



EDUCATIONAL OBJECTIVE: Readers will try to improve their skills in communicating with patients of other cultures

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Overcoming health care disparities via better cross-cultural communication and health literacy

ABSTRACT

Health care disparities have multiple causes; the dynamics of the physician-patient encounter is one of the causes that can be modified. Here, we discuss specific recommendations related to cross-cultural communication and health literacy as practical steps to providing more equitable health care to all patients.

KEY POINTS

To provide optimal care, physicians and staff need to think about ways to accommodate patients of other cultures and backgrounds, in particular by learning more about the patient's culture and by examining themselves for possible bias.

Even people who read and write very well may have limited health literacy. We should not assume that patients understand what we are talking about.

Weiss (2011) advocates six steps to improve communication with patients in all encounters: slow down; use plain, nonmedical language; show or draw pictures; limit the amount of information provided; use the "teach-back" technique; and create a shame-free environment, encouraging questions.

The "teach-back" technique is a simple way to confirm a patient's understanding at the end of the visit. This involves asking the patient in a nonthreatening way to explain or show what he or she has been told.

AN ENGLISH-SPEAKING MIDDLE-AGED woman from an ethnic minority group presents to her internist for follow-up of her chronic medical problems, which include diabetes, high blood pressure, asthma, and high cholesterol. Although she sees her physician regularly, her medical conditions are not optimally controlled.

At one of the visits, her physician gives her a list of her medications and, while reviewing it, explains—not for the first time—the importance of taking all of them as prescribed. The patient looks at the paper for a while, and then cautiously tells the physician, "But I can't read."

This patient presented to our practice several years ago. The scenario may be familiar to many primary physicians, except for the ending—ie, the patient telling her physician that she cannot read.

Her case raises several questions:

- Why did the physician not realize at the first encounter that she could not read the names of her prescribed medications?
- Why did the patient wait to tell her physician that important fact?
- And to what extent did her inability to read contribute to the poor control of her chronic medical problems?

Patients like this one are the human faces behind the statistics about health disparities—the worse outcomes noted in minority populations. Here, we discuss the issues of cross-cultural communication and health literacy as they relate to health care disparities.

■ DISPARITY IS NOT ONLY DUE TO LACK OF ACCESS

Health care disparity has been an important topic of discussion in medicine in the past decade.

In a 2003 publication,¹ the Institute of Medicine identified lower quality of health care in minority populations as a serious problem. Further, it disputed the long-held belief that the differences in health care between minority and nonminority populations could be explained by lack of access to medical services in minority groups. Instead, it cited factors at the level of the health care system, the level of the patient, and the “care-process level” (ie, the physician-patient encounter) as contributing in distinct ways to the problem.¹

■ A CALL FOR CULTURAL COMPETENCE

In a policy paper published in 2010, the American College of Physicians² reviewed the progress made in addressing health care disparities. In addition, noting that an individual’s environment, income, level of education, and other factors all affect health, it called for a concerted effort to improve insurance coverage, health literacy, and the health care delivery system; to address stressors both within and outside the health care system; and to recruit more minority health care workers.

None of these things seems like anything a busy practicing clinician could do much about. However, we *can* try to improve our cultural competence in our interactions with patients on an individual level.

The report recommends that physicians and other health care professionals be sensitive to cultural diversity among patients. It also says we should recognize our preconceived perceptions of minority patients that may affect their treatment and contribute to disparities in health care in minorities. To those ends, it calls for cultural competence training in medical school to improve cultural awareness and sensitivity.²

The Office of Minority Health broadly defines cultural and linguistic competence in health as “a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that

enables effective work in cross-cultural situations.”³ Cultural competence training should focus on being aware of one’s personal bias, as well as on education about culture-specific norms or knowledge of possible causes of mistrust in minority groups.

For example, many African Americans may mistrust the medical system, given the awareness of previous inequities such as the notorious Tuskegee syphilis study (in which informed consent was not used and treatment that was needed was withheld). Further, beliefs about health in minority populations may be discordant with the Western medical model.⁴

■ RECOGNIZING OUR OWN BIASES

Preconceived perceptions on the part of the physician may be shaped by previous experiences with patients from a specific minority group or by personal bias. Unfortunately, even a well-meaning physician who has tried to learn about cultural norms of specific minority groups can be at risk of stereotyping by assuming that all members of that group hold the same beliefs. From the patient’s viewpoint, they can also be molded by previous experiences of health care inequities or unfavorable interactions with physicians.

For example, in the case we described above, perhaps the physician had assumed that the patient was noncompliant and therefore did not look for reasons for the poor control of her medical problems, or maybe the patient did not trust the physician enough to explain the reason for her difficulty with understanding how to take her medications.

Being aware of our own unconscious stereotyping of minority groups is an important step in effectively communicating with patients from different cultural backgrounds or with low health literacy. We also need to reflect about our own health belief system and try to incorporate the patient’s viewpoint into decision-making.

If, on reflection, we recognize that we do harbor biases, we ought to think about ways to better accommodate patients from different backgrounds and literacy levels, including trying to learn more about their culture or mastering techniques to effectively explain treatment plans to low-literacy patients.

The American College of Physicians has called for cultural competence training in medical school

■ ALL ENCOUNTERS WITH PATIENTS ARE ‘CROSS-CULTURAL’

In health care, “cross-cultural communication” does not refer only to interactions between persons from different ethnic backgrounds or with different beliefs about health. Health care has a culture of its own, creating a cross-cultural encounter the moment a person enters your office or clinic in the role of “patient.”

Carillo et al⁵ categorized issues that may pose difficulties in a cross-cultural encounter as those of authority, physical contact, communication styles, gender, sexuality, and family.

Physician-patient communication is a complicated issue. Many patients will not question a physician if their own cultural norms view it as disrespectful—even if they have very specific fears about the diagnosis or treatment plan. They may also defer any important decision to a family member who has the authority to make decisions for the family.

Frequently, miscommunication is unintentional. In a recent study of hospitalized patients,⁶ 77% of the physicians believed that their patients understood their diagnoses, while only 57% of patients could correctly state this information.

■ WHAT DOES THE PATIENT THINK?

A key issue in cross-cultural communication, and one that is often neglected, is to address a patient’s fears about his or her illness. In the study mentioned above, more than half of the patients who reported having anxieties or fears in the hospital stated that their physicians did not discuss their fears.⁶ But if we fail to do so, patients may be less satisfied with the treatment plan and may not accept our recommendations.

A patient’s understanding of his or her illness may be very different from the biomedical explanation. For example, we once saw an elderly man who was admitted to the hospital with back pain due to metastatic prostate cancer, but who was convinced that his symptoms were caused by a voodoo “hex” placed on him by his ex-wife.

TABLE 1

Questions to elicit a patient’s explanatory model of illness

- 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?
- What are the chief problems your illness has caused for you?
- What do you fear most?

BASED ON INFORMATION IN 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.

Kleinman et al⁷ proposed a list of questions to explore a patient’s “explanatory model” of illness (TABLE 1). These can often uncover unsuspected views of the causes and processes of disease and may enlighten the interviewing physician of the need to bridge the gap between the patient’s understanding of the illness and the biomedical explanation of it. They help to elicit the patient’s perspective and can help to establish a treatment plan that will also address what is important to the patient. They are easy to use in practice and are time-efficient in the long run.

For example, for the man who thought that his ex-wife put a hex on him, asking him “What do you think has caused your problem?” during the initial history-taking would allow him to express his concern about the hex and give the physician an opportunity to learn of this fear and then to offer the biomedical explanation for the problem and for the recommended treatment.

What happens more often in practice is that the specific fear is not addressed at the start of the encounter. Consequently, the patient is less likely to follow through with the treatment plan, as he or she does not feel the prescribed treatment is fixing the real problem. This process of exploring the explanatory model of illness may be viewed on a practical level as a way of managing expectations in the clinical care of culturally diverse populations.

Many patients will not question a physician if their own cultural norms view it as disrespectful

■ **HEALTH LITERACY:
MORE THAN THE ABILITY TO READ**

The better you know how to read, the healthier you probably are. In fact, a study found that a person’s literacy level correlated more strongly with health than did race or formal education level.⁹ (Apparently, attending school does not necessarily mean that people know how to read, and not attending school doesn’t mean that they don’t.)

Even more important than literacy may be *health* literacy, defined by Ratzan and Parker as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”⁸ It includes basic math and critical-thinking skills that allow patients to use medications properly and participate in treatment decisions. Thus, health literacy is much more than the ability to read.

Even people who read and write very well may have trouble when confronted with the complexities of navigating our health care system, such as appointment scheduling, specialty referrals, and follow-up testing and procedures: their health literacy may be lower than their general literacy. We had a patient, a highly trained professional, who was confused by instructions for preparing for colonoscopy on a patient handout. Another similar patient could not understand the dosing of eye drops after cataract surgery because the instructions on the discharge paperwork were unclear.

However, limited health literacy disproportionately affects minority groups and is linked to poorer health care outcomes. Thus, addressing limited health literacy is important in addressing health care disparities. Effective physician-patient communication about treatment plans is fundamental to providing equitable care to patients from minority groups, some of whom may be at high risk for low health literacy.

Below, we will review some of the data on health literacy and offer suggestions for screening and interventions for those whose health literacy is limited.

36% have basic or below-basic reading skills

Every 10 years, the US Department of Education completes its National Assessment of

Adult Literacy. Its 2003 survey—the most recent—included 19,000 adults in the community and in prison, interviewed at their place of residence.¹⁰ Each participant completed a set of tasks to measure his or her ability to read, understand, and interpret text and to use and interpret numbers.

Participants were divided into four categories based on the results: proficient (12%), intermediate (53%), basic (22%), and below basic (14%). Additionally, 5% of potential participants could not be tested because they had insufficient skills to participate in the survey.

Low literacy puts patients at risk

Although literacy is not the same as health literacy, functionally, those who have basic or below-basic literacy skills (36% of the US population) are at high risk for encountering problems in the US health care system. For example, they would have difficulty with most patient education handouts and health insurance forms.

Limited health literacy exacts both personal and financial costs. Patients with low health literacy are less likely to understand how to take their medications, what prescription warning labels mean, how to schedule follow-up appointments, and how to fill out health insurance forms.^{11–14}

Medicare managed-care enrollees are more likely to be hospitalized if they have limited health literacy,¹⁵ and diabetic Medicaid patients who have limited health literacy are less likely to have good glycemic control.¹⁶ One study showed annual health care costs of \$10,688 for Medicaid enrollees with limited health literacy compared with \$2,891 for all enrollees.¹⁷ The total cost of limited health literacy to the US health care system is estimated to be between \$50 and \$73 billion per year.¹⁸

**Screening for limited health literacy:
You can’t tell just by looking**

Given the high costs of low health literacy, identifying patients who have it is of paramount importance.

Groups who are more likely to have limited health literacy include the elderly, the poor, the unemployed, high school dropouts, members of minority groups, recent immigrants, and people for whom English is a second language.

A patient’s understanding of his or her illness may be very different than the biomedical explanation

However, these demographic factors are not sufficient as a screen for low health literacy—you can't tell just by looking. Red flags for low health literacy include difficulty filling out forms in the office, missed appointments, nonadherence to medication regimens, failure to follow up with scheduled testing, and difficulty reading written materials, often masked with a statement such as “I forgot my glasses and will read this at home.”

A number of screening tests have been developed, including the Rapid Estimate of Adult Literacy in Medicine (REALM)¹⁹ and the Test for Functional Health Literacy in Adults (TOFHLA).²⁰ These tests are long, making them difficult to incorporate into a patient visit in a busy primary care practice, but they are useful for research. A newer screening test asks the patient to review a nutrition label and answer six questions.²¹

The most useful screening test for clinical use may consist of a single question. Questions that have been validated:

- “How often do you need to have someone help you when you read instructions, pamphlets, or other written material from your doctor or pharmacy?” Positive answers are “sometimes,” “often,” or “always.”
- “How confident are you filling out medical forms by yourself?” Positive answers are “somewhat,” “a little bit,” or “not at all.”^{22–24}

These questions can be included either in the initial screening by a nurse or medical assistant or as part of the social history portion of the interview with the physician.

A “brown bag review” can also be helpful. Patients are asked to bring in their medications (often in a brown bag—hence the name). Asking the patient to identify each medication by name and the indication for it can uncover knowledge gaps that indicate low health literacy.

The point to remember is that patients with low health literacy will probably not tell you that they do not understand. However, they would appreciate being asked in a non-threatening manner.

Make your office a shame-free environment

Many experts advocate a “universal precau-

tions approach,” in which interventions to address low health literacy are incorporated into routine office practice for all patients. Practice sites should adopt a culture of a “shame-free environment,” in which support staff encourage patients to ask questions and are trained to offer assistance to those having difficulty reading or filling out forms.

On a broader level, medical offices and hospitals can partner with adult-learning specialists to help patients gain skills to navigate the health care system. All signage should be clear and should use plain language as opposed to medical terms. Medical forms and questionnaires should be designed to collect only essential information and should be written at a sixth-grade reading level or below. Patient instructions and educational materials should also be clear and free of jargon.

The ‘teach-back’ technique

The “teach-back” technique is a simple method to confirm patient understanding at the end of the visit. This involves asking patients in a nonthreatening way to explain or demonstrate what they have been told. Examples:

- “I want to make sure I have explained things correctly. Can you tell me how you plan to take your medication when you go home?”
- “I want to make sure I have done a good job explaining things to you. When you go home and tell your spouse about your visit today, what will you say?”

These questions should be asked in a non-threatening way. Put the burden of explanation on yourself as the first step, and let the patient know you are willing to explain again more thoroughly any instructions that may have not been clearly understood.

Other measures

Pictures and computer-based education may be useful for some patients who have difficulty reading.

Weiss²⁵ advocates six steps to improve communication with patients in all encounters: slow down; use plain, nonmedical language; show or draw pictures; limit the amount of information provided; use the teach-back technique; and create a shame-free environment, encouraging questions.

Patients with low health literacy will most likely not tell you that they do not understand

Improving health literacy, as it relates to cross-cultural communication of treatment plans, must encompass understanding of health beliefs often based on cultural norms, in order to come to agreement on a mutually acceptable plan of care. Physicians should be aware of preferences for nontraditional or complementary treatments that may reflect specific cultural beliefs.

■ IF THE PATIENT DOES NOT SPEAK ENGLISH

Verbal communication across language barriers poses another layer of challenge. A trained interpreter should be used whenever possible when treating a patient who speaks a different language than that of the practitioner. When family members are used as interpreters, there are risks that the patient may not fully disclose facts about the history of illness or specific symptoms, and also that family members may place their own “twist” on the story when translating.

The physician should speak directly to the patient in a normal tone of voice. In this setting, also remember that nonverbal communication can be misinterpreted. Gestures should be avoided. Finally, be aware that personal space is viewed differently depending on cultural background, as is eye contact.

It is helpful to have a pre-interview meeting with the interpreter to explain the format of the interview, as well as a post-interview

meeting to ensure all parties felt they effectively communicated during the encounter.

■ TOWARD EQUITABLE CARE

Health care disparities are the result of multiple determinants. In December 2008, a National Institutes of Health summit conference cited not only barriers to access, but also the interaction of biological, behavioral, social, environmental, economic, cultural, and political factors, and noted that the causes and effects of health disparities transcend health care.²⁶

Clearly, an individual physician’s efforts will not be all that is needed to eliminate health disparities. A team-based approach is essential, using skills of nonphysician members of the health care team such as nurses, medical assistants, social workers, and case managers. Continued opportunity for professional training and development in provider-patient communication skills should be offered.

However, the impact of effective cross-cultural communication and managing low health literacy populations on the physician-patient level should not be understated. As practitioners treating patients from diverse backgrounds, improving self-awareness, eliciting the patient’s explanatory model, and assuring understanding of treatment plans for patients with low health literacy or with language barriers, we can do our part in working toward equitable care for all patients. ■

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