

Running Head: CULTURAL CHALLENGES IN HEALTHCARE

Cultural Challenges in Healthcare

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Abstract

It is important for a doctor to communicate with their patient, and for the patient to communicate with their doctor in order to assess the best treatment for a problem. But what happens when there are language or cultural barriers? How does culture affect healthcare? There are many cultural competency resources that can help both clinicians and patients access, comprehend, and assess the role of culture in healthcare. Cultural competency is one the main ingredients in closing the disparities gap in health care. It's a way patients and clinicians can come together and talk about health concerns without cultural differences hindering the conversation. This paper explores and evaluates historical cultural problems in healthcare, the current state of intercultural communication problems between patients and their doctors, and what is needed for the future to help solve communication barriers between different cultures in the healthcare setting.

Historical Problems in Health Care

Culture and language may influence health, healing, and wellness belief systems that one may have. It could also affect the behaviors of patients seeking health care and their attitudes toward health care providers as well as the delivery of services by the provider who looks at the world through his or her own limited set of values, which can compromise access for patients from other cultures.

Historically, different cultures and races have not been offered the best medical care because of cultural differences, miscommunication, or prejudice. The slow response to HIV/AIDS in the 1980s by the federal government is an example of healthcare discrimination, because the disease first affected gays. As Martin & Nakayama (2008) explained, a disease that strikes a minority of the population (gays, people of color, drug users, and poor people), will not receive the same adequate medical attention that the rest of the population will receive. This showed the lack of trust between the health care system and minority communities.

Attending nursing or medical school does not purge feelings of racism, homophobia, sexism or other kinds of prejudice (Martin & Nakayama, 2008). Prejudicial ideologies, as Martin & Nakayama (2008) explained, or sets of ideas based on stereotypes, can affect health care professionals and patients. If a patient's medical chart is in a different language or if they speak a different language, a health care professional cannot legally treat the patient unless a translator is present. But what if the translator is the patient's spouse and the patient is asked about a STD (sexually transmitted disease), that the spouse could have potentially given the other? Using a formally trained medical interpreter is necessary to facilitate accurate communication. The use of untrained interpreters, friends, or family members may pose a problem due to their lack of

knowledge regarding medical terminology and disease entities. This situation is heightened when children are used as interpreters (Campinha-Bacote, 2003). This raises ethical and legal questions on how the patient can be treated. When mistrust occurs, a patient may seek out medical help in their immediate community, or turn to alternative medicine (such as gays with AIDS).

Health and Culture

Health is defined as a state of balance between the body, mind, and spirit as well as a sense of harmony with the environment, according to Spector (2002). Regardless of culture, one's health is a balance of all facets of the person—the body, mind, and spirit (Spector, 2002).

The Amish population in Lancaster County, Pennsylvania pose an interesting cultural healthcare challenge. They are reluctant to seek preventive health care and delay necessary medical treatment which further places the Amish population at odds with the conventions of mainstream society. However, the Amish are dependent on the American culture for professional health services because they have no professionally educated providers among themselves (Brewer & Bonalumni, 1995). An emergency room clinician may be unaware of, or unable to accept, the indigenous care beliefs and practices of the Amish, and may deliver and teach culturally incongruent care and treatments (Brewer & Bonalumni, 1995). The clinician should make efforts to understand the historical and socio-cultural factors that influence the health care beliefs and practices of the Amish. Brewer & Bonalumni (1995) noted that emergency room clinicians should respect Amish opposition to specific medical practices, but also continue to offer services to individual families.

During the initial phase of internalizing the shock of diagnosis, culture provides a foundation for interpretation and response. Cultural beliefs may relate the sickness to personal

weakness, God's will, or destiny, which are some common beliefs related to breast cancer that are shared by Asian, Arab Israeli, Indian, and Jordanian women (Kim & Flaskerud, 2008). The idea of being a "good patient" may be viewed differently through the cultural lens of the patient, family, and healthcare providers. Kim & Flaskerud (2008) explained that cultures that place value on independence, autonomy, and self-direction may emphasize assertiveness and the wishes and rights of the patient. Clinicians should practice active listening and explorative questioning to identify the patient and family's cultural interpretation of the illness and be supportive, understanding, and responsive to their needs.

It All Starts at the Front Desk

Many interactions precede an actual encounter with the health care provider. Families must make appointments, ask questions about insurance, check in and provide information at each visit, and be escorted in to see the clinician. Families' experiences in getting services are affected as much, if not more, by these interactions than by their encounters with the health care provider. The National Center for Cultural Competence (NCCC) believes that staff require organizational support to develop the attitudes, behaviors, skills, and knowledge necessary to serve families in culturally and linguistically competent ways (Bronheim, 2009). Typically, health care organizations develop policies, provide training, and direct resources to address the cultural and linguistic competence of health care professionals. According to Bronheim (2009), the front desk is not involved in organizational efforts to achieve cultural and linguistic competence, because they are often excluded from planning meetings and training activities. The front desk may not be aware of the attitudes, behaviors, and skills necessary to serve diverse populations. It also may not recognize that these performance requirements should be an integral

part of their job. Because of the key roles the front desk staff plays for families in accessing health care and other services, organizations need to make specific efforts to support them, because ultimately cultural and linguistic competence starts at the front desk (Bronheim, 2009).

Patient-centered Communication

Patient-centered communication is defined by the American Medical Association's Ethical Force Program (2006), as a moral philosophy with three core values: consider the individuals' needs, wants, perspectives and individual experiences; offer individuals opportunities to provide input into and participate in their care; and enhance partnership and understanding in the patient-physician relationship. Patient-centered communication is not just about patient-doctor conversations; it is an element of any ethical, high-quality health care interaction as described by the American Medical Association's Ethical Force Program (2006).

A Puerto Rican man was hospitalized in an intensive care unit on a ventilator. His prognosis was very poor and his family was asked whether he would want to be removed from the ventilator. This already difficult decision was made even more complex because his family included almost 40 people, half of whom spoke English and half of whom spoke only Spanish. Both family groups were having a hard time understanding what was going on and the non-English speakers did not fully trust that the English-speaking family members were telling them the whole story.

Before the situation got out of control, however, one of the patient's nurses contacted the hospital's Cross-Cultural Communication Department. Outreach workers and interpreters worked with clinical staff to explain the situation to the family in both languages and in clear, simple terms that everyone could understand. Each family group designated a spokesperson who could ask questions, express concerns and contribute to the final decision. When the final decision was made, all the family members agreed that it was the right one. (American Medical Association, The Ethical Force Program, 2006).

Patient-centered communication contributes to ethical, high-quality health care because it helps

ensure that people have the information they need to make informed decisions and take part in their own care.

The American Medical Association's Ethical Force Program (2006), described six content areas and three subareas for assessment of patient-centered communication. In order to assess and improve patient-centered communication for vulnerable populations, health care leaders and decision makers should: (1) Understand your organization's commitment, (2) Collect information, (3) Engage communities, (4) Develop workforce, (5) Engage individuals, by considering (5a) Socio-cultural context, (5b) Language, and (5c) Health literacy, and finally (6) Evaluate performance, as noted by the American Medical Association's Ethical Force Program report (2006). It is important to be realistic about what the American Medical Association's Ethical Force Program (2006)'s report can accomplish for patient-centered communication. Even if all the expectations are met, it cannot be verified that all possible communication gaps are closed. This report addresses the importance of communication with the patient, especially if the patient is a member of another culture, speaks another language, and is literate about their health, to understand their health status.

Power in Health Care Communication

Doctors have power over their patients. There is an imbalance of power with regard of medical knowledge and access to treatment, since patients need their doctor to write prescriptions, give referrals to specialists, order medical tests and doctors ultimately determine what kind of treatment the patient receives (Martin & Nakayama, 2008). Physician-patient communication could be challenged by the patient, but the power imbalance is built into the health care system in the United States.

Web-based social media and healthcare is becoming increasingly popular. Medical records are increasingly becoming digitized in the health care industry instead of having paper charts. Hawn (2009) explained in “Take Two Aspirin And Tweet Me In The Morning: How Twitter, Facebook, And Other Social Media Are Reshaping Health Care,” how hospital networks, patient support groups, new media tools like weblogs, instant messaging platforms, video chat, and social networks are reengineering the way doctors and patients interact. Hawn (2009) described Hello Health, a private and secure social network, which is a new-age medical practice based in Brooklyn, where a patient can have a “cyber-visit” for a \$50-100 fee. Hawn (2009) suggested that providers should be tapping into e-health and social media because it makes patients happier with a more patient-centered health care system. However, Hawn (2009) explained a downside to this trend; Internet-based communication can never adequately substitute for the in-person exam. Medical standards have not yet been developed to govern this type of “care.” Additionally, many independent practitioners or small group practices don’t have the time or the money to adapt to the use of social media.

Intercultural Communication Competence in Healthcare

The increasing population growth of racial and ethnic communities and linguistic groups, each with its own cultural traits and health profiles, presents a challenge to the health care industry in the United States. The clinician and the patient each bring their individual learned patterns of language and culture to the health care experience which must be transcended to achieve equal access and quality health care. Gibson and Zhong (2005)’s study examined medical providers own ability to communicate across cultures and patient’s perceptions of medical providers ability to communicate with a diverse patient population. Communication in

health care is essential. Effective communication is crucial between the patient and provider, because misunderstandings can lead to misdiagnosis and even death. Intercultural communication competence (ICCC) is important to understanding different cultures and to interact on an effective level (Gibson and Zhong, 2005). Language barriers and empathy can lead to miscommunication in the health care setting. Gibson and Zhong (2005) studied 136 participants in southern California, and researched four hypotheses, (1) positive relationship between empathy and intercultural communication among medical providers; (2) bilingual medical providers as more competent health care providers; (3) medical providers with intercultural experience as more competent than those without intercultural experience; and (4) medical providers' self-reported ICCC and patient-perceived medical providers' ICCC. Their research, and common sense would reason that medical providers who possess the abilities to listen well and place themselves in the patient's place are motivated, knowledgeable, skillful, appropriate and effective when communicating across cultures, and technical skills needed to administer effective medical treatment may outweigh any language differences (Gibson and Zhong, 2005).

By understanding, valuing, and incorporating the cultural differences of America's diverse population and examining one's own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture.

Cultural Desire and Competence

Cultural competence is "the process in which the nurse continuously strives to achieve the ability and availability to effectively work within the cultural context of a client individual, family or community," as defined by *The Process of Cultural Competence in the Delivery of Healthcare Services Model* (Campinha-Bacote, 2003). As Campinha-Bacote (2003) explained, obtaining cultural knowledge about the patient's health-related beliefs and values involves understanding their world view. The patients' world views will explain how they interpret their illness and how it guides their thinking, doing, and being. Being deaf can be defined physiologically as a loss of hearing, however, the majority of deaf people define it culturally, not physiologically (Campinha-Bacote, 2003).

Communication and cultural barriers are challenged even more when there are physical handicaps involved, such as being deaf. Campinha-Bacote (2003) explained conscious vs. unconscious competence. "*Conscious competence* is the intentional act of learning about the patient's culture, verifying generalizations and providing culturally responsive nursing interventions. *Unconscious competence* is the ability of the nurse to spontaneously provide culturally responsive care to patients from diverse cultural backgrounds." (Campinha-Bacote, 2003).

It is important for a clinician to tell themselves "In caring for this cultural group, have I "ASKED" myself the right questions?" "ASKED" represents questions regarding desire, awareness, knowledge, skill, and encounters. "*Awareness*: Am I aware of my personal biases and prejudices towards cultural groups different than mine? *Skill*: Do I have the skill to conduct a cultural assessment and perform a culturally-based physical assessment in a sensitive manner?"

Knowledge: Do I have knowledge of the patient's world view and the field of biocultural ecology? *Encounters:* How many face-to-face encounters have I had with patients from diverse cultural backgrounds? *Desire:* What is my genuine desire to "want to be" culturally competent?" (Campinha-Bacote, 2003). In order for a patient to receive quality health care the ASKED model is highly effective, since all patients expect various outcomes, but all need to be treated with proper care and effective communication from their clinicians regardless of intercultural barriers.

Regulations and cultural barriers

Ethics committees are often used by health care organizations to help make ethical decisions in certain medical cases. As Martin & Nakayama (2008) explained, they are staffed by health care professionals, religious leaders and/or social workers. Study failures in the past led to major changes in U.S. law and regulation on the protection of participants in clinical studies, including the necessity for informed consent, communication of diagnosis, and accurate reporting of test results.

In many cultures the family is very involved in health care of other family members, However, in the United States medical information is confidential and is only given to the patient, unless consent is waived by the patient, or as Martin & Nakayama (2008) explained, if the patient is incapacitated or incapable of understanding then other family members may make medical decisions.

Informed consent is a crucial part in healthcare and intercultural communication. Wilson-Stronks & Galvez's 2007 study found that most hospitals indicated that they take patient linguistic needs into account during the informed consent process. Hospitals are increasingly

reliant on electronic medical record systems. These systems can provide improved access to patient data across the continuum of care and can improve access to information needed for quality improvement activities. However, if the development of these systems fails to consider collection of patient race, ethnicity, language, and other important identifiers, it will be missing vital information necessary to help improve the quality and safety of care in an intercultural setting (Wilson-Stronks & Galvez, 2007).

Future Growth and Research

The practice of health communication has contributed to health promotion and disease prevention in several areas. One is the improvement of interpersonal and group interactions in clinical situations. The quality of provider-patient communication can affect numerous outcomes, including patient adherence to recommendations, public health laws, and the patient's health status. Health care is a cultural construct, arising from beliefs about the nature of disease and the human body and effective communication delivery of health services treatment and preventive interventions is necessary for care of patients. Health care professionals need to receive more training in effective communication skills, as it is needed for cultural and language differences and better understanding of medical terms among those who may be illiterate.

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