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# Physician cultural competence: Cross-cultural communication improves care

## ■ ABSTRACT

Cross-cultural communication is a skill worth learning. For the busy clinician, using this skill during the patient encounter will enhance the quality of care by improving the doctor-patient relationship, and will perhaps even increase the efficiency of the encounter.

## ■ KEY POINTS

When translation is needed, professional interpreters should be used; friends or family may be reluctant to discuss certain issues and may inadvertently distort information.

Several cultural issues may cause problems in cross-cultural encounters: authority, physical contact, communication styles, gender, sexuality, and family.

Physicians should try to understand how the patient understands his or her illness, using skills in interpreting both verbal and nonverbal cues.

The role of family in decision-making in many cultures should be acknowledged when discussing a treatment plan, and specifically in the context of end-of-life issues.

We should be aware of our own culture, values, and belief system, as our own biases may affect our interactions with patients.

Training programs should aim at enhancing the cultural competence of health care providers by teaching and developing cross-cultural communication skills.

**Y**OUR PATIENT'S CULTURE makes a difference in his or her care—and so does your own. As the demographics of this country change, our ability to provide optimal care will increasingly rely on our skills in communicating with patients from diverse backgrounds. And to communicate successfully across cultural barriers we need to understand what culture is and to raise our own cultural self-awareness.

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Cross-cultural communication is a skill worth learning. For the busy clinician, using this skill during the patient encounter will enhance both the quality of care and the doctor-patient relationship, and perhaps even increase the efficiency of the encounter.

This paper defines and discusses cultural competence, with specific emphasis on the relevance of culture to communication skills and the doctor-patient relationship. The role of culture-specific information, cultural issues at the end of life, and the relevance of racial concordance in the doctor-patient interaction will also be discussed.

## ■ US MINORITY POPULATION IS INCREASING

Data from the US census of 2000 show that the percentages of ethnic minorities in the United States are increasing. The white population now accounts for 75.1% of the total population (down from 80.3% in the census of 1990), black or African American 12.3%,



Hispanic or Latino 12.%, and American Indian and Alaska native 0.9%.<sup>1</sup>

## ■ WHAT IS CULTURE?

Culture has been defined as “beliefs and behaviors that are learned and shared by members of a group,”<sup>2</sup> with the distinction that it “encompasses more than ethnic, racial, national, and gender designations.”<sup>3</sup>

The American Medical Association’s *Cultural Competence Compendium*<sup>4</sup> defines a culture as “any group of people who share experiences, language, and values that permit them to communicate knowledge not shared by those outside the culture.”

This definition applies to us physicians too: “physicians reflect many individual cultural attributes, but they also participate to some extent in the culture of medicine.”<sup>4</sup> Thus, when a patient without any medical background enters the examination room, one type of cultural barrier is already present. The increasing use of complementary medical therapies makes those of us in the “culture of medicine” question our own attitudes toward those nontraditional treatments that our patients may find extremely beneficial.

## ■ CULTURE AFFECTS HEALTH CARE

Cultural differences may have many effects on care. Cultural differences between the physician and patient may create communication barriers so significant that our patients leave the office not knowing what we are telling them.

Recent publications on disparities in health care<sup>5,6</sup> raise thought-provoking questions as to why such disparities may exist and to what extent cultural bias, on the part of both the physician and the patient, plays a role. For example, why are there substantial racial differences in access to renal transplantation?<sup>6</sup> Or why is the rate of surgical treatment lower among blacks with early-stage, non-small-cell lung cancer as compared with white patients?<sup>5</sup>

## ■ WHAT IS A CULTURALLY COMPETENT PHYSICIAN?

The American Medical Association<sup>3</sup> defines culturally competent physicians as those who

can provide patient-centered care by adjusting their attitudes and behaviors to the needs and desires of different patients and account for the impact of emotional, cultural, social, and psychological issues on the main biomedical ailment.

Medical schools recognize the need for skills in cultural competence. In the 1999–2000 academic year, 87% of medical schools included content on cultural competence, and 67% included information regarding cultural practices related to death and dying as part of a required course or clerkship.<sup>7</sup>

Federal initiatives such as the Healthy People 2010 plan<sup>8</sup> and the Culturally and Linguistically Appropriate Services (CLAS) Standards Project,<sup>9</sup> created by the Office of Minority Health Center for Linguistic and Cultural Competence in Health Care, have identified cultural competence in health care as an issue of national significance. The former has the goal of eliminating health care disparities in six different areas by the year 2010, while the latter proposes 14 national standards to facilitate culturally competent care in health care organizations.

## ■ RAISING SELF-AWARENESS

Gardenswartz and Rowe,<sup>10</sup> in their book *Managing Diversity in Health Care*, define six “realities of cultural programming”:

- **Culture is not overt**, and “cultural rules are not discussed unless a rule is broken.” Even more importantly, it may not be obvious just by looking at someone what his or her “culture” may be.
- **We are all essentially ethnocentric**, feeling that our own culture is best.
- **We observe, interpret, then act**; we often misinterpret the actions of others by not understanding their cultural norms.
- **We may not know when we are offending others.**
- **Awareness and knowledge increase our choices**; by becoming more aware of our differences and possible barriers in relating to people of diverse backgrounds, we will have greater opportunity for successful interactions.

**A culture gap exists between doctors and lay people**

- Understanding one's own "software" is a first step; raising self-awareness regarding our own value systems and potential for bias is a crucial step in becoming a culturally competent health care provider.<sup>10</sup>

Thoughtful reflection upon these concepts is helpful in creating a framework for increasing one's own cultural competence.

### ■ CULTURE AND THE DOCTOR-PATIENT RELATIONSHIP

Effective communication is essential in establishing a diagnosis and treatment plan. Cultural competence as it relates specifically to the medical interview refers to the skills required for a health care provider to conduct an effective interview and to create an acceptable plan of care when working with patients from different cultural backgrounds.

Carrillo et al<sup>11</sup> identified several cultural issues that may cause problems in cross-cultural encounters: authority, physical contact, communication styles, gender, sexuality, and family.

### ■ A THREE-FUNCTION MODEL

Cole and Bird<sup>12</sup> created a "three-function model" of the medical interview:

- Function 1: building the relationship
- Function 2: assessing the patient's problems
- Function 3: managing the patient's problems.

This model is extremely valuable in teaching about doctor-patient communication and can be applied in the setting of cross-cultural communication. Communication across cultural barriers may present specific problems at each stage of the interview.

The following discusses specific aspects of the doctor-patient encounter that may be affected by cross-cultural barriers, following the general order of the three-function model.

### ■ BUILDING THE RELATIONSHIP: VERBAL AND NONVERBAL COMMUNICATION

At the beginning of the interaction, when the focus is on building rapport with the patient, issues of both verbal and nonverbal communication need to be considered.

### Verbal communication

If a language barrier exists, a trained interpreter is needed.

Although it is often more convenient to ask an accompanying family member or friend to interpret during the encounter, one should use a professional interpreter whenever possible, as family members or friends are frequently not comfortable with relaying the patient's personal information or may inadvertently reflect the patient's story in their own context. I recall a situation when a patient's friend was serving as an interpreter and was describing the patient's complaint of headache, but then added in a comment, without input from the patient, that she thought the patient was really suffering from depression.

Other key points to remember when interviewing a patient in the presence of an interpreter:

- Speak to the patient directly, using a normal tone of voice
- Avoid slang or technical terms
- Ask one question at a time.

### Subtleties of nonverbal communication

Understanding the subtleties of nonverbal communication is also crucial when providing care across cultural barriers.

**Gestures** are not universal, and their use may cause unnecessary miscommunication.

**Personal space.** Different cultures have different concepts about personal space. In Western culture, which includes the mainstream United States, personal space (the space between individuals during a one-on-one private conversation) is considered to be 18 inches to 4 feet, whereas social space (the space between individuals in a social setting) is 4 to 12 feet.<sup>13</sup> In many cultures, such as Latin American or Middle Eastern, personal space is much closer, which may lead the physician to misinterpret a patient's behavior or emotional state when interacting with patients from these backgrounds.

**Eye contact** can also be misinterpreted. In the mainstream US culture, we often assume that a person who does not maintain eye contact is not being truthful or may be suffering from depression. In many other cultures, direct or prolonged eye contact with the

Due to cultural differences, some patients leave the office not knowing what we are telling them



physician may be thought to signify disrespect on the part of the patient; thus, eye contact may be avoided.

### ■ HOW DOES THE PATIENT UNDERSTAND DISEASE AND ILLNESS?

In the second part of the encounter, when gathering data and assessing the patient's problems, the "disease-illness concept" becomes significant.

Kleinman et al<sup>14,15</sup> describe diseases as "abnormalities in the structure and function of body organs and systems," while illnesses are "experiences of disvalued changes in states of being and in social function: the human experience of sickness." They further comment that "illness behavior is a normative experience governed by cultural rules."<sup>14</sup>

The way a patient experiences his or her biomedical ailment is influenced by specific cultural norms, or personal health belief systems. Certain diseases may be "acceptable," such as intermittent abdominal discomfort diagnosed as irritable bowel syndrome, and others are not, such as the same symptom attributed to an underlying anxiety disorder.

### ■ ELICIT THE PATIENT'S EXPLANATORY MODEL

A culturally competent health care provider should not only focus on the diagnosis of disease, but also attempt to understand the illness behavior, which may be based on cultural beliefs as well. To this end, the physician should elicit the patient's *explanatory model of illness*,<sup>14,15</sup> which is a basic tenet of doctor-patient communication, but is even more crucial with cross-cultural communication.

The patient's explanatory model is his or her own interpretation of what is wrong, why it is wrong, and what could (or should) be done about it. Kleinman et al<sup>14</sup> refer to the "cultural construction of clinical reality." For example, if a patient believes in the hot/cold theory of illness, common in many nonmainstream US cultures, with the belief that ailments are caused by "extreme shifts from hot to cold" and vice versa,<sup>16</sup> their belief in prescription medications as a cure to the problem may be limited and thus not accepted.

Instead, the patient may place more value on a folk remedy that "corrects" the hot/cold balance.

**Specific questions** suggested by Kleinman et al<sup>14</sup> that may be helpful when trying to elicit the explanatory model are:

- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is your sickness? Will it have a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

### ■ MANAGING THE PATIENT'S PROBLEMS

In the final part of the encounter, with the focus on managing the patient's problems, the art of negotiation is crucial in cross-cultural communication. Some tips:

- Acknowledge and respect the role of the family in medical decision-making when discussing diagnosis and treatment options.
- Inquire about the use of alternative or complementary treatments, many of which are culture-specific (ie, Chinese herbal remedies, Eastern Indian ayurvedic medicine).
- Provide patient education materials, with consideration of language barriers and illiteracy.
- Confirm the patient's understanding by asking him or her to repeat your instructions.

Finally, as stated by Platt and Gordon in their *Field Guide to the Difficult Patient Interview*,<sup>17</sup> "Tell the patient what he/she wants to know before explaining what he/she needs to know." For example, if you find during the course of the interview that the patient's greatest fear is that his or her constellation of symptoms represents an underlying malignancy, make sure to address how likely or unlikely you feel this possibility may be, in addition to discussing your other diagnostic considerations.

**Confirm the patient's understanding by asking him or her to repeat your instructions**

### ■ CULTURE-SPECIFIC INFORMATION: IS IT NEEDED?

Is cultural competence merely excellent doctor-patient communication, or is culture-specific or ethnicity-specific information useful?

The ideal scenario would be of a combination of communication skills on a background of familiarity with ethnicity-specific information when dealing with cross-cultural encounters. However, even while attempting to learn about specific cultural norms, the dangers of stereotyping need to be acknowledged, realizing that factors such as socioeconomic status, educational level, occupation, and family values and belief systems may have as important a role in determining culture as does ethnicity.

#### **First recognize your own culture**

As stated above, an important step towards increasing cultural competence in communicating with patients is to first become aware of one's own cultural belief system and preferences. Consider the following "key cultural values" in the mainstream US culture, as identified by Gardenswartz and Rowe,<sup>10</sup> which may be quite different in other cultures and thus may present barriers to cross-cultural communication:

- Status is usually based on accomplishments in the mainstream US culture; in other cultures the role in the family or gender may be the more important determinants
- Privacy may be given greater emphasis in other cultures, with issues of modesty and shame being more prominent
- Fatalism, or a sense of an external locus of control is more common in other cultures, while the culture of mainstream US focuses on a feeling of an internal locus of control, with the attitude of "you control your own destiny"
- A greater emphasis on the individual vs the group is seen in the mainstream US culture
- Telling the patient both good and bad news is expected in the US culture, while withholding bad news from patients is common in other cultures.

These concepts are most relevant regarding cultural components of end-of-life issues as discussed below.

### ■ END-OF-LIFE ISSUES

Issues of cross-cultural communication become especially important when dealing with end-of-life issues.

For example, end-of-life decision-making may be very difficult for a patient who believes in an external locus of control and thus feels that he or she may not be powerful enough to make decisions about issues such as withholding resuscitation efforts, should the situation arise.

For another example, in many cultures the decision-making power would be given to the family member of highest status, which may be the eldest male in the family.

Kagawa-Singer and Blackhall<sup>18</sup> identified six issues related to end-of-life care that may be influenced by cultural beliefs:

- Responses to inequities in care
- Communication and language barriers
- Religion and spirituality
- Truth-telling
- Family involvement in decision-making
- Hospice care. Concern about historical occurrences of inequities in health care may create an increased desire for futile care at the end of life, and possibly a lack of interest in hospice services,<sup>18</sup> because of an underlying concern that not all the best options are being offered.

Religion and spirituality should be acknowledged and respected, and the practice of withholding terminal diagnoses should be recognized, realizing that an acceptable agreement needs to be reached between the physician, the patient, and the patient's family regarding this issue. People in many cultures believe that informing the patient of a terminal diagnosis may hasten death. Suggested questions to ask a patient in this situation may include "How much would you like to know about your illness?" or "Would you prefer I discuss your diagnosis with you, or with your family?"

Different forms of grief expression also need to be understood; for example, loud wailing at the death of a loved one may be common in some Middle Eastern cultures.<sup>2</sup>

Finally, beliefs regarding postmortem testing may be significantly shaped by cultural norms.<sup>2</sup> For example, both orthodox Jewish

**Tell patients  
what they want  
to know before  
what they need  
to know**



and Muslim family members may not be willing to consent to an autopsy.<sup>2</sup>

## ■ RACIAL CONCORDANCE

Is the doctor-patient relationship better if the doctor is the same race as the patient?


Saha et al<sup>19</sup> analyzed data from the 1994 Commonwealth Fund's Minority Health Survey of 2,201 white, black, and Hispanic respondents who reported seeing a physician regularly. Compared with black respondents with nonblack physicians, black respondents with black physicians were more likely to rate their physicians as excellent overall, and as treating them with respect. They were also more likely to state they received preventive care and all the care they needed. Hispanic patients with Hispanic physicians in this study were more likely to be satisfied with health care overall, but not necessarily with their physicians.

## ■ REFERENCES

1. **US Census Bureau.** United States Census 2000. <http://www.census.gov>. Accessed 2/20/03.
2. **Galanti G.** Caring for Patients from Different Cultures. Philadelphia: University of Pennsylvania Press, 1997.
3. **Rohack JJ.** Report of the Council on Medical Education. American Medical Association, CME Report 5-A-98. <http://www.ama-assn.org/meetings/public/annual98/reports/cme/cmerpt5.htm>. Accessed 2/20/03.
4. **American Medical Association.** Cultural competence compendium. <http://www.ama-assn.org/ama/pub/category/4848.html>. Accessed 2/20/03.
5. **Bach PB, Cramer LD, Warren JL, Begg CB.** Racial differences in the treatment of early-stage lung cancer. *N Engl J Med* 1999; 341:1198–1205.
6. **Ayanian JZ, Cleary PD, Weissman JS, Epstein AM.** The effect of patients' preferences on racial differences in access to renal transplantation. *N Engl J Med* 1999; 341:1551–1669.
7. **Barzansky B, Jonas HS, Etzel SI.** Educational programs in US medical schools, 1999–2000. *JAMA* 2000; 284:1114–1120.
8. **Office of Minority Health.** Closing the health gap. [www.omhrc.gov/omhhome.htm](http://www.omhrc.gov/omhhome.htm). Accessed 2/20/03.
9. National Standards for Culturally and Linguistically Appropriate Services in Health Care. Executive Summary. Washington D.C.: March, 2001.
10. **Gardenswartz L, Rowe A.** Managing Diversity in Health Care. San Francisco: Josey-Bass, Inc., 1998.
11. **Carrillo JE, Green AR, Betancourt JR.** Cross-cultural primary care: a patient-based approach. *Ann Intern Med* 1999; 130:829–834.
12. **Cole SA, Bird J.** The Medical Interview: The Three-Function Approach. St. Louis: Mosby, Inc., 2000
13. **Luckman J.** Transcultural Communication in Health Care. Albany: Delmar, 2000.
14. **Kleinman A, Eisenberg L, Good B.** Culture, illness, and care: clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 1978; 88:251–258.
15. **Eisenberg L.** Disease and illness. Distinctions between professional and popular ideas of sickness. *Cult Med Psychiatry* 1977; 1:9–23.
16. **Salimbene S.** What Language Does Your Patient Hurt In? A Practical Guide To Culturally Competent Patient Care. Amherst: Diversity Resources, 2000, p.119.
17. **Platt FW, Gordon GH.** Field Guide to the Difficult Patient Interview. Baltimore: Lippincott Williams & Wilkins, 1999.
18. **Kagawa-Singer M, Blackhall LJ.** Negotiating cross-cultural issues at the end of life: "you got to go where he lives." *JAMA* 2001; 286:2993–3001.
19. **Saha S, Komaromy M, Koepsell TD, Bindman A.** patient-physician racial concordance and the perceived quality and use of health care. *Arch Intern Med* 1999; 159:997–1004.
20. **Hiok-Boon Lin E.** Intraethnic characteristics and the physician-patient interaction: "cultural blind spot syndrome." *J Fam Pract* 1983; 16:91–98.

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It is difficult to make conclusions about whether racial concordance itself significantly contributes to the quality of the doctor-patient relationship, but increasing the level of cultural competence of the health care provider to the level where the patient feels that his or her values and preferences are understood and treated with respect would likely have a great impact on cross-cultural communication, even in racially discordant doctor-patient interactions.

In this regard, the concept of the "cultural blind spot syndrome" also deserves mention.<sup>20</sup> This refers to the sometimes erroneous assumption that no barriers exist if the patient seems to be similar to the physician.<sup>13</sup> A racially concordant physician-patient relationship may not be successful at all if there is discordance in other determinants of culture, such as education level, socioeconomic status, or degree of assimilation into the mainstream culture. 

**First become aware of your own cultural belief system and preferences**