CROSS-CULTURAL EDUCATION PRIMER

Developed by the Culturally Competent Care Education Committee at HMS, the following is a brief primer on the key concepts of cross-cultural care. The goal is:

- To establish the importance of socio-cultural factors and their impact on health beliefs, behaviors, and medical care.
- To learn a set of key concepts and skills that enhance the ability to communicate with, diagnose, and treat patients from diverse socio-cultural backgrounds (including identifying core cross-cultural issues, eliciting the explanatory model, determining the social context, using an interpreter, and provider-patient negotiation).
- To learn the practical application of these concepts and skills in the clinical setting

BACKGROUND

As clinicians, we see patients from all backgrounds and we need to find ways to communicate with them effectively. Patients present varied perspectives, values, beliefs, and behaviors regarding health and well-being. For example, they vary in their recognition of symptoms, their thresholds for seeking care, their ability to communicate symptoms to a health care provider who understands their meaning, their ability to understand the prescribed management strategy, their expectations of care (including preferences for or against diagnostic and therapeutic procedures), and their adherence to preventive measures and medications (Einbinder and Schulman 2000). The goal of the emerging field of cross-cultural education is to improve health care providers' ability to understand, communicate with, and care for patients from diverse backgrounds. Training in this area focuses on enhancing awareness of sociocultural influences on health beliefs and behaviors, and providing skills to understand, and manage these factors in the medical encounter (Carrillo et al., 1999)

KEY COMPONENTS OF CROSS-CULTURAL CARE

- "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 should include the social factors that influence individuals as well.
- It should be noted that culture is not equivalent to just race or ethnicity (we all belong to multiple cultures, including the "medical culture"), and that culture is fluid, not static. As such, attempts to identify norms or values of the "Latino", "Asian", or

"Gay" patient may not be effective, and instead contribute to stereotyping. If there are opportunities to learn about communities, that should be encouraged, yet teaching tools and skills to care for patients from *any* culture should be the ultimate goal of cross-cultural education.

THE CROSS-CULTURAL "REVIEW OF SYSTEMS"

- The following four steps should be carried out when you are caring for all patients, but in particular those from a different social or cultural background than yourself. It should be thought of as a "review of systems" focused on issues that if not tended to may lead to poor health outcomes.

Step One: Identify the Core Cross-Cultural Issues

When you see a patient from a different sociocultural background that you may not be familiar with, you should consider a broad set of core cross-cultural issues that may be important for that individual. You should try to place the individual patient on a continuum as it relates to issues that are important to all cultures:

Styles of Communication: How does the patient communicate?

This includes issues relating to:
Eye contact, physical contact, and personal space
Relating "bad news" – patient preferences
Deferential vs. confrontational/Stoicism vs. expression of symptoms

Mistrust and Prejudice: Does the patient mistrust the health care system?

One should:
Recognize prejudice and its effects
Build trust and reassure your patient of your intentions
Keep in perspective "what's at stake" for patient; showing respect for patient's concerns

Autonomy, Authority, and Family Dynamics: How does the patient make decisions?

What is the:
Role of family vs. individual in decision making
Role of support – family of origin, partner, friends
Role of authority figure within family or social group
Role of community leaders or spiritual leaders in important decisions

Role of Physician and Biomedicine: What does the patient expect of us? What is our role?

What are the patients':
Expectations for physician and biomedicine
Perspectives about the physician (service provider vs. gatekeeper)
Views on alternative medicine vs. biomedicine

Traditions, Customs and Spirituality: How do these factors influence the patient?

These include:
Issues regarding medical procedures (e.g., drawing blood)
Rituals pertinent to the medical encounter
Culturally specific "alternative" therapies (including culturally specific diet/preferences)

Sexual and gender issues: How central are these issues to the patient's life?

Including:
Gender concordance/discordance -- Attitudes towards physical exam, gender of physician
Use of preferred pronoun for patients who are transgender or transsexual
Shame/embarrassment in discussion of sexual issues
Differences in sexual behavior, orientation and identity

Step Two: Explore the Meaning of the Illness

- Oftentimes, patients may have very different understandings about diseases and treatments. These perspectives may very much shape the patient's behavior. 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, when there is non-adherence to a treatment, or when there is some sort of conflict.

This can be done by asking the patient the following questions:

1) What do you think has caused your problem? How?

2) Why do you think it started when it did?

3) How does it affect you?

4) What worries you most? (Severity? Duration?)

5) What kind of treatment do you think you should receive? (Expectations?)

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 should be considered to when identifying the patient's social context:

Tension (social stress/support systems)

Does the patient have social support, or are they isolated?

Environment change (degree and reason for change, expectations, acculturation)

What was the patient's previous health care experience, and how does that shape their interaction with the health care system now?

Life control (including social status, poverty, education)

What resources does the patient have? Can they afford medications?

Literacy and Language

Does the patient have limited English proficiency or literacy, and how does this affect health care?

Step Four: Negotiate

Once the above information is obtained, the physician should engage in negotiation with the patient to try to achieve the best possible outcome (sometimes what is acceptable is better than what is optimal, if the risk of trying to secure the optimal is losing the patient's trust). Oftentimes, this requires exploring the meaning of the illness for the patient, and then compromising and formulating a mutually acceptable plan.

Logistics of Using a Trained Interpreter

Sometimes you may have to care for a patient with limited, or no English proficiency. In those cases, securing a trained interpreter is critical. Once you've secured an interpreter, you should follow these guidelines:

1. **Pre-interview**
   Prior to visit with patient, meet briefly with interpreter to discuss logistics, known issues, and the goals for the encounter.
2. **Etiquette**
   When possible, try to arrange a triangular positioning—you facing the patient, with the interpreter on the side or behind you. Talk to the patient (in first person, with direct eye contact). If you wonder about meaning or length of response, ask the patient and interpreter to clarify.
3. **The Dialogue**
   Try to use single questions, short phrasing…attend to the interpreters need to interpret what you are saying, and break long statements and questions down to shorter segments.
4. **Debriefing**
   Give and get feedback from the interpreter and ask for questions.

Using Casual Interpreters (i.e family, although never a child)

In some instances, you may not have a formal interpreter available. In that case, you may have to use a "casual" or "ad-hoc" interpreter. This might include a co-worker, or a family member, but never a child. In this case, the following can serve as a guide on how to proceed:

1. A fundamental approach is to recognize the importance of the perspective of the family member or friend, get that perspective, then emphasize the importance of getting information as directly as possible from the patient.
2. Trust your senses: if the responses seem inadequately translated, or the history is confusing, insist on getting a trained interpreter.
3. Keep in mind that when using family or a friend, there is a major challenge of confidentiality and/or embarrassment and therefore making this a distant choice.
4. Additionally, in context of domestic violence, spouses or partners should not be used as interpreters.

REFERENCES

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Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: A patient-based approach. *Annals of Internal Medicine* 1999; 130:829-834

Einbinder LC, Schulman KA. The effect of race on the referral process for invasive cardiac procedures. Med Care Res Rev 2000;1:162-177.

Green AR, Betancourt JR, Carrillo JE. The social history revisited: integrating social factors into cross-cultural medical education. Acad Med 2002;77:193-197.

***Framework adapted from Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. Ann Intern Med. 1999:130:829-834.**

Additional Online Resources

University of California San Francisco School of Medicine
http://medicine.ucsf.edu/resources/guidelines/culture.html

Resources from the National Center of Cultural Healing
http://www.culturalhealing.com/healthprofessions.htm