on health and clinical care. The field of cultural competence focuses on addressing these issues. Health care providers need a practical set of tools and skills that will enable them to provide quality care to patients during a brief encounter, whatever differences in background that may exist. Cultural competence has evolved from the gathering of information and making of assumptions about patients on the basis of their sociocultural background to the development of skills to implement the principles of patient-centered care.
Conclusion: This patient-based approach to cross-cultural care consists of first, assessing core cross-cultural issues; second, exploring the meaning of the illness to the patient; third, determining the social context in which the patient lives; and fourth, engaging in negotiation with the patient to encourage adherence. Addressing adherence is a particularly challenging issue, the determinants of which are multifactorial, and the ESFT (explanatory/social/fears/treatment) model—derived from the patient-based approach—is a tool that identifies barriers to adherence and provides strategies to address them. It obviously is impossible to learn everything about every culture and that should not be expected. Instead, we should learn about the communities we care for. More important, we should have a framework that allows us to provide appropriate care for any patient—one that deals with issues of adherence—regardless of the patient's race, ethnicity, or cultural background.
Key Words: Adherence, Cross-cultural, Cultural competence, Explanatory model.

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Introduction

There is a growing body of literature that delineates the impact of sociocultural factors, race, ethnicity, and limited-English proficiency on health and clinical care.[1] Every day health care providers see patients who present varied perspectives, values, beliefs, and behaviors regarding health and well-being, in part influenced by their sociocultural background. The field of cultural competence focuses on addressing this issue, helping to improve the health care provider's ability to communicate with patients effectively and to provide quality health care to those from diverse sociocultural backgrounds. The paper tries to define cultural competence and to present a practical framework to address cross-cultural challenges emerging during a clinical encounter, with a particular focus on the issue of nonadherence.

Culture and Cultural Competence

Culture is defined as an integrated pattern of learned beliefs and behaviors that can be shared among groups and include thoughts, styles of communicating, ways of interacting, views on roles and relationships, values, practices, and customs.[2] Culture shapes how we explain and value our world and provides us with the lens through which we find meaning. We all belong to more than one "culture" (e.g., social, professional, religious, etc.) that goes beyond race, ethnicity, or country of origin.

In health care, culture affects numerous aspects of the interactions between patients and clinicians. Many have thought of cultural competence in health care as simply the skills needed to address language barriers in the clinical encounter or learning as much as possible about patients from specific cultures.[3] Although the former is important and remains a key component of cultural competence, the latter is more problematic.

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Previous efforts in cultural competence have aimed to teach about the attitudes, values, beliefs, and behaviors of certain cultural groups: the key practice "do's and don'ts" for caring for "the Hispanic patient," for example.[4] In certain situations, learning about a particular local community or cultural group can be helpful, but, when broadly applied, this approach can lead to stereotyping and oversimplification of culture without respect for its complexity. Cultural competence has evolved from the gathering of information and the making of assumptions about patients on the basis of their background, to the development of skills for implementing the principles of patient-centered care. Patient-centeredness encompasses the qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient. Culturally competent providers take this approach a step further, expanding the repertoire of knowledge and skills classically defined as "patient-centered" to include those that are especially useful in cross-cultural interactions.[5]

The Emergence of Cultural Competence

Cultural competence has emerged as an important goal for three very practical reasons. First, as the United States becomes more diverse, clinicians will increasingly see patients with a broad range of perspectives regarding health and well-being, often influenced by their social or cultural background.[1] For instance, patients may present their symptoms quite differently from the way we read about them in our textbooks; they may have different thresholds for seeking care or expectations about the care they receive. In addition, they may hold beliefs that influence whether or not they adhere to our recommendations. As our nation becomes more multicultural, these issues will become increasingly apparent.

Second, research has shown that effective provider-patient communication is directly linked to improved patient satisfaction, adherence, and subsequently, health outcomes.[6] Thus, when sociocultural differences between patient and provider are not understood, explored, or communicated during the clinical encounter, patient dissatisfaction, nonadherence, and poorer health outcomes may result. This ripple effect may occur in many clinical encounters, yet may be more pronounced among multicultural and minority patients.

For example, a survey of 6,722 Americans age 18 and over shed light on this issue and is particularly relevant given the important link between provider-patient communication and health outcomes.[7] White, African-American, Hispanic, and Asian-Americans who had had a medical visit in the last two years were asked whether they had trouble understanding their doctor, whether they felt the doctor listened, and whether they had medical questions they were afraid to ask. The survey found that 19% of all patients experienced one or more of these problems: whites experienced them 16% of the time compared with 23% of the time for African-Americans, 33% of Hispanics, and 27% of Asian-Americans. In addition, provider-patient communication without an interpreter, in the setting of even a minimal language barrier, is recognized as a major challenge to effective health care delivery.[8-10] Finally, two recent Institute of Medicine Reports—*Crossing the Quality Chasm*[11] and *Unequal Treatment*[12]—both highlighted the importance of patient-centered care and cultural competence as a means of improving quality, achieving equity, and eliminating racial/ethnic disparities that persist today in health care. These recommendations are based on the premise that improving provider-patient communication is an important component of addressing differences in quality of care that are based solely on the race, ethnicity, or culture of the patient.

Case Study I
A Cross-Cultural Challenge

To better understand the principles of cultural competence in practice, we will review a real clinical case as a starting point for analysis.

The patient is a 58-year-old woman with a past medical history significant for hypertension and hypercholesterolemia, both diagnosed about five years ago. She is from the Dominican Republic and speaks English fairly well with an accent. She works part-time transporting blood samples at the local community hospital. The job provides her with a modest salary and some benefits.

The patient comes in with questions after switching doctors following the retirement of her physician. She brings a handwritten letter, which looks like a summary of her medical conditions, a few progress notes, and some random lab reports. After a brief review of the notes and summary, you see that the patient's hypertension has always been difficult to control (ranging from 138/86 to 170/110), and it has been variable through-

out the year. You also see she is described as a "pleasant woman who never misses an appointment."

The patient has just taken her blood pressure, and it is 166/104 with a heart rate of 84. She comes to you for advice, and when asked says she takes her medication "every day."

Why is her blood pressure not under control? What might explain the persistence of her condition? Given her poorly controlled hypertension, how might you approach this case?

How to Approach This Case: A Framework for Cross-Cultural Care

In certain situations, learning about a particular local community or cultural group can be helpful. For instance, following the principles of community-oriented care, it is important to explore the beliefs, values, and customs as well as the demographic and historical experiences of the cultural groups that you see most frequently. This may be especially true with new groups of immigrants that may reside in the same neighborhood as other newcomers. They may share the immigration experience and have common beliefs about disease, illness, and expectations of health care. The pharmacist must maintain a balance between learning about the individual and learning about groups; this is one of the key tightropes of cross-cultural health care, and one that must be understood clearly. However, this learning process—when broadly applied—can lead to stereotyping and oversimplification of culture without respect for its complexity. For instance, Latinos may have some commonalities (the Spanish language for example), but they represent many different countries, ethnicities, and cultures, each with very different characteristics. Even within Latino subgroups there is a tremendous diversity based on social status, acculturation, age, local environment, and individuality, among other factors. The same can be said of Asian cultures as well.

The complex cultural and personal characteristics that make human beings as diverse as they are, also makes any standardized guide to dealing with them cumbersome, stereotypical—and fairly useless. Ultimately, there are hundreds of distinct ethnicities, nationalities, and cultural groups in the United States, each with their own complex set of beliefs, values, and health behaviors. It would be nearly impossible to learn meaningful and clinically relevant information about all of these groups.

Learning about the key issues that might be affecting our Hispanic patient, a patient-based approach to cross-cultural care is much more effective and appropriate. This approach represents a melding of medical interviewing techniques with sociocultural, ethnographic tools of medical anthropology. First, it assesses core cross-cultural issues; second, it explores the meaning of the illness to the patient; third, it determines the social context; fourth, it engages in negotiation to improve adherence.[5]

Assessing Core Cross-Cultural Issues

Interactions between patients and health care professionals often lead to misunderstandings that reflect inherent differences in cultural values and expectations. These misunderstandings can originate from health care providers being inattentive to "hot-button" issues that can result in outcomes that range from mild discomfort, to noncooperation, to a major lack of trust that causes the disintegration of the therapeutic relationship. Certain core cross-cultural issues recur across various cultures. Rather than attempt to learn an encyclopedia of culture-specific issues, a more practical approach is to explore the various types of problems that are likely to occur in cross-cultural medical encounters and to learn to identify and manage these as they arise.

There are five core cross-cultural issues that should be taken into account with patients to avoid misunderstandings:

- Styles of communication (includes culturally based customs concerning both verbal communication and nonverbal communication such as eye contact, touch, and personal space)
- Mistrust and prejudice
- Decision-making and family dynamics (includes patients who follow the Western model of autonomous decision making versus those who include family and others to make decisions)
- Traditions, customs, and spirituality
- Sexual and gender issues (includes attitudes towards sexuality, sexual orientation, and gender roles)

Once a potential core issue is recognized, it can be explored further by inquiring about the patient's own belief or preference, which may be quite different from our cultural norm.

Explore the Meaning of the Illness

When patients seek care for a medical issue, they generally come with certain beliefs about the cause of their symptoms, concerns about their illness, and expectations about potential treatment. The overall conceptualization of the illness experience has been called the patient's explanatory model.[13] In essence, the explanatory model represents the "meaning of the illness or treatment" for the patient—how they understand and explain their condition or potential treatment. For example, patients may feel that taking a certain medication may actually cause a certain illness or side effect, not prevent it. One common explanatory model is that taking insulin causes blindness or kidney failure; patients may not understand that worsening diabetes was the reason they started insulin, not the idea that these complications began as a result of the insulin. Exploring and understanding these ideas can be extremely useful with all patients, but particularly for patients whose cultural backgrounds and perspectives on health and illness may differ significantly from the Western model of biomedicine.

Common sense and lay health beliefs are probably the most typical type of explanatory model that clinicians will encounter. Because these beliefs seem to make sense and have often been learned and reinforced over years, patients can strongly adhere to them. Limited education, low health literacy, lack of information, or mistrust of medicine may lead people to develop their own ideas about the causes, consequences, and appropriate treatment of their illness. Sometimes, beliefs are simply misunderstandings about medical information, such as the idea that a patient can control diabetes simply by avoiding sugar.

Obviously, there is individual variation in how tightly people adhere to their beliefs. Some will be happy to learn "the truth" from a physician. Others will ignore whatever they are told if it doesn't take into account their own particular perspective and respect their common sense. While patients initially may be hesitant to reveal their beliefs and fears, this problem often can be overcome by further respectful questioning and reassurance. Focusing on what others may believe, or in hypothetical situations, may take some of the pressure off the patient. The questions can also be adapted for use in various contexts besides illness. For example, they may be used to explore the meaning of a particular procedure or treatment for a patient, such as a breast biopsy or chemotherapy.

Determine the Social Context

The manifestations of a person's illness are inextricably linked to those factors that make up the individual's social environment.[14] This social context is not only limited to socioeconomic status, but also encompasses migration history, social networks, literacy, and other factors.[15] The social context can be broken down into three specific areas with particular relevance to the clinical encounter:

- Change in environment (such as migration)
- Literacy and language
- Life control, social stressors, and supports

Engage in Negotiation

Health care providers and patients rarely see things in exactly the same way. Cross-cultural interactions add additional layers of complexity to this situation, which may be especially pronounced when caring for patients from diverse sociocultural backgrounds. For example, in many cultures, questioning an authority figure (such as a health care professional) is considered inappropriate or impolite. Culture also affects patients' perspectives on illness and treatment—and their trust in clinicians' recommendations. Much of the emphasis of cross-cultural communication has to do with exploring patients' perspectives. But when their views differ significantly from our views and recommendations, what are we to do? While there is no simple answer to this question, we can often turn to the process of cross-cultural negotiation for some guidelines.

Social and cultural factors determine differences in expectations, agendas, concerns, meanings, and values between patients and physicians. Thus, even when sociocultural backgrounds are similar, substantial differences may exist because of these separate perspectives. The knowledge and skills presented previously provide insights that facilitate the process of cross-cultural negotiation.

Negotiating a mutually acceptable agreement between patient and provider is described in six phases:

- Relationship building
- Agenda setting
- Assessment
- Problem clarification
- Management
- Closure[16,17]

Skills that are developed can be used both to negotiate explanatory models and to negotiate management options. Negotiation of explanatory models involves an acknowledgement of differences in belief systems between patient and provider. Negotiation is not about trying to convince patients who are refusing medical treatment that they should accept what we say. It is about getting beyond the notion that whatever we think as physicians and medical professionals is automatically right for everyone. It is also about teaching people what we know in a way that they can understand—and that also values their system of beliefs.

A Focus on Adherence: The Case of Hypertension

The latest report of the Joint National Committee on the Detection, Evaluation, and Treatment of Hypertension (JNC VII) states that despite the availability of an array of potent medications, the rates of hypertension control in the United States have been decreasing over the past few years.[18] Poor patient adherence is one of the most important therapy-limiting factors in hypertension. One study found that 10% to 15% of hypertensives are lost to follow-up, and 20% to 40% of patients do not sufficiently comply with prescribed antihypertensive therapy.[19] Another study showed that approximately 50% of patients with hypertension fail to keep follow-up appointments, and only 60% take their medications as prescribed.[20]

Many factors affect adherence, both outside and within the provider-patient and pharmacist-patient encounters. Social and financial barriers, such as the absence of prescription coverage and physical difficulty obtaining medications because of work hours, family responsibilities, or poor social support, can clearly affect compliance.[12] Within the medical and pharmacist encounter, multiple factors influence adherence at the individual patient level. These relate more specifically to issues of patient empowerment, perception of the severity of the illness, general health attitudes, and sociocultural variations in health beliefs, values, and behaviors.[22-29] Adherence with standard medical treatment plans may be affected if a patient has health beliefs and behaviors that diverge from the biomedical paradigm.

A New Approach to Adherence: The ESFT Model[34]

Asking what patients think causes their problem, identifying potential social/financial barriers to compliance, addressing concerns about side effects, and checking patients' understanding of the instructions, have been shown to enhance provider-patient communication and subsequent patient satisfaction and adherence.[33]

Based on the literature on communication, there are four "domains" of communication in particular that, when addressed by providers, may yield improved satisfaction, medical adherence, and health outcomes.

Determining the Explanatory Model (Domain E)

Research has shown that it is important for a health care provider to understand the patients' conceptualization of their illness. For example, if patients understand hypertension to be episodic, or related to stress, as opposed to a continuous, asymptomatic condition, they may only take their antihypertensive medication sporadically. If the health care provider does not understand this particular patient's model, and the patient holds to this model despite basic education on hypertension, it might be expected that the patient will not adhere to the prescribed regimen. Once an explanatory model is elicited, appropriate focused education and management strategies can be negotiated.

Determining Social/Financial Risk for Nonadherence (Domain S)

Prescribers should assess the patient's ability to afford a prescribed medication or ability to physically obtain a prescribed medication. This is of particular importance in elderly populations who may be socioeconomically disadvantaged or have Medicare without prescription benefits. Even the new Medicare Part D program—especially in the "donut hole" (where drugs are not covered)—patients can face a payment burden that can lead to financial risk for nonadherence. If social/financial barriers to adherence are identified, health care providers may work to seek equivalent, less costly medications to access pharmaceutical outreach program, and referral to the appropriate social services programs for assistance.

Determining Fears/Concerns About Medication and Side Effects (Domain F)

Patients may have specific fears or concerns about a particular medication or side effect that may prevent them from following a prescribed therapeutic regimen. This may include something they have heard about the prescribed medication, as well as the medication's

size, color, or dosage. It is important that health care providers address this issue directly to avoid nonadherence. If providers identify specific fears or concerns about a prescribed medication, they can address this directly or adjust the regimen to an alternative that is more favorable to the patient.

Determining Patient Understanding of the Treatment Regimen (Domain T)

Problems with provider-patient communication may lead to a patient's poor understanding of the prescribed regimen. One way to address this is via "therapeutic contracting," or "playback." To be sure that the patient understands the regimen, the health care provider has the patient repeat back the instructions. This approach should be supplemented by providing written instructions to the patient describing the prescribed regimen. With patients for whom literacy is a problem, for example, the health care professional should provide pictorial instructions (for example, drawings that represent the time of day to take the medication: rising sun for morning, full sun for mid-day, setting sun for the evening, etc.).

Keep in mind, all of these steps can be used with caregivers of the elderly and geriatric population, whether a family member or home health aide. These caregivers can help facilitate the inquiry process as well as promote adherence. Given the growing geriatric population, adapting and applying these tools and skills to caregivers will undoubtedly improve cross-cultural communication.

Case Study II
Applying the Cross-Cultural Approach and ESFT Model

Now we can revisit the case of our patient. While other approaches to cultural competence might lead us to believe (and falsely assume) that the patient might be fatalistic, and thus not take her medications, applying the patient-based approach to cross-cultural care yielded very different information.

Upon presentation, the health care provider performs the ESFT (explanatory/social/fears/treatment) screening for nonadherence (see Table 1). First, the patient's explanatory model is determined (she'd never been asked this before). The provider discovers that she thinks her hypertension is a result of anxiety and nervousness, in particular when her son visits a few days a week, leaving her to care for her grandchildren. As a result, she has

Table 1. A Clinician's Guide to Understanding Cultural Differences

The ESFT (explanatory/social/fears/treatment) model guides clinicians in understanding a patient's outlook and helps practitioners with therapeutic approaches. These are questions to ask patients.

Explanatory Model of Health and Illness

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

Social and Environmental Factors

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

Fears and Concerns

- Are you concerned with the dosage, color, or size of pill?
- Have you heard anything about this medication?
- Are you worried about the side effects?

Therapeutic Contracting (Treatment)

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

been taking her antihypertensives "almost every day, but mostly when her son visits," but at different times during the day.

Next, the provider finds out that the patient does not have difficulty getting her medication and can easily afford her copayment. Then, a review of her fears and concerns about the medication reveals she has heard some things that concern her from one of her neighbors. The neighbor, who is taking diuretics for her hypertension, says that she sometimes cannot go out because she is worried about needing to go to the bathroom so often.

A review of the patient's regimen shows that she is not on diuretics, and the patient is relieved. Finally, her explanatory model is negotiated, incorporating the biomedical model. She is made to understand that her blood pressure is always high, but perhaps, as she says, higher when she's anxious. As a result, the patient is encouraged, and agrees, to take her antihypertensive medication every day at the same time. She repeats to you that she will take her medication once a day, at the same time, every day. On her subsequent three visits to pick up refills, her blood pressure is much better controlled.

Conclusion

Communicating effectively across cultures is a critical component of providing quality health care to diverse populations. Ultimately, health care providers need a practical set of tools and skills that will enable them to provide quality care to all patients—whatever their differences in background—in what is likely to be a brief encounter.

Adherence is a changing, and increasingly complex, multifactorial health behavior. Provider-patient communication has been linked to patient satisfaction, compliance, and health outcomes. Instead of categorizing patients as "nonadherent," a more discerning approach would be to recognize factors related to provider-patient communication that put patients at risk for nonadherence, and then intervening accordingly. The ESFT model provides an individual, patient-based communication tool that helps providers screen for barriers to adherence and illustrates strategies for interventions that might improve outcomes for all patient populations.

It obviously is impossible to learn everything about every culture—and that should not be the goal. Instead, we should learn about communities where we are the care providers. More important, we should have a framework that allows us to care for any patient, regardless of his or her race, ethnicity, or cultural background. The patient-based approach to cross-cultural care and communication described here enables health care providers to help eliminate perceived barriers to social and cultural misunderstanding. This approach can facilitate all medical encounters, including the elderly, but is particularly important in the setting of cultural and social differences.

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