

## **Cross-Cultural Primary Care: A Patient-Based Approach**

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In today's multicultural society, assuring quality health care for all persons requires that physicians understand how each patient's sociocultural background affects his or her health beliefs and behaviors. Cross-cultural curricula have been developed to address these issues but are not widely used in medical education. Many curricula take a categorical and potentially stereotypic approach to "cultural competence" that wed patients of certain cultures to a set of specific, unifying characteristics. In addition, curricula frequently overlook the importance of social factors on the cross-cultural encounter. This paper discusses a patient-based cross-cultural curriculum for residents and medical students that teaches a framework for analysis of the individual patient's social context and cultural health beliefs and behaviors. The curriculum consists of five thematic units taught in four 2-hour sessions. The goal is to help physicians avoid cultural generalizations while improving their ability to understand, communicate with, and care for patients from diverse backgrounds.

It is much more important to know what sort of a patient has a disease, than what sort of disease a patient has. -William Osler (1)

Concern about cultural competence in health care has increased in recent years as providers and policymakers strive to close the gap in health care between people of different sociocultural backgrounds (2, 3). Medical providers today face the challenge of caring for patients from many cultures who have different languages, levels of acculturation, socioeconomic status, and unique ways of understanding illness and health care. Patient satisfaction and compliance with medical recommendations are closely related to the effectiveness of communication and the physician-patient relationship (4). Because sociocultural differences between physician and patient can lead to communication and relationship barriers (5), teaching physicians the concepts and skills needed to overcome these barriers should lead to improved outcomes.

Implementation of culturally competent health care has been sparse and generally inadequate (6, 7). Some efforts have focused on important structural changes, including training bilingual and bicultural providers, instituting interpreter services, and developing culturally and linguistically specific literature and health care resources (8). However, many feel that providers themselves should be trained to care for patients of different sociocultural backgrounds (6-14). Such training programs often emphasize cultural sensitivity but do not teach practical cross-cultural skills. Other attempts to educate providers rely heavily on a categorical construct that lumps patients of similar cultures into groups and outlines their "characteristic" values, customs, and beliefs (15-17). Although this knowledge can be helpful, the suggestion that members of particular ethnic or racial

groups behave in characteristic ways risks stereotypic oversimplification. For example, would a poor, black Cuban immigrant residing in Harlem fit into the African American or Hispanic profile? How would he compare with an upper middle-class Mexican American? This contrast also highlights the importance of socioeconomic factors, which are often underemphasized in cultural competency programs (18-20). A clear need exists for a more discerning approach.

We present the ideology and structure of a patient-based cross-cultural curriculum that we have developed and implemented. It represents a melding of medical interviewing techniques with the sociocultural and ethnographic tools of medical anthropology. The curriculum comprises a set of concepts and skills taught in five thematic modules that build on one another over four 2-hour sessions.

## **Structure and Content**

### **Module 1: Basic Concepts**

Culture is defined as a shared system of values, beliefs, and learned patterns of behaviors (21) and is not simply defined by ethnicity. Culture is also shaped by such factors as proximity, education, gender, age, and sexual preference. In interactive small groups, participants reflect on their own cultures and how these influence their personal perspectives on illness and health care. They also explore the extent to which the "medical culture" has become incorporated into their cultural outlook (22). Self-realization of this potential biomedical bias is critical in negotiating cross-cultural interaction.

The definition of disease as a pathophysiologic process is compared and contrasted with the patient-centered and more subjective concept of illness (23, 24). Through descriptive clinical vignettes and videotaped patient interviews, physicians gain an appreciation for the diverse conceptualizations of illness (explanatory models) that patients may present to their physicians. The module concludes with a discussion of the attitudes that are fundamental to a successful cross-cultural encounter: the triad of empathy, curiosity, and respect.

### **Module 2: Core Cultural Issues**

Sociocultural differences, when misunderstood, can adversely affect the cross-cultural physician-patient interaction (5, 19, 21, 25-27). Such misunderstandings often reflect a difference in culturally determined values, with effects ranging from mild discomfort to noncooperation to a major lack of trust that disintegrates the therapeutic relationship. Core cultural issues are situations, interactions, and behaviors that have potential for cross-cultural misunderstanding. These include issues relating to authority, physical contact, communication styles, gender, sexuality, and family, among other sensitive subjects. Failure to take these "hot-button" issues into account can compromise the success of the cross-cultural encounter.

To learn every aspect of each culture that could influence the medical encounter is

impractical, if not impossible. Cultural groups are very heterogeneous, and individual members manifest different degrees of acculturation, making it difficult and even counterproductive to "teach" a culture as a whole. In fact, these core issues recur in many dissimilar cultures. For example, a lower level of patient autonomy and an emphasis on the role of the family in medical decision making has been found among certain subpopulations of Korean and Hispanic patients (28). Rather than attempting to learn an encyclopedia of culture-specific issues, a more practical approach is to explore the various types of problems that are likely to occur in cross-cultural medical encounters and to learn to identify and deal with these as they arise.

Once the physician recognizes a potential core issue, it can be explored further by inquiring about the patient's own belief or preference. Each patient's situation is unique and is influenced by personal and social factors as well as by culture. Direct questioning and discovery of core issues can avoid cultural pitfalls and help guide further exploration in cross-cultural encounters. The curriculum uses the following vignette to initiate dialogue within the group.

A 34-year-old, healthy Egyptian woman presents as a new visitor to a male physician. She is accompanied by her husband. Her husband seems somewhat domineering, answering all of the medical history questions himself. When the conversation is shifted back to the patient, he states that she does not speak English very well. During the physical examination, the husband leaves the room, and it becomes clear that the patient is proficient in English. A history of menstrual irregularity is elicited; this problem had been denied or minimized previously. When the patient is asked to disrobe for the physical examination, she becomes noticeably uncomfortable in the presence of the male physician.

This vignette illustrates two core cultural issues: family dynamics and the role of gender in the physician-patient encounter. Participants are encouraged to discuss their impressions of this situation and how the issues may be influenced by social and cultural factors. This leads to a focused discussion of how best to approach a dominant authority figure in a cross-cultural encounter to gain the necessary information without offending either patient or spouse. By learning to ask about patient preferences for physician gender rather than making assumptions, physicians gain a sensitivity that may help to prevent uncomfortable situations.

### **Module 3: Understanding the Meaning of the Illness**

A patient enters the physician's office with certain beliefs, concerns, and expectations about his or her illness and the medical encounter. This conceptualization of the illness experience can be described as the patient's explanatory model (23). This is the patient's understanding of the cause, severity, and prognosis of an illness; the expected treatment; and how the illness affects his or her life. In essence, it is the meaning of the illness for the patient. Patients' explanatory models of illness are to a large extent culturally determined, but there are other important influences. Social factors, such as socioeconomic status and education, may play a role in shaping the

conceptualization of an illness (29). This module of the curriculum further elaborates on the explanatory model, how it may affect the physician-patient encounter, and how to explore it with an individual patient.

The concept of explanatory models is not esoteric. An example of a simple explanatory model that physicians deal with every day is a patient's conceptualization of the common cold. Patients may understand the cold as being caused by "being out in the cold" and potentially leading to pneumonia if not treated with antibiotics. Although physicians are accustomed to the management of this scenario, more complex illnesses with less obvious explanatory models present greater challenges, especially when patients have sociocultural backgrounds that are unfamiliar to the physician.

The first part of Table 1 summarizes a set of questions developed by Kleinman, Eisenberg, and Good for eliciting a patient's explanatory model (22). Although patients may initially be hesitant to reveal their beliefs and fears, this hesitation can often be overcome through further respectful questioning and reassurance. Focusing on what others may believe or on hypothetical situations may take some of the pressure off the patient. The questions can also be adapted for use in various contexts other than illness (18, 19, 23). For example, they may be used to explore the meaning of a particular procedure or treatment for a patient, such as a breast biopsy or chemotherapy. Two questions shown in Table 1 help to determine the patient's agenda: that is, what the patient hopes to gain from the encounter. This may influence the meaning of the illness for the patient and can save time and effort when determined from the outset.

This module also emphasizes the various folk beliefs, alternative medical practices, and illness behaviors that may influence and manifest as the patient's explanatory model (30-34). Physicians learn to recognize and explore prevalent folk beliefs by using the explanatory model questions. They also learn to appreciate alternative medical practices used by patients through the illness behavior questions in Table 1. These questions serve as basic guidelines for further cross-cultural exploration.

The application of these techniques requires practice, which participants gain through interviewing actors specialized in medical training. In one exercise, an actress plays Mrs. B., a 58-year-old Dominican woman with hypertension. Despite being seen by several physicians, having multiple tests to rule out secondary causes, and having tried various medications over the years, her blood pressure has remained poorly controlled. On the basis of information obtained from a traditional interview, the physicians surmise that the patient may not be complying with her regimen. By using the skills they learned, the physicians explore Mrs. B.'s explanatory model for hypertension—an episodic problem related to tension and stress that requires treatment only as necessary. This understanding facilitates the ensuing negotiation process. In another exercise, an actor plays Mr. G., an Azorean fisherman whose diabetes is poorly controlled. The actor presents with "burning feet." The physicians make headway only when they explore the patient's explanatory model. They discover that Mr. G. believes that the burning in his feet is caused by hundreds of fish bites he suffered while casting nets offshore. He rarely

injects insulin because this reminds him of the fish bites, and he fears that burning may develop over other parts of his body.

#### **Module 4: Determining the Patient's Social Context**

The manifestations of a person's illness are inextricably linked to the social factors that make up his or her social environment (35, 36). A vast literature defines the relation of these social factors to health status (37-40) and elucidates the effects of social class barriers between patient and physician (41). In this module, physicians learn practical techniques to explore and manage the social factors that are most relevant to the medical encounter. These define the patient's social context, which includes not only socioeconomic status but also migration history, social networks, literacy, and other factors.

Social context is explored through four avenues, any of which may apply to a particular patient: 1) control over one's environment (such as financial resources and education), 2) changes in environment (such as migration), 3) literacy and language, and 4) social stressors and support systems. The second part of Table 1 lists several interview questions designed to elicit this information. These should serve as a social context "review of systems." Like the traditional review of systems, they are used selectively in a focused, problem-oriented manner. They are guidelines that may be modified to fit the clinical scenario.

Mr. M. is a 53-year-old African-American man originally from North Carolina. He has a severe cough that has gradually worsened over the past year. He noticed some blood-streaked sputum 4 months ago. Mr. M. came north with his family 5 years ago and holds down two jobs. He cannot afford to take time off from work because of his illness; he is the sole wage earner for his four children, wife, and mother-in-law. Besides this, he has avoided medical attention for fear of a serious diagnosis that would prevent him from supporting his family in the future. He is also concerned about the possibility of expensive tests, medications, or operations.

This vignette illustrates the important effect that lack of control over one's environment can have on one's health-seeking behavior and symptom threshold. Some patients will present at the earliest stages of their disease. Others, like Mr. M., will tolerate a great deal of symptomatic distress before feeling sick enough to present to the medical system. Although this may reflect culture or personal characteristics, there is clearly a socioeconomic component. Knowing this helps the physician develop a plan that is sensitive to Mr. M.'s concerns, which might include accessing available financial supports and social services.

In the case of Mrs. B., the 58-year-old Dominican woman with hypertension, the physicians eventually learn that she is illiterate and has great difficulty with her complex medical regimen. This crucial aspect of the case is revealed only by respectfully asking social context questions about literacy. Issues of language and interpretation are also

reviewed. The following vignette highlights the inappropriateness of a family interpreter and the inadequacy of an untrained interpreter.

Mrs. R., a 29-year-old Puerto Rican seamstress and single mother, brought her 12-year-old daughter to her first medical appointment. The physician was troubled by the child's interpreting ability and called in a female laboratory technician who is from Central America. The new interpreter summarized the patient's wordy monologue in one brief sentence. She said that the patient felt tired and fatigued during sexual intercourse. The physician ordered a complete blood count and thyroid studies and scheduled the patient for a return appointment in one month. Mrs. R. left the office feeling unrelieved. The laboratory technician had incorrectly interpreted "fatiga" and did not understand that the patient was reporting "shortness of breath," or asthma. A trained Spanish interpreter would have understood the variable regional meanings of the word "fatiga."

Important social issues may also be discovered through the explanatory model questions, particularly "How has this illness affected your life?" and "What worries you most?" Once these issues are recognized, participants discuss strategies and resources for dealing with the social issues that arise.

## **Module 5: Negotiating Across Cultures**

Social and cultural factors determine differences in expectations, agendas, concerns, meanings, and values between patients and physicians (30). The physician serves as the expert on disease, whereas the patient experiences and expresses a unique illness (42). Thus, even when the patient's and physician's sociocultural backgrounds are similar, substantial differences may exist because of these separate perspectives. The tools of this curriculum are designed to be broadly applicable beyond the strictly cross-cultural setting.

The skills learned in the previous modules provide participants with insights that facilitate the process of cross-cultural negotiation. Reaching a mutually acceptable agreement between patient and provider is described in six phases: relationship building, agenda setting, assessment, problem clarification, management, and closure (43). The six phases are integrated with the strategies of Katon and Kleinman (44) to provide a framework for cross-cultural negotiation. Negotiation skills can be used to address both explanatory models and management options ( Table 1).

Negotiation of explanatory models involves acknowledgment of differences in belief systems between patient and provider. If the patient does not seem to "buy in" to the biomedical explanation of an illness, a compromise can often be reached by presenting the problem in terms and concepts that reflect the patient's explanatory model. For example, Mrs. B. believes strongly that her hypertension is episodic and stress-related. She may not understand the importance of taking daily antihypertensive medication because this does not fit her explanatory model. A compromise of explanatory models is reached by explaining that although her blood pressure does go up when she is stressed, her arteries are under stress all the time, which she may not feel. Taking

the medication regularly helps to relieve this stress; however, it cannot take away the stress in her life. For this, she may need such measures as counseling and relaxation techniques. Patients whose beliefs are less ingrained may be quick to accept the biomedical model. Others, such as Mrs. B., may require more creative negotiation.

## **Conclusions**

Despite the multitude of cultures in the United States, physicians are inadequately trained to face the challenges of providing quality care to socially and culturally diverse populations. The skills learned through this curriculum can help promote communication and cooperation, improve clinical diagnosis and management, avoid cultural blind spots and unnecessary medical testing, and lead to a progressive depth of understanding between patient and physician. The key aspects of this curriculum are summarized in Table 2. Experience with the cross-cultural curriculum has been very positive, and participant feedback has been enthusiastic. Evaluation done before and after the curriculum has demonstrated successful learning of the concepts and skills. The curriculum has been successfully adapted to the medical student and attending physician; specific areas are emphasized on the basis of the extent of practical clinical experience of the target audience. In general, it is weighted toward theory for medical students and applied skills for residents and practicing physicians.

The patient-based cross-cultural curriculum enables medical students, residents, and practicing physicians to cut through perceptual barriers and lift veils of social and cultural misunderstanding. This approach can facilitate all medical encounters but is particularly important in the setting of cultural and social differences. These tools help physicians do what "good doctoring" is all about-listening, asking the right questions, and meeting the patients where they are.

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