Effective communication between patients and health care providers is a critical element to quality health care. Increasingly diverse racial, ethnic, and sociocultural backgrounds of patients challenge health care providers for delivery of health care services. An awareness of personal factors that have an impact on patient care is an important component of cultural competency for health care providers. Effective communication can improve outcome measures such as patient satisfaction, adherence to treatment, and disease treatment outcomes (Stewart, 1995). Becoming aware of patients’ attitudes, beliefs, biases, and behaviors that may influence patient care can help clinicians improve access to and quality of care. Health disparities and minority and foreign-born populations are increasing across the United States. The U.S. Census Bureau predicts that within the next 50 years, nearly one-half (48%) of the nation’s population will be from cultures other than Caucasian, non-Hispanic. Despite improvement in overall health for the majority of Americans, the burden of health disparities continues to affect minority populations disproportionately.

The HHS Office of Minority Health (OMH, 2007a) identified health disparities and four areas for attention, including access to health care, improved data collection/analysis, health professions development, and cultural competence. To assist health care organizations in providing effective, timely, and respectful care that is compatible with patients’ cultural health beliefs and practices, the Office of Minority Health issued the National Standards for Culturally and Linguistically Appropriate Services in Health Care in December 2000 (Office of Minority Health, 2007b).

Cross-Cultural Encounters

Every clinical encounter is cross-cultural. Developing partnerships with our patients can help us to learn and better understand the familial, community, occupational, and environmental contexts in which they live. There is no one way to treat any racial and ethnic group, given the great sociocultural diversity within these broad classifications. For physicians and nurses to learn the aspects of each culture that could influence the medical encounter is impractical because cultural groups are very heterogeneous. A patient-centered, more unified approach is needed in which the physician and nurse treat each patient as an individual, within the context of his or her environment (Carrillo, Green, & Betancourt, 1999). Patient-centered care establishes a partnership among practitioners, patients, and families to ensure that decisions respect patients’ needs and preferences.
and solicit patients’ input to make decisions and participate in their own care.

Patient centeredness is furthered when patients receive information in their language, when health care providers have greater awareness of potential communication difficulties, and care is provided by taking into account the context of the patient’s cultural beliefs and practices. Patient-centered care empowers the patient as an “expert” of his or her unique illness experience (Tervalon & Murray-Garcia, 1998).

The distinction between the words *disease* and *illness* is important in providing culturally competent care. Disease refers to physiologic and psychologic processes; illness refers to the psychosocial meaning and experience of the perceived disease for the individual, the family, and those associated with the individual (Kleinman, Eisenberg, & Good, 1978).

A culturally competent health care provider addresses both a patient’s disease and illness. These findings correspond to the recent emphasis in undergraduate and graduate medical and nursing education on cultural competency (Accreditation Council for Graduate Medical Education, 2006; International Council of Nurses, 2006; Long, 2000). The U.S. Accreditation Council for Graduate Medical Education (2006) requires all residency programs to have a systematic approach to teaching their physicians-in-training in the area of cultural competency. Cross, Bazron, Dennis, and Isaacs (1999) outlined a philosophical framework for developing and implementing a patient care delivery system that provides services in a culturally appropriate way to meet the needs of culturally and racially diverse groups. They also developed a comprehensive cultural competence model that can be used to assist health care professionals to work effectively in cross-cultural situations.

The quality of the information during the medical interview is essential in establishing rapport with patients, and for making an accurate assessment of a patient’s condition, taking into account psychosocial aspects of patient’s problems. Various methods are described in the literature for teaching interpersonal and communication skills (Duffy et al., 2004; Office of Minority Health, 1999). Some of the most frequently taught are the SEGUE model, the 4 E’s, and the BATHE model. The BATHE model provides a useful mnemonic for eliciting the psychosocial context through asking simple questions about background, affect, trouble, handling, and empathy (Stuart & Lieberman, 2002).

*Background:* The simple question “What is going on in your life?” elicits the context of the patient’s visit.

*Affect:* Asking “How do you feel about what is going on?” or “What is your mood?” allows the patient to report and label the current feeling state.

*Trouble:* “What about the situation troubles you the most?” helps the physician and patient focus and may bring out the symbolic significance of the illness or event.

*Handling:* “How are you handling that?” gives an assessment of functioning and provides direction for an intervention.

*Empathy:* “That must be very difficult for you” legitimates the patient’s feelings and provides psychological support.

**Talking the Talk**

Considering that approximately 20% of U.S. residents speak a language other than English at home, health care providers should expect to communicate with non-English speaking populations (Language Map Data Center, 2007). The presence of English-speaking family members may facilitate patients’ ability to understand and express health care concerns. On the other hand, studies have reported that doing so can create an environment where the patient is uncomfortable with expressing health concerns of a personal and private nature and prefers a professional interpreter (Meadows, Thurston, & Melton, 2001; Ngo-Metzger et al., 2003). This is especially true when one considers the very personal and sensitive topics of sexuality, elimination, and gynecologic issues. Despite the fact that English-speaking physicians will be less likely to provide patient-centered encounters to patients requiring an interpreter (Perez-Stable & Napoles-Springer, 2000), it is difficult to compare such a visit with an encounter where there is a language barrier and an interpreter is not available.

Overall, the literature (Baker, Parker, Williams, Coates, & Pitkin, 1996; Ngo-Metzger et al., 2003; Perez-Stable & Napoles-Springer, 2003) has demonstrated the positive impact of professional interpreters on patient-physician interaction. Physicians with access to trained interpreters reported a significantly higher quality of patient-physician communication than physicians who used other methods (Hornberger, Itakura, & Wilson, 1997). Patients also considered the quality of interpreter services to be very important. They preferred using professional interpreters rather than family members, and preferred gender-concordant translators. One reason may be that it is less difficult to communicate issues of a private nature to a professional interpreter rather than family. The fear of the family knowing and then sharing things of a personal nature are lessened. Furthermore, they expressed the need for help in navigating health care systems and obtaining support services (Ngo-Metzger et al., 2003).

Providing language access services is good medical practice. Addressing language barriers can reduce the harm that comes from critical health care information not being communicated correctly, and it contributes to greater patient satisfaction and adherence to treatment. Interpreters should be chosen carefully to exhibit a set of competencies, not just language skills. In 2003, the
Health Literacy

Health literacy is an emerging field focusing on literacy within the context of health. Every 10 years, the U.S. Department of Education conducts a nationwide study of the English-language literacy skills of U.S. adults. The most recent study, the 2003 National Assessment of Adult Literacy (National Center of Education Statistics, 2005), defines literacy as “the ability to use printed and written information to function in society, to achieve one’s goals, and to develop one’s knowledge and potential.” The survey responses from 21,000 individuals 16 years and older revealed that between 40% and 50% of the adult population have literacy skills at basic or below basic levels. Approximately 5% of those sampled (representing about 11 million U.S. adults) could not be tested because of cognitive impairment, spoke a language other than English or Spanish, or had rudimentary literacy skills and assessment could not be performed. Health literacy is another term, defined by the American Medical Association (Schwartzberg & VanGeest, 2005) as “a constellation of skills, including the ability to perform basic reading and numerical tasks required to function in the health care environment.” Similarly, the Healthy People 2010 (U.S. Department of Health and Human Services, 2000) defines health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services to make appropriate health decisions.” In a review of 85 studies with approximately 30,000 subjects combined, Paasche-Orlow, Parker, Gazmarian, Nielsen-Bohman, and Rudd (2005) found that the prevalence of low health literacy was 26% and the prevalence of marginal health literacy was another 20%. There was an association between low health literacy skills and advanced age, ethnicity (such as Hispanic, African American), low socioeconomic and educational status, and immigrant status. However, the majority of those with limited health literacy skills were white, born in the United States, and currently employed.

It is important for health care providers to be aware that people may be ashamed to acknowledge that they can not understand health-related information and will not ask for help. Health literacy is one of the risk factors for poor health knowledge, health behaviors, and health outcomes. A recent review (DeWalt, Berkman, Sheridan, Lohr, & Pignone, 2004) highlighted links between health literacy and outcomes such as increased rate of hospitalizations, outpatient visits, health care costs, noncompliance with adherence to instructions, diabetes mellitus complications (for example, retinopathy), depression, and others. An essential component of patient health care providers’ communication is the ability to provide information that can improve patient understanding. This starts with increased awareness of the high prevalence of low health literacy; the use of nonmedical terms, pictures, or diagrams; providing only focused information; and determining the degree of patient comprehension.

Culturally competent care is the responsibility of all health care personnel, not only physicians. The office environment is a critical element of providing culturally competent medical service. It involves assessing

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**Case Study**

Eleanor is an 81-year-old Appalachian woman whose daughter brings her to the office because her mother has difficulty urinating. The interaction between the nurse and Eleanor is as follows:

**Nurse:** “Can you tell me why you are here?”

**Eleanor:** “Honey, I don’t know for sure. My daughter said I should come in here and see you all.”

**Nurse:** “Why? Is there something going on?”

**Eleanor:** “Yeah, I’m having a hard time passing water.”

**Nurse:** “Tell me what you mean.”

**Eleanor:** “I told you, I can’t pass water right.”

**Nurse:** “Ok, well, I need you to urinate in this cup, ok?”

**Eleanor:** “What do you want me to do?”

**Nurse:** “I need you to put your water in this cup.”

**Eleanor:** “Ok.”

The nurse takes the sample and the urinalysis is inconsistent with “typical” urine. The nurse questions the sample and requests another. This time the daughter hears the conversation and intervenes. She explains to her mother she should catch some of the water she passes as soon as it comes out of her and not get it from the toilet. The mother nods understanding. The next urinalysis is indicative of a urinary tract infection. She is given antibiotics and fluid instructions. This is an example of “its not what we say, but how we say it.”
Culturally competent care is the responsibility of all health care personnel, not only physicians.

References


