

# Issues and Opportunities in the Delivery of Health Care Across Cultural and Linguistic Barriers

Presented by

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# Objectives

- Define challenges in current health care system
- Demonstrate the impact of culture on health care delivery and decision making of providers, patients and families.
- Offer successful methods of bridging cultural and language barriers

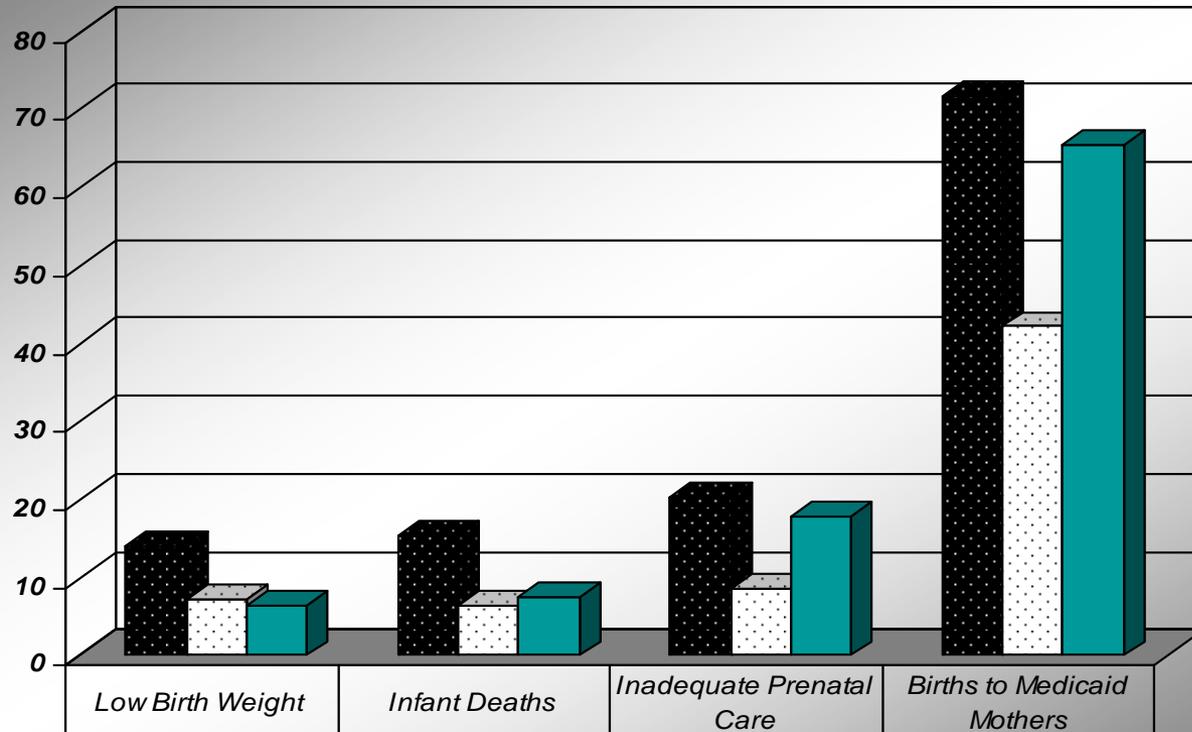
# Challenges for Health Care Organizations and Providers

- More culturally diverse society – 33% of American population comprised of racial and ethnic minority groups, 40% by 2030, 50% by 2056
- Increased demand for patient-centered and equitable care – regulatory agencies, government, payers
- Minimal evidence of improved health care outcomes for ethnic minorities despite significant medical advances
- Evidence of lower quality of care for minorities and limited English proficient patients (LEP) when controlling for insurance, co-morbidity, education and SES – IOM report “Unequal Treatment”
- About 90 million (47%) US adults have limited capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions (2003 National Assessment of Adult Literacy)

# Need for Cultural Competence

- Respond to current and projected demographic changes in the United States
- Reduce long-standing disparities in the physical and mental health status of people from differing racial, ethnic and cultural backgrounds
- Improve the quality of services and health care outcomes
- Comply with legislative, regulatory and accreditation mandates
- Decrease the likelihood of liability/malpractice claims

# Missouri Maternal and Child Health



■ African Americans	13.9	15.3	20.2	71.8
□ Whites	7.1	6.5	8.5	42.2
■ Hispanics	6.3	7.4	17.9	65.4

Rates per 100 births  
Missouri 2002 -2006

# What causes Racial/Ethnic Disparities in Health?

- Social Determinants
- Access to Care
- Health Care – systems and clinical decision making

# Clinical Decision Making and Stereotyping

- Automatic aspects; group → individual
- “Cognitive Misers” → cognitive shortcuts to save resources; principle of “least effort”
- Primal → race, gender, age
- Activated most when:
  - Stressed
  - Under time constraints
  - Multitasking

# IOM's Unequal Treatment

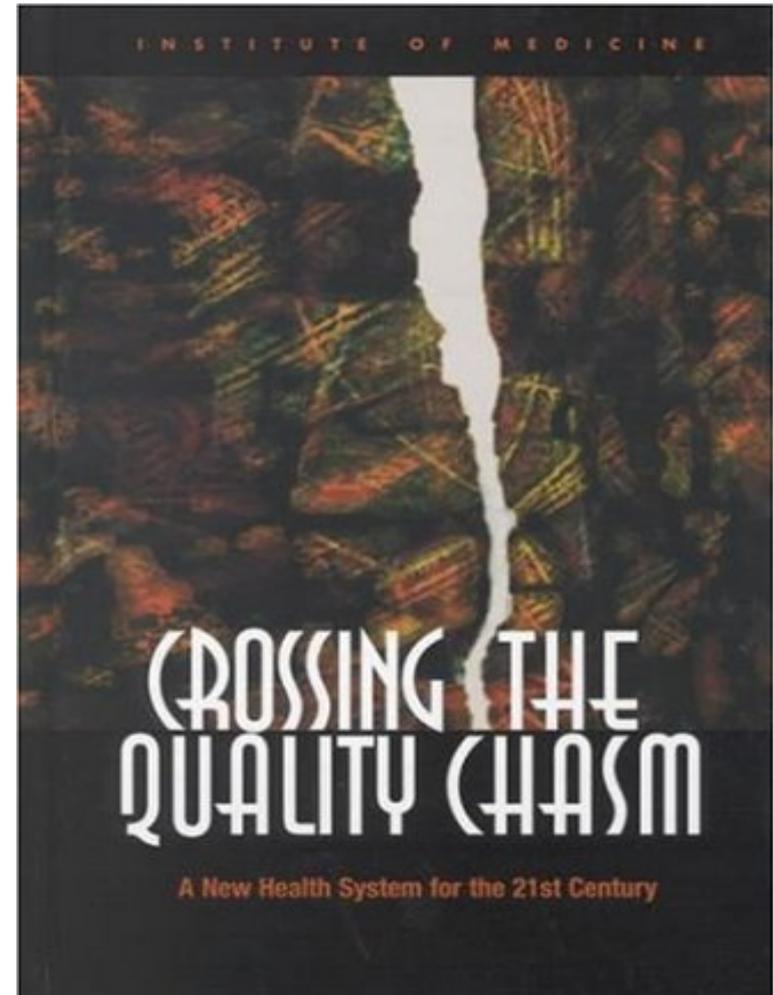
## Recommendations

- Increase awareness of existence of disparities
- Address systems of care
  - Support race/ethnicity data collection, quality improvement, evidence-based guidelines, multidisciplinary teams, community outreach
  - Improve workforce diversity
  - Facilitate interpretation services
- Provider education
  - Health Disparities, Cultural Competence, Clinical Decisionmaking
- Patient education (navigation, activation)
- Research
  - Promising strategies, Barriers to eliminating disparities

# Quality Health Care

Health care should be

- Safe
- Effective
- Patient-centered
- Timely
- Efficient
- Equitable



# Why Consider Culture?

- Helps us to understand the values, attitudes and behaviors of patients
- Helps us to avoid stereotypes and biases that can undermine our efforts to deliver equitable care
- Plays a critical role in the development and delivery of services that are responsive to the needs of the recipient

Cultural competence can help  
to better meet the needs of diverse  
populations.

# Cultural Competence education to....

- Assist health care workers to understand and respond effectively to the cultural and linguistic needs brought by patients during the health care encounter.
- Develop health care workers and patient care teams' competency levels resulting in improved interactions with patient/clients in the context of difference.

# Perspective of Physician Associations

American Medical Association (AMA)

Association of American Medical Colleges (AAMC)

American Academy of Pediatrics (AAP)

American Academy of Family Physicians (AAFP)

# Culturally Competent Practice

*“A set of congruent practice skills, behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations.”*

Substance Abuse and Mental Health Services Administration (1997). *Cultural competence guidelines in managed care mental health services for Asian & Pacific Islander populations.*

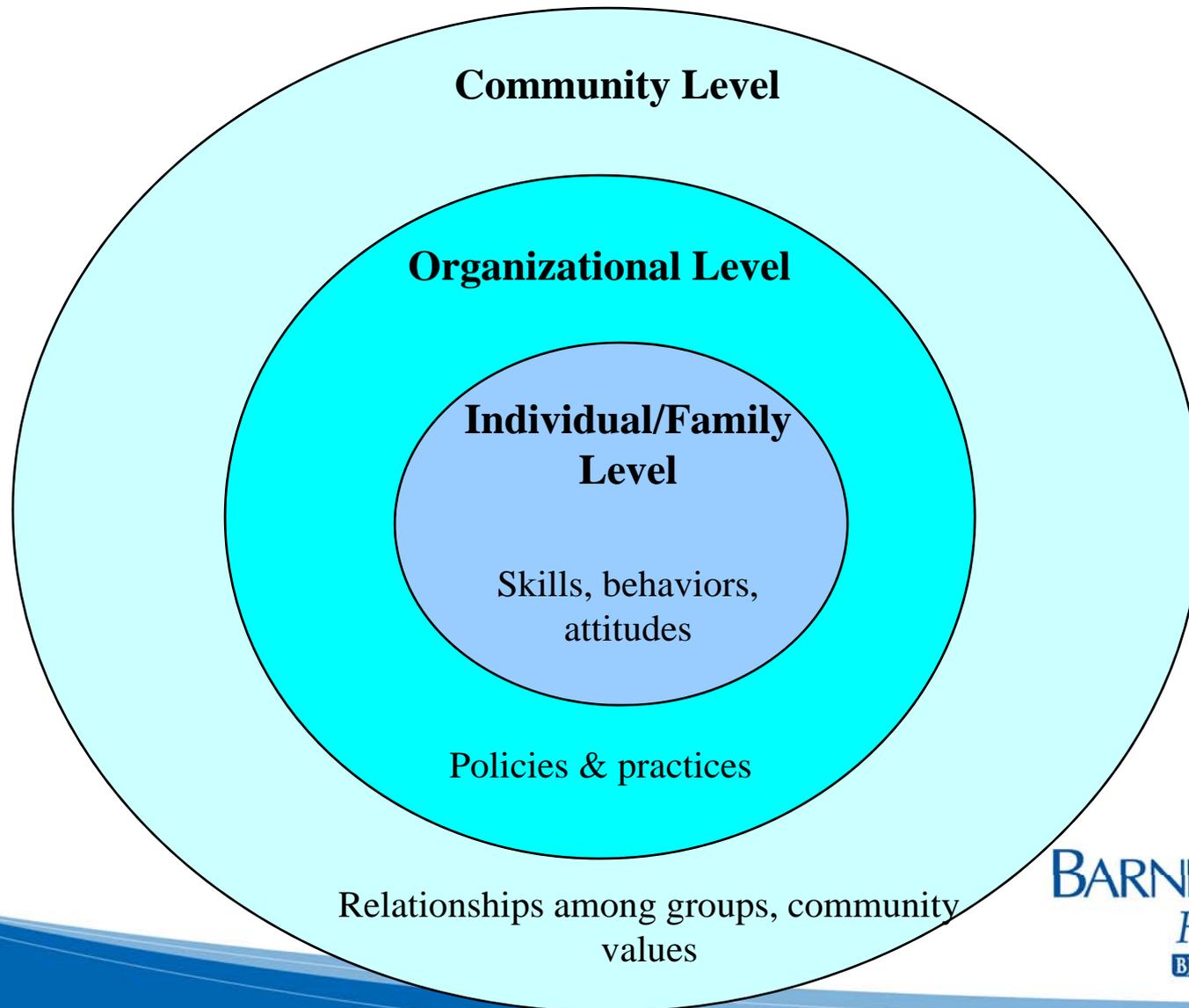
*“A set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities, within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs and to work with knowledgeable persons of and from the community in developing focused interventions, communications and other supports.”*

Orlandi, M. A. (1992). *The challenge of evaluating community-based prevention programs: A cross-cultural perspective.*

# Aspects of Cultural Competence

- Building Awareness of others
- Understanding personal biases and stereotypes
- Acquiring skills, using tools and resources to enable culturally congruent behaviors
- Adapting policies and procedures to create a culturally competent environment

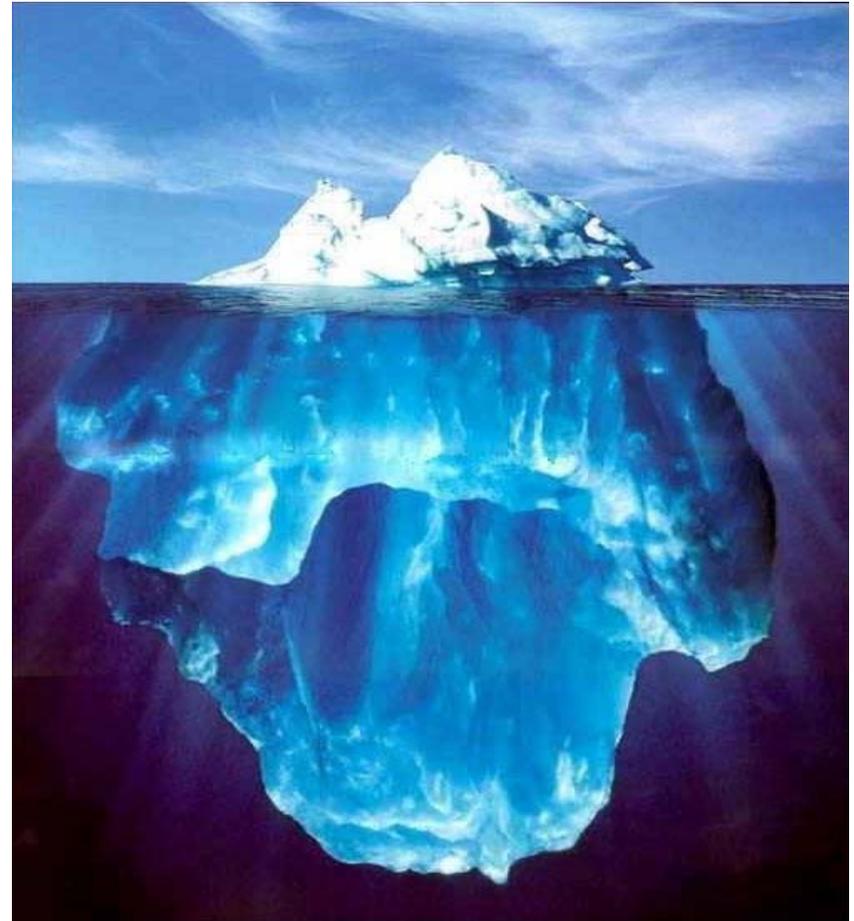
# Trans-Cultural Competence



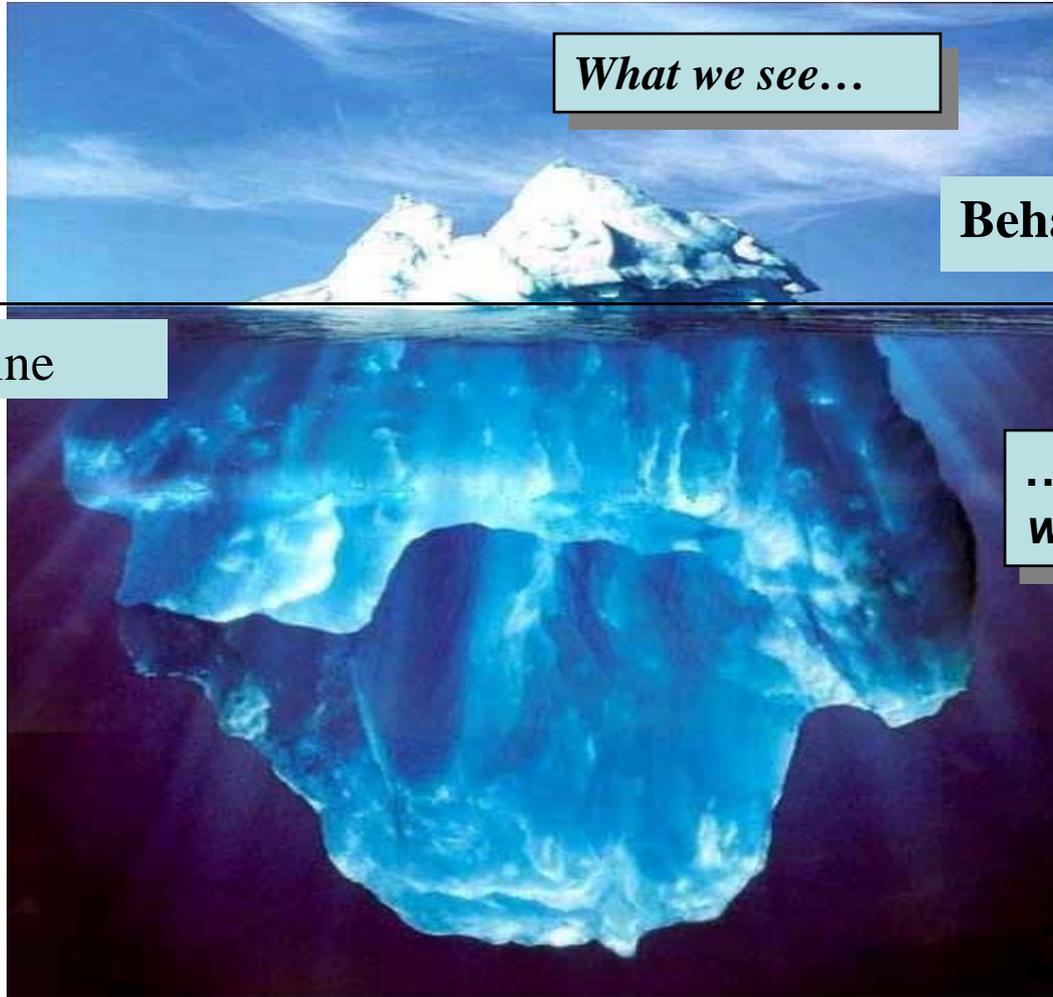
# World View

## *Explanation of Behaviors*

*Do you really understand  
what is driving a person's  
behavior?*



# Behavior & What Drives It



*What we see...*

**Behaviors**

**Water Line**

*...and what drives what we see*

**Values  
Beliefs  
Assumptions**

# Components & Levels of Culture

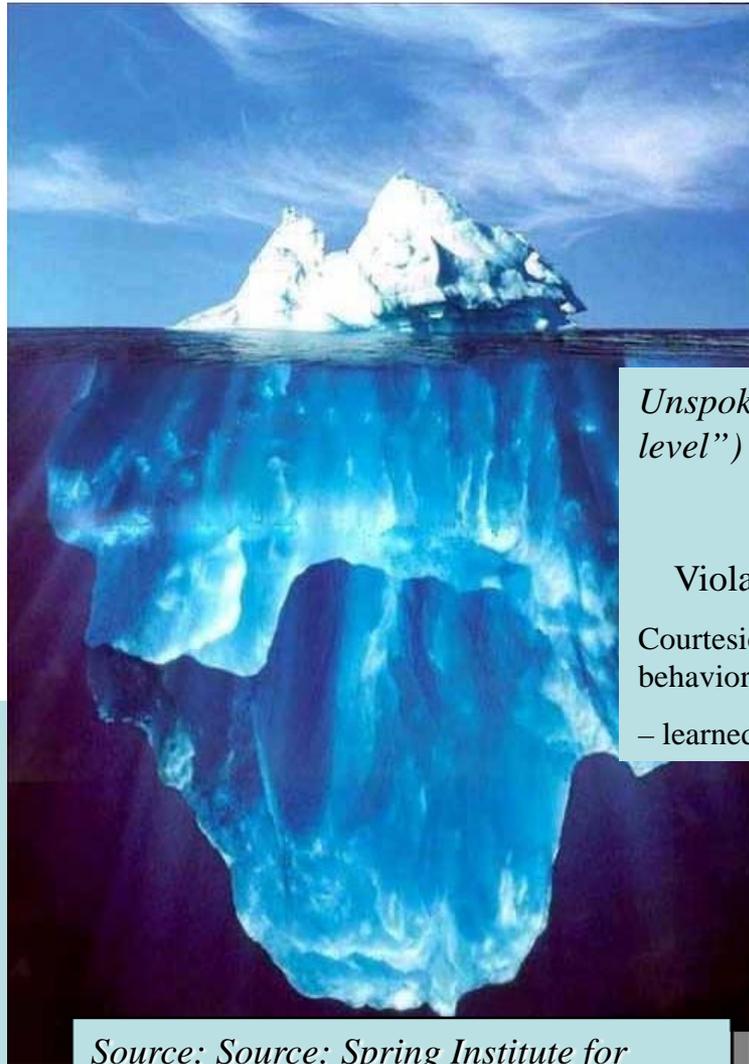
## *Visible Culture (“above sea level”)*

Emotional loading low

Few misunderstandings

Food, music, language, architecture

- learned cognitively



## *Unspoken Rules (“partly below sea level”)*

Emotional loading high

Violations produce negative feelings

Courtesies, use of time, punctuality, eating behaviors, social interactions, shopping

– learned by trial & error

## *Unconscious Rules (“completely below sea level”)*

Emotional loading intense

Violations taken personally, affecting relationships

Touching, space, body contact, tone of voice, non-verbal communication – learned through modeling, usu. in early childhood

*Source: Source: Spring Institute for Intercultural Learning*

# Why We Should Care about Cultural Construct Differences?

They can ...

- lead to frustration
- create distrust
- impede interventions/actions
- adversely affect clinical outcomes
- adversely affect work output

# Cultural Constructs

- Option One: Immerse yourself in the study of particular cultures
- Option Two: Develop skills at discerning cultural perspectives as part of assessment & interpersonal techniques

*Which do you think would be more effective?*

# Cultural Construct

## *World View*

- Locus of control
- Concept of self
- Communication style
- Power distance

# *Locus of Control*

## ***Internal -***

### ***Optimist/activist***

- Fate little importance
- Few things CAN'T be changed
- I am master of my destiny

## ***External -***

### ***Realist/fatalist***

- Fate is my path
- Many things must be accepted as they are
- My destiny is set

*Which of these views fits with your own view?*

# *Concept of Self*

## ***Individualist***

- Self is smallest unit of survival
- Protecting self protects others
- Independence & leadership is prized & taught

## ***Collectivist***

- Primary group smallest unit of survival
- Protecting others protects self
- Dependence & blending is prized & taught

*Which of these views fits with your own view?*

# Communication Style

## **Direct (“Low Context”)**

- People say what they mean & mean what they say
- Words convey information
- Words are primary carrier of information
- Goal is getting/receiving information

## **Indirect (“High Context”)**

- Read “between the lines” for meaning
- Words convey power
- What not said (& implied by omission) as meaningful as what is said
- Goal is to create/preserve/strengthen relationship

*Which of these views fits with your own view?*

# *Power Distance*

## **Low**

- Power to be shared
- Potential leadership nurtured
- Discourse & disagreement with authority may be healthy

## **High**

- Power centralized
- Followers are managed
- Open disagreement with authority carries consequences

*Which of these views fits with your own view?*

“If that is what awaits me then I would hope to face it with God’s help.”

“No, please... you must ask my husband. He will tell you what we must do. Please you must wait and talk to him.”

“[The doctor]said it was **Rok**. All this treatment is useless and just makes her ill. We will care for her now.”

*“I realize that you think this is impossible. But, if you make her hear this thing...if you tell her that it is cancer... she will just die. Flat out. She will put her energy into preparation for death...and she will die. It is not a matter of patho-physiology...well, once she stops eating, perhaps it is.”*

# Another Way of Looking at Culture

Linear-Active	Multi-Active	Reactive
Task-oriented	People-oriented	People-oriented
Organized planners	'Big picture' organizers	Looks at general principles
Dominated by timetable	Timetable unpredictable	Reacts to others' timetable
Germans, Swiss, N. American (majority)	Latin Americans, Arabs, Africans	Japanese, Chinese, Koreans, Finns

*Source: Lewis, R. D. (1999). When cultures collide.  
London: Nicholas Brealey Publishing.*

# Things health care providers need to know

- People have various beliefs about transitions that accompany health, illness, birth and death
- Most of these beliefs are mediated by culture, age, and length of time in the U.S.
- Health care providers need to assess both cultural group patterns and individual variations within a cultural group

Providing appropriate, cross-cultural health is impossible without partnerships based on

- Trust
- Respect
- Responsible relationships between health care providers and patients, their families and communities

# Sensitive approach

## ASK

- Awareness
- Sensitivity
- Knowledge

# Sensitive approach

- Reflect on own beliefs about, and approach to health transitions
- Acknowledge our own biases about specific groups of people that may inadvertently be communicated to patients and families
- Awareness of own verbal and non-verbal communication styles allows us to avoid social gaffes that may offend patients and families
- Flexibility in how we communicate enhances our trust-worthiness.

# A cultural assessment

- What is the patient's ethnic affiliation?
- Who are the patient's major support persons and where do they live?
- With whom should we speak about the patient's health or illness?
- What are the patient's primary and secondary languages, and speaking and reading abilities?
- What is the patient's economic situation? Is income adequate to meet the patient's and family's need?
- If patient is an immigrant...Where did they grew up?
- What decade did they arrive in the U.S.? – time has an impact on acculturation, communication, health beliefs and practices. May be tricky is patient is an illegal alien and may result in patient not returning for care.
- Why did you leave your homeland and what brought you to the U.S.?

# The Explanatory Model

*Arthur Kleinman, Ph.D.*

A culturally sensitive approach to asking about a health problem

- What do you call your problem?
- What do you think caused your problem?
- Why do you think it started when it did?
- What does your sickness do to you? How does it work?
- How severe is it? How long do you think you will have it?
- What do you fear most about your illness?
- What are the chief problems your sickness has caused you?
- Anyone else with the same problem?
- What have you done so far to treat your illness: What treatments do you think you should receive? What important results do you hope to receive from the treatment?
- Who else can help you?

# Variations in communication

## *It's Not Just Words*

### **Conversational style and pacing**

Silence may indicate respect or acknowledgement that the listener heard the speaker

Saying “no” may be rude, silence may mean no

Answers can be blunt and to the point ....or may entail storytelling

To convey anger the person may speak loudly or repetitively ....or may simply emphasize something

### **Touch**

There may be cultural prohibitions against touching certain parts of the body – the head, the feet before the head

Physical contact among those of the same gender such as greeting with an embrace or walking hand-in-hand, is more appropriate than among unrelated persons of the opposite gender.

Examination of the genitals by someone of the opposite gender may be Problematic.

# Variations in communication

## Eye Contact

Culturally appropriate eye contact may vary from intense to fleeting  
Avoiding direct eye contact may be a sign of respect – an effort not to invade one's privacy, or may be appropriate behavior b/w genders

## Personal space

Standing too close may be perceived as “aggressive”  
Backing off may be perceived as “distant” or “cold”

## Time orientation

Some cultures pace life according to clock time, which they value more highly than personal or subjective time  
Others place greater value on interacting with people and completing interpersonal encounters  
Being “on time” is secondary importance

# Communicating through Interpreters

- Use qualified interpreters who have passed qualification standards and completed interpreter education programs.
- Do not use family members, friends, young children or youth to interpret.
- Do not rely on untrained workers or employees to interpret.
- Use telephone language lines when it is necessary.

# HIPAA and Language Access

May use and disclose protected health information without individual's authorization, when:

- Interpreter is member of the workforce (e.g., bilingual employee, contract interpreter on staff, volunteer), or
- When engaging the services of a person or entity (e.g., a telephone interpreter services or telecommunications service) to perform interpreter services as a business associate, or
- The patient identifies a family member, close friend, or any other person as his or her interpreter for a particular health care encounter\*

\*Use of family members and friends is not recommended.

# Effective use of an interpreter

- Make eye contact directly with patient.
- Speak directly to patient, not the interpreter.
- Know policies & procedures regarding the use of an interpreter.
- Pace the communication, so there is adequate time for the interpretation.
- Try not to stand between patient & interpreter.

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