CHAPTER 5

Cultural Competence in Primary Care

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CHANGING PERSPECTIVES

The nation and the world have changed. Understandings and perceptions that formerly served us well have disappeared. Nowhere is that more true than in the health professions. Of course, we could be speaking about the radical new therapies that keep people alive longer or the rapidly changing health systems that are attempting to reduce the costs generated by these new therapies. However, when cultural differences are examined, the topic is more fundamental—our understanding of what human beings are have changed. We now recognize that the individuals with whom we work are just as much social and cultural beings as they are biologic beings, and, more important, that this new understanding makes a difference in how we care for patients. Clinicians need to know theory, data, and practice guidelines for how to work safely and comfortably across cultures. Those who have used this knowledge for the past few decades report that not only do they feel more competent in their patient care, but also that they feel better about their practices. Opening up perceptions and relationships with patients from backgrounds and cultures other than one's own—that is, taking a culturally competent approach—enhances satisfaction among clinicians.

This chapter focuses more on how to deliver culture-sensitive care than on the characteristics of specific ethnic groups. There are a number of reasons for this approach. The most important reason is that the beliefs and behaviors of members of all cultural groups in the United States change constantly; another is that simply being a member of a particular group does not mean that the patient thinks or acts in a particular way. Individuals' beliefs are often derived from their cultural backgrounds, including their health beliefs. This chapter focuses on how to assess the individual first and foremost and explores how culture may or may not affect one's individual beliefs.

CHANGING DEMOGRAPHICS

As the US population continues to diversify, health care clinicians will confront a growing number of patients from various cultures. The populations of many non-European–descended ethnic groups are growing more rapidly than that of people of European descent, and projections are that they will continue to grow (Table 5-1).

According to the US Bureau of the Census (1998), the nation's Asian and Pacific Islander population is expected to grow to more than 11 million and represent 4.1% of the total population by the turn of the century. Predictions are that by the middle of the next century,

TABLE 5-1 **Ethnic Populations in the United States (Population 270,993,000)**

	EUROPEAN AMERICANS	AFRICAN AMERICANS	HISPANIC AMERICANS (OF ANY RACE)	ASIAN AMERICANS AND PACIFIC ISLANDERS	NATIVE AMERICAN INDIANS, ESKIMOS AND ALEUTIAN PEOPLE
Estimated ethnic population	223,535,000	34,525,000	30,769,000	10,504,000	2,369,000
Percent of population	82.5%	12.7%	11.4%	3.9%	0.9%

From U.S. Bureau of the Census (December 28, 1998) Resident population of the United States: Estimates by sex, race, and Hispanic origin, with median age. www.census.gov/population/estimates/nation/intfile3-1.txt. Accessed January 15, 1999.

this group will reach 34 million and make up 9% of the nation's population.

The African American population increased by 11% from 1990 to 1998, and the non-Hispanic white population increased 3%. The African American population is projected to continue to grow almost twice as fast as the European-descent population through the year 2050.

According to the Census Bureau in 1997, nearly 1 in 10 US residents was foreign born (25.8 million people). This represents twice as many foreign-born residents as in 1970. Almost one-third of these foreign-born residents are naturalized citizens. Recently, the biggest influx of immigrants has come from Mexico, Central and South America, and the Caribbean: Population statistics from Hispanic Americans are changing to reflect this.

RACIAL AND ETHNIC DISPARITIES IN HEALTH CARE

Race and ethnicity correlate with health disparities among the US population. African Americans, Hispanics, American Indians and native Alaskans, and Pacific Islanders experience disparities in health care, resulting in an increased incidence of illness and death. According to statistics (US Department of Health and Human Services, 1998), "infant mortality rates are 2½ times higher for African-Americans and 1½ times higher for Native Americans. African-American men under 65 suffer from prostate cancer at nearly twice the rate of whites; Vietnamese women suffer from cervical cancer at nearly five times the rate of whites; and Latinos have two to three times the rate of stomach cancer." The incidence of heart disease in African American men is nearly twice the rate of whites. Diabetes is nearly three times more prevalent in Native Americans and African Americans have 70 percent higher incidence than white Americans (USDHHS, 1998).

CULTURAL COMPETENCE

In this changing world, in which culture has been uncovered as a significant part of health care practice, clinicians have worked hard to alter their practices to match new realities. One response has been to work on *cultural competence,* defined here as the (1) professional attitudes, (2) practice skills, and (3) system savvy for working cross-culturally. Cultural competence is a process, a journey, that depends on knowing oneself better and opening up to the world. None of this is new, but it requires extending central qualities in ways that many have not considered. In fact, enhanced awareness is a central quality.

Professional Attitudes

Competent clinicians strongly value the patient and believe that they have the best interests of the patient at heart. However, *ethnocentrism,* the belief that one's own way of life is the only right and good one, consistently causes problems. For example, a female clinician became upset when the newly immigrated Russian woman refused her care. This provider assumed that the opportunity to have a same-gender and competent clinician would be welcomed by the patient. Unknown to the clinician, the Russian woman expected an older man, in keeping with what she felt was the gravity of her problem (Box 5-1).

BOX 5-1 CLINICIAN RELATIONS

Cultures in which there is a tendency for respect to be accorded to elders support such orientations toward clinicians. In another example, a young Chinese family doctor ran into the same problem (Lin, 1983). Most Asian cultures and many Native American people feel greater respect for the older clinician. In contrast, many Americans may actually look to younger people as being more competent because they are closer to the cutting edge of information.

Culture clashes such as this might involve the clinician ignoring the possibility that the patient believes and expects differently than he or she does or could be an active rejection of another culture's practice. For example, even though Southeast Asian refugees and immigrants have been in the United States in large numbers for more than 20 years, there continue to be reports that the skin abrasions that result from coin rubbing or cupping healing techniques (Muecke, 1983) are called to the attention of child protective service personnel as a sign of child abuse (Box 5-2).

BOX 5-2 SKIN MARKINGS

Coin rubbing, in which tiger (or other) balm is rubbed on an area of skin and then a copper penny is scraped along the skin, is a common practice among some Southeast Asian groups. One purpose is to scrape the illness out; however, the clinician should ask to discover how that particular family conceptualizes the practice. Cupping, in which air is heated under an inverted cup placed on the skin, similarly sucks the illness out of the body. This practice is best known among some Asian groups, many Latino groups, and people from the far north of Europe. Another Asian practice that might cause a noticeable skin mark is moxibustion in which a small plug of herb is burned on the skin along the same meridians used by acupuncturists.

We outline some techniques for reducing one's ethnocentrism in this chapter. The primary strategy is to use *cultural relativism,* the practice of understanding cultural patterns from that culture's perspective rather than

one's own. Cultural relativism does not imply that the clinician must adopt the cultural beliefs and practices of others, merely that they be understood in context. The illness-disease distinction (see p. 70) helps reduce ethnocentrism and promote cultural relativism.

Practice Skills

Practice skills include (1) being able to carry out a culturally competent assessment, (2) attending to both biomedical and cultural features of the presenting problems, and (3) being able to negotiate a satisfactory treatment plan without imposing one's own perspectives on the patient. For example, one provider was surprised by the answer to her assessment question, taken from the explanatory model interview (Box 5-3), "What do you think caused your illness?" Her patient, a woman in her 70s who had recently had a stroke, believed that fellow church members had placed a witchcraft substance under her rug, causing the patient to fall. Her evidence included the fact that the plants in the room had recently died for no apparent reason. In this case, intervention consisted of providing support to the patient's family who were taking care of their mother.

System Savvy

Finally, system savvy is an easily overlooked part of cultural competence because American culture (and thus its health care system) places a heavy emphasis on treating the individual, sometimes within a family context. This individualistic cultural emphasis can be counteracted by remembering that all problems have a system component. Certain cultural situations can be improved with help from a culture broker (Tripp-Reimer, 1985), but usually this role is prohibited, and interpreters are allowed to translate only on a word-for-word basis. Culture brokers know each culture well enough that they can translate cultural patterns for patients and clinicians; that is, they can explain to each what the cultural context is for the other.

BOX 5-3

EXPLANATORY MODEL QUESTIONS

- What is the name of your illness?
- When did it start? Why then?
- What do you think caused it?
- How does it work in your body?
- Is it dangerous? Will it last a long time?
- What have you been doing to take care of it?
- What would you like me to do today?
- Do you fear anything about your illness?

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System savvy refers to the ability to take the system into account during treatment as well as the willingness to change the system when necessary; it includes the clinician's ability to work around an existing system to accomplish a culturally appropriate goal. (Frequently, this needs to happen because European American culture is embedded in many health care system activities that seem logical only to people from that culture.) In addition to "subverting" a system to accomplish patient outcomes, clinicians also need to work to change the system through their joint actions: for example, to explicitly change policy in the agency. In this respect, system change is probably more important than other aspects of cultural competence because the new care pattern continues even though the original practitioner may not be present.

CULTURE-SENSITIVE CARE

A productive practice approach that promotes cultural competence is "culture-sensitive care." Three principles are included that work in a variety of health care situations, including primary care, acute care, tertiary care, home health care, and even management and administration. The basic principles of culture-sensitive care are knowledge, mutual respect, and negotiation (Chrisman, 1991).

Knowledge

Three types of knowledge are needed: (1) knowledge of cultures and cultural patterns, (2) advanced clinical knowledge, and (3) knowledge of oneself.

KNOWLEDGE OF CULTURES AND CULTURAL PATTERNS

We see *culture* as a learned, shared, and symbolically transmitted design for living (Chrisman, 1991). Each of the many cultures of the world has its own design, its own set of patterns that orient members to the world around them.

The more knowledge clinicians have of cultural concepts (e.g., values, beliefs, and customs) and of specific cultural patterns (e.g., the ways that foods are labeled as "hot" or "cold" among Latinos and other groups), the easier it is to relate to patients (Box 5-4).

In addition, further learning comes more easily once a foundation is laid. For example, knowledge about modesty is important in the clinical setting. Many ethnic and cultural groups, such as Latinos, Asians, and Native Americans, are well known for their modesty. This knowledge encourages the clinician in such situations to think ahead and to think in a culturally receptive fashion. It is also important to remember that these patterns are not absolute. Some Yakama Indian women, with whom Chrisman and his colleague June Strickland worked, stripped for their visits to the sweat lodge but were offended at health clinician requests to disrobe for examinations.

BOX 5-4

HOT AND COLD BELIEFS

Belief that aspects of the world have specific qualities is widespread and closely related to sickness and health. Among Latinos, illnesses may be caused by an imbalance of hot elements and cold elements. If that is the case, the illness can be cured by treating with the opposite quality (Maduro, 1983; Logan, 1977). For example, a headache may be believed to be the result of too much "cold" (perhaps the temperature outside). This can be treated by adding some "hot," such as fried meat. Sometimes, the hot-cold beliefs of a family can influence their requests of biomedical clinicians. In one case, a family saw penicillin as "hot" because it had relieved what they saw to be a "cold" problem. This became problematic when penicillin was prescribed for what they saw as a "hot" health problem. Hot and cold qualities are also linked with the yin-yang distinctions made among many Asian health care systems. These properties also can be found in the health care beliefs of some groups from the Middle East.

Values

An understanding of the concept of values, for example, is essential. *Values* are internalized standards by which people judge whether one's own or others' beliefs and behaviors are viewed positively or negatively (Chrisman, 1991). Ignoring patients' values is an invitation to a treatment error. For example, a clinician in the emergency department took care of a Native American elder who had endured a heart attack. The woman asked repeatedly if she were going to die. The clinician reassured her that she would not but silently worried, frequently checking the patient and the monitor. The clinician placed a high value on saving human life and on exercising high-quality health care. But what of the patient? Luckily, the clinician also valued an open relationship with the family and thus discovered from the woman's daughter that her mother was more than 100 years old, had made her peace with life, and was ready to pass on to a new one. Only the efforts of the family had brought the elder to the emergency department. The clinician then asked the elder whether she wanted to die and was told yes. The elder did not place value on high-technology care of an individual; instead, she evaluated her life as successful, and she looked toward the next step. The clinician then worked with the elder and the family to arrange a discharge and plans to help the older woman remain comfortable (Box 5-5).

Acquiring Cultural Knowledge

Cultural knowledge may be acquired in various ways. More and more individuals and groups present workshops at which cultural hints as well as some concepts underlying cultural competence are presented. Frequently, speakers discuss cultural patterns as well as common clinical problems and their solutions. Of course, the local transcultural nursing society branch or department of anthropology at a nearby university may also be helpful. Other sources are printed, electronic, and video materials. The reference section contains a number of key references to enhance your knowledge. A computer search may be made of MEDLINE or Nursing and Allied Health (CINAHL) databases by use of such search words as cultural sensitivity, cultural competence, names of various ethnic groups, and types of diagnoses. For example, "Hispanics and diabetes" and "African Americans and hypertension" generate numerous references. Of course, each list must be carefully screened to discover whether the focus is on the culture or the biology of the subject. Finally, friends and coworkers frequently have helpful cultural knowledge.

Clinicians usually receive an enthusiastic reception when they approach others with a real desire to learn, and a desire to honor the knowledge that the person has. People are often pleased to talk about their ways of life, particularly if they believe it will help others. In clinical interviews, however, the clinician should be careful about *asking* about folk or religious practices; people may not want to expose what they consider to be the superstitions of their groups. However, if one *listens* for such patterns and shows unbiased interest in peoples' stories, he or she often hears about some folk practices, especially when they find that the clinician is interested and does not laugh. For example, a clinician recounted her experience with a group of Native American women

BOX 5-5

VALUE ORIENTATIONS

A significant concept related to this story of dying and technology is that of value complex. Kluckhohn and others in the 1950s discovered that there were five basic problems that groups had to solve. These groups had developed five value orientations to guide member experiences in real situations. The researchers found that cultures had different ways of conceptualizing

- Time: past, present, and future orientations
- Relationships: lineal, collateral, and individual
- Relationships with nature: superordinate, subordinate, and harmonious
- Personality type: being, being-in-becoming, and doing
- Innate predisposition: evil, neither good nor evil, and good. Related to this dimension is a belief about whether these predispositions are mutable or not (Kluckhohn, 1990).

Western health care's focus on cure is related to Western culture's emphasis on overcoming nature and on our belief that the individual (versus a lineal or collateral group) is the relevant social unit in need of health care.

BOX 5-6

INDIAN TIME

This term is sometimes used by Native Americans to refer to the fact that they do not view arriving at a specific time imperative, as do members of the European American culture, whom they see as overly focused on punctuality. African Americans and Mexicans may use a similar phrase. This concept is likely to arise when people talk about attending an appointment on time. It is essential that clinicians look beyond the term and recognize that many factors influence whether people can arrive at a clinic when European American cultural patterns demand. Immigrants from many Central and South American countries are accustomed to arriving at the clinic very early in the morning because the custom in those countries is to serve those who arrive first earlier than others. Russian and other Eastern European immigrants have arrived with the same system in mind. Understanding the context and not simply an isolated cultural practice is also part of system savvy.

who were late for a day surgery appointment. The women laughed and attributed their tardiness to "Indian time." When the clinician told the group that she had learned about that in school, the women were so pleased that they told her stories all day (Box 5-6).

PRACTICE KNOWLEDGE

Knowledge of one's practice includes not only the technical skills involved in culture-sensitive care but also competence in professional clinical skills and knowledge. Professional clinical competence is important because attention to the client's culture is difficult and requires new ways of thinking. Thus, expert level clinical practice skills are extremely helpful.

SELF-KNOWLEDGE

Most important of all is *knowledge of oneself.* In contrast to more technical mechanisms for assessment and treatment, cultural work depends on the practitioner as the instrument. An individual who does not know himself or herself is uncalibrated. Each of us needs to know that a great deal of information is unknown to us. Just as important is to know personal attitudes toward the various groups with which one works. In addition to introspection to determine reactions to various ethnic and social groups, it may be helpful to attend diversity training workshops in which there are opportunities to interact with people from a variety of human populations. These allow discovery of biases and of similarities and differences with other participants. In addition, these workshops often offer tips on how to avoid common interactive problems (Chrisman and Schultz, 1997).

Mutual Respect

The amount of knowledge a clinician has is largely within his or her control; however, this is not as true of mutual respect. It is relatively easy to avow respect for patients and all the cultures they represent. In fact, this is most important because it means the attribution of basic humanity to the people with whom we work, and it means that we will treat them humanely (Lenburg et al., 1995, p 37). The key is how to *elicit* respect from the patient so there is *mutual* respect. Clinicians who accomplish this have been careful enough in their interactions to have offended minimally, and to have stored up credit for the times when they will, inevitably, make a mistake and offend someone culturally. Ways of eliciting respect from patients and families include the following:

- Asking how they perceive the problem
- Asking what they have done to treat it
- Incorporating their ideas of appropriate treatment with practitioner recommendations
- Learning and using respectful terms of address
- Learning and using sayings in the family's language

In fact, carrying out other aspects of culture-sensitive care contributes to mutual respect.

Just as knowledge and experience are the energy for success as a clinician—one is rewarded for knowing his or her job—mutual respect is the energy behind the multicultural therapeutic relationship. Mutual respect leads to the kinds of shared understanding that are easier within cultural boundaries but not impossible across them. It leads to being asked to be the baby's godmother, to visiting the family's home for a special meal, and to sitting with the family during the dying process (see Chapter 7).

Negotiation

The final element in culture-sensitive care is negotiation, another common aspect of therapeutic actions (Box 5-7). Negotiation is crucial to cross-cultural clinical care, providing an approach to avoid problems of cultural imposition (Leininger, 1988). The process of negotiation (based on the work of Katon and Kleinman, 1981; see also Berlin and Fowkes, 1983) is founded on knowledge and depends on, and promotes, mutual respect. Without knowledge of cultural differences and a culturally appropriate practice style, it is difficult to negotiate. Without mutual respect, there is rarely enough trust in the therapeutic relationship for the process to work.

A clinician must negotiate whenever he or she experiences a contrast or a conflict in the care desired by the client and proposed by the clinician. However, like other aspects of cultural competence, the negotiation process can be used in nearly every encounter. Its essence is the explanatory model interview in which the patient's

BOX 5-7

NEGOTIATION: STEPS FOR INTEGRATING CLINICIAN AND PATIENT EXPLANATORY MODELS

Step 1
Elicit the patient's and the family's explanatory models. Listen carefully for values and beliefs. Be open, interested, and respectful.

Step 2
Explain your explanatory model for the health condition based on your clinical knowledge and expertise.

Step 3
Compare the two views, acknowledging similarities and differences.

Step 4
Compromise by blending treatment modalities. Support patient/family ideas that are supportive or neutral and gently dissuade them from ideas that are harmful.

perspective is elicited (Box 5-3). Remember that this process assures the patient that the clinician cares enough to ask. Treatment plans may be based on what the patient knows and a sense of how the patient characterizes the health problem (Zola, 1966).

The second step, recounting the clinician perspective, should be equally personal as the patient has risked. That is, it is important that the clinician provide information based on his or her own experience rather than on textbook or other second-hand knowledge.

The two perspectives need to be compared honestly without the desire to manipulate the patient. Patients and families have the right to make their own informed decisions, and a significant task of the clinician is to facilitate that process. The comparison should include positive and negative aspects of both patient and clinician perspectives, such as side effects, costs, convenience, and consequences for family and community relationships.

Compromise seems difficult; traditional Western health care has a remarkable success rate and therefore high value in the minds of both patients and clinicians. Clinicians are necessarily ethnocentric about the value of their style of health care—to be less might jeopardize one's own confidence. However, Western health care has much to learn about the care of people culturally different from white middle class norms or those with chronic illnesses. Compromise might be the most successful strategy, particularly because it empowers the patient and the family. Essential elements are to promote family treatments that are positive or neutral (doing neither harm nor good in a biomedical sense) and to discourage those believed to be harmful. For example, the clinician may not believe in a particular herbal tea for a Mexican American child with *caida de la mollera* ("fallen fontanelle," Clark, 1970) but can recognize the need to rehydrate a dehydrated child (Box 5-8).

BOX 5-8

CAIDA DE LA MOLLERA

Fallen fontanelle is a folk illness found among the babies of some Mexican Americans. Symptoms of crying, diarrhea, and vomiting lead the mother to feel the child's fontanelle. If it is depressed, the mother and her family might say that the fontanelle has fallen, become dislocated. To confirm the diagnosis, the mother feels the palate, and if a bump is found, that indicates that the fontanelle has slipped down toward the roof of the mouth. Treatment usually includes the attempt to replace the fontanelle by pushing on the palate or using a poultice on the head to suck the fontanelle back to its rightful spot.

THE TECHNIQUES OF CULTURE-SENSITIVE PRACTICE

The Illness-Disease Distinction

The illness-disease distinction is the crucial element of the care of *all* patients because each person is distinct from the other. Listening for and conceptualizing both illness and disease ensure that the person as well as the body receives care.

The essence of all multicultural practice is to recognize, value, and be able to work with multiple views of the world. The illness-disease distinction facilitates this. *Disease* is an understanding of sickness that is structured around the pathophysiology of the mind or body; frequently, diagnostic tools or laboratory tests are required to achieve this understanding. In contrast, *illness* is the patient and family's description, experience, and explanation of the disease process (Chrisman, 1991). Illness reflects the family's culture and those broader social and cultural factors that influence it, such as ethnicity, race, social class, religion, and region of the country. The clinician's understanding of illness also ensures a gateway into what treatments will be most acceptable to the client and family. With practice, clinicians have been able to "listen with illness and disease ears" to be able to comprehend the disease so that professional treatments may be suggested and to understand the illness so that the patient receives holistic, sensitive care.

Patients from different cultures may describe their health problems in a variety of ways that may seem strange. This may present significant difficulty in "listening for illness." On some occasions, clinicians avoid asking about cultural beliefs because they do not know what to do next. In addition, the mode of logic to link symptoms with an illness label may also be strange. For example, there is not always a one-to-one match between symptoms and illness labels, as is the case in Western health care. The same symptoms might be linked to food, some kind of supernatural cause, or perhaps just

accident. This may be difficult for clinicians to understand in current evidence-based Western health care practice. Other health care systems view the situation more holistically, taking family, community, and cosmos into account. (In some respects, this may sound like a biopsychosocial approach, but the context is much larger.) One way for clinicians to listen for illnesses with which they are unfamiliar is to use "illness belief systems." This concept artificially clusters a variety of illnesses into four groups that share common characteristics. Clinicians have benefited from this approach while they acquired the additional knowledge necessary to understand a wide variety of folk beliefs. The four systems are (1) germ theory, (2) equilibrium, (3) god and spirit caused, and (4) sorcery and witchcraft (Box 5-9).

THE GERM THEORY BELIEF SYSTEM

The first of these, germ theory, represents the way lay people understand and interpret Western biomedicine. That is, the relevant illnesses are called "flu," or "cold," or "cancer," or "heart disease." They are seen to originate from germs that penetrate the body from outside such as from degeneration of the body leading to higher susceptibility and from smoking or the environment.

THE EQUILIBRIUM BELIEF SYSTEM

Equilibrium is a complex and widespread set of illness beliefs that can be divided into two types: (1) humoral pathology and (2) harmony. Humoral pathology is the system used in Europe during the middle ages and was brought to the New World through Spain. Other instances of this system are found in the Mediterranean region and across to India. It is a belief system about balances (among hot and cold, wet and dry) and among various humors and body organs.

A harmony system is also about balances and is based on a variety of Native American belief systems. These have in common the notion that there need to be harmonious relationships among all aspects of the cosmos: earth, humans, animals, the spirit world, and the like. A lack of harmony anywhere can cause one or another kind of illness. East Asian medicine has features that link the balance ideas of humoral pathology with the harmony features of Native American (and other) beliefs. That is, the beliefs include the attributes of hot and cold, but they are part of much broader yin and yang beliefs in which yin is cold, but it is also dark, wet, and female, versus yang, which is hot, but also light, dry, and male. In addition, harmonious relationships are expected among all aspects of the cosmos.

BOX 5-9

ILLNESS BELIEF SYSTEMS

Germ Theory: Lay people's translations of biomedical beliefs.
Equilibrium: Balance theories found among most cultures but well developed as "hot" and "cold" among Latinos and yin and yang among many Asians.
God- and Spirit-Caused: Supernatural entities play a role in the illness. God may punish or test one's faith. Spirits frequently represent family values through ancestors.
Sorcery and Witchcraft: These beliefs in the power of humans to do evil generate a great deal of fear for the victim.

THE GOD- AND SPIRIT-CAUSED BELIEF SYSTEM

Most clinicians are familiar with God-caused health problems, even though traditional health care does not include this category. Many people from a variety of cultures in the United States believe that their illnesses could have been caused by the wrath of (the Judeo-Christian) God or perhaps as God's test of his or her faith. God can also cause illnesses as an unknowable part of His plan, according to the Judeo-Christian ethic. Spirit-caused illnesses are less frequently seen among European Americans, even though spirit beliefs are ubiquitous across world cultures. Spirits may be ancestor spirits, as among many Asians, or spirits of the dead who have stayed behind to cause trouble, as among some Puerto Ricans.

THE SORCERY AND WITCHCRAFT BELIEF SYSTEM

Sorcery and witchcraft are technically different phenomena, but both refer to humans with the power to cause supernatural harm to other people. Patients who believe that witchcraft (the more common term) has been used on them are legitimately frightened. After all, it is difficult to fight such a power. Usually, the patient needs to turn to a folk specialist (e.g., a root doctor among African Americans) for help, but the clinician can be helpful by providing support to the patient and the family.

Interviewing

The culturally appropriate interview can sound virtually the same as other health interviews, but the key is listening rather than asking. The core of cultural competence in assessing the patient and discussing his or her health problems is the explanatory model interview (Kleinman, et al, 1978) (Box 5-3). This model is not the only way to assess the patient. In fact, attitude and listening skills are more important than the list of questions. Any standard set of assessment questions may be used, but the most important thing to remember is to listen for both illness and disease. It is essential that clinicians engage in efforts to reduce their ethnocentrism and increase cultural relativism because this increases the possibility of being able to listen to beliefs and practices that are outside the clinician's experience but are central to the patient and family.

TABLE 5-2 **Culturally Sensitive Interview**

TRADITIONAL WESTERN HEALTH CARE HISTORY MODEL	INTERVIEW EXAMPLE: BLENDING EXPLANATORY MODEL (SEE BOX 5-3) AND TRADITIONAL MODEL	CULTURE-SENSITIVE LISTENING: LISTENING FOR ILLNESS (CULTURAL PERCEPTION) AND DISEASE (BIOMEDICAL PERCEPTION)
Introduction	Mr. Smith? Hi, I'm J.P., a primary care clinician. I will be working with you today. How would you like to be addressed? or What name would you like me to use?	In every culture, your name has special significance, and the way you are addressed may have great meaning. Never assume that it is acceptable to use the person's first name, or for them to use yours. Age, gender, and cultural norms all play a role in how individuals wish to be addressed.
Chief complaint	What brought you in today? (Ascertain what symptom is of concern.) What is the name of your problem?	Asking a patient to name the problem will give you clues to the patient's beliefs about the origin of the illness.
Symptom analysis		
Onset/Duration	When did it start? Can you think of anything that brought this on? What do you think caused your problem? Why do you think it started then? How long do you think it will last?	This will provide information about the patient's insight into the problem and may reveal underlying beliefs.
Location	What parts of your body are affected? How does it work in your body?	Actively listen to understand the patient's perception of the condition.
Frequency/chronology	How often do you notice it in your body? Have you noticed it before? Are you generally getting better? Worse? About the same? What is it like?	This may add information regarding previous episodes and treatment modalities as well as patient expectations for treatment.
Quality	Is it dangerous?	Show empathy, interest, and respect for the patient's concerns.
Quantity	Will this last a long time? How much of a problem is it?	Encourage the patient to explain.
Aggravating or alleviating factors	Is there anything that makes it better? Makes it worse? (Ask about various common cultural practices.)	This shows interest and gives the patient permission to talk about the illness and his or her conceptualization of the condition.
Associated symptoms	Do you have any other symptoms with this? Is this causing any other problems in your body?	Again, this gives insight into the patient's perceptions.
Treatments tried	Have you talked with anyone else about this? Did they make any suggestions? Have you tried any other medicines or home remedies? Did these help? Are there any special remedies that you have been advised to try or that are recommended by your healers? Who recommended the remedies you have tried?	Knowing, understanding, and accepting culturally determined treatments and respecting those who utilize them often enables you to develop treatment plans that blend traditional healing measures with allopathic health care practices.
Effect on ADLs	What bothers you most about this illness? How has it affected your daily life?	Provides insight into the patient's illness and allows interpretation of the disease effects
Patient perceptions	What do you think is going on? Is there anything you fear about your illness? What would you like me to do today?	Positions the clinician to better provide a culturally appropriate plan of care.
Conclusion	Is there anything else I should know or that you would like to tell me? What would you like me to do today?	Patients may or may not be able to tell you what they would like you to do. In some cultures, it may be presumptuous to tell a provider what to do or to express an opinion.

ADLs = Activities of daily living.

THE EXPLANATORY MODEL INTERVIEW

The explanatory model interview is based on a great deal of research within health care anthropology (see Box 5-3). For example, the name of the illness is frequently important. "High blood" is different from high blood pressure (Snow, 1974; Blumhagen, 1980) and "sugar diabetes" may signal some common perspectives on diabetes that contrast with professional information. Asking about the cause and about what has been and can be done for the problem is almost always helpful. For example, in one case in which there was no cultural difference between patient and clinician, the clinician asked a child why he was sick with a cold, and he answered that he had been naughty. This is something a clinician can work with at the family level, even though not much can be done for the cold. The clinician went on to ask about what he thought could be done for the cold and associated sore throat and received an astonishingly high number of good suggestions, such as to drink juice, to suck on a Popsicle, to eat good foods, such as fruits and vegetables; and to wash his hands. In cross-cultural cases, the treatment question may offer insight into both beliefs about the illness and who within the family or community is relevant as a helper.

The explanatory model interview asks patients to do what clinicians rarely ask of them: to provide their own opinions. Sometimes, patients are surprised and comment that the clinician is supposed to know those answers (e.g., what is it and what caused it?). When this happens, the clinician should explain that in the clinician's patient-centered practice, he or she needs to know the patient's opinions as much as the clinician needs to know some of their laboratory values. Other times, patients say that they do not know the answer. On these occasions, the clinician should wait; usually, the patient answers the question. Alternatively, the clinician can ask, "What's your best hunch?"

INTEGRATION OF CULTURE-SENSITIVE QUESTIONS IN HEALTH ASSESSMENT

The symptom analysis, or the history of the present illness, provides an excellent framework for the incorporation of a sociocultural assessment in the health care process (see Table 5-2 and Chapter 6, "Critical Thinking in Ambulatory Care," for discussion of Symptom Analysis). For most clinicians, a lack of in-depth knowledge of other cultures' norms is considered to be a major practice barrier. Clinicians fear that they are not being sensitive in providing care when they are unfamiliar with the patient's usual health practices. Concerns about what to say, what to do, and how to act interfere with care. The key to successfully providing culturally appropriate care is the ability to listen to—and to hear—the patient's concerns. Although a working knowledge of the individual's cultural heritage is helpful, the clinician's ability to embrace the richness of diversity is more important. Integrating the explanatory model questions into the symptom analysis is particularly useful when the biomedical aspects are complex.

The basic explanatory model questions can be added to the symptom analysis to understand the meaning the patient gives to the illness. Table 5-2 illustrates this approach in a typical episodic visit for evaluation of a problem.

INTERVIEWING TECHNIQUES

The cross-cultural interview is useful with everybody because all humans are cultural beings. These techniques take on higher significance when the cultural differences between patient and clinician are wider. Some useful things to remember when interviewing a patient from another culture are to:

- Learn as much about the patient as possible before the encounter. Even a brief look at the personal information in the chart can be helpful. For example, one clinician noted that the person had only been in the city for a few months and asked about it. Not only did this make the patient feel welcome, it also divulged essential information about the lack of health care resources and support system and led to an assessment of depression. In another case, the clinician knew that Somali women are extremely proud of their male children. When she first met the Somali patient, who had been to multiple providers without any satisfaction, she remarked at how good looking her boys were and how well cared for they seemed. This overt assessment not only fit the value system of the mother but also affirmed that she was doing a good job.
- Attend to issues such as eye contact, touching, body spacing, and voice modulation. Maintaining a neutral demeanor until culturally appropriate body language is known is essential. For example, some Native Americans shake hands with a much less vigorous handshake than a middle class white person; in addition, some are uncomfortable with much eye contact. Clinicians who like to pat children on the head are often shocked to learn that this is extremely offensive to some Southeast Asian mothers because of the potential spiritual consequences.
- Avoid the *ethnocentric reactions of anger, laughter, shock, and revulsion* when a patient says something that is strongly at variance with one's own culture. These reactions, which are almost automatic, signal to the patient that this is an area that should be avoided, and the clinician loses potentially important information. By carefully cultivating a supportive, valuing demeanor, the clinician can train himself or herself to treat patients with the constant respect they deserve.

Working With Interpreters

An interpreter is one more significant tool available to the clinician for the therapeutic encounter (Box 5-10). Like other tools, this one requires knowledge and skill; unlike other tools, this one is human, with a full range of human reactions to the world (Putsch, 1985). In courts of law, the interpreter is charged with a direct,

BOX 5-10 WORKING WITH INTERPRETERS

- Create a professional relationship with your interpreters.
- Assess their medical knowledge.
- Assess their position in the community.
- Remember confidentiality in small ethnic communities.
- Do not use children, relatives, or friends to interpret.
- Interpreting is human communication, not a technical interchange of words.
- Address questions to your patient and not to the interpreter.
- Speak at a normal pace in a normal voice.
- Ask only one question at a time.
- Avoid jargon, technical terms, and long speeches.
- Allow sufficient time for an interpreted visit.

word-by-word interpretation because of the narrow rules of evidence in that system. In health care, the outcome is not based on an adversarial relationship as exists in the courts; instead, there is a strong American value placed on working *with* the patient and the family to achieve a positive result to the health problem. Clinicians, too, generally expect a word-by-word translation and are confused when a long interchange between interpreter and patient results in a short translated statement. This confusion is understandable, but it reflects a lack of appreciation for the complexity of the health care encounter when an interpreter is present.

Working with an interpreter requires that the clinician form a relationship with the interpreter so that the clinician can clarify his or her desired style of interpretation. The clinician should also assess the interpreter's health care knowledge and position in the community. The refugee and immigrant communities from which most interpreters come are heterogeneous and may include long-standing ethnic animosities that could intrude on the quality or validity of the patient encounter. In addition, there might be some problems with confidentiality or with a more sophisticated interpreter wishing to conceal the less sophisticated patient's use of "superstitious" folk medicine. The clinician should maintain eye contact with the patient even though the interpreter is translating the words.

When the clinician and the patient are interacting through another person, eye contact may be difficult to manage or evaluate. Silence is even more difficult to fathom because the clinician is not in charge of the conversation. Space is affected by the role the interpreter plays. The clinician may have less access to specific health beliefs if the interpreter feels that it would be improper for the clinician to hear or for the patient to divulge health beliefs that might reflect poorly on the ethnic group.

Most important, the clinician should not use family members as interpreters. One reason for this is that they are unlikely to know health care terminology. Another reason, of course, is that the intimate social relationship may inhibit open communication between the clinician and the patient. Too often, the patient has been unable to say or ask something because it would have been inappropriate for the family member interpreter to hear it. The clinician should make sure that there is enough time for the visit; using an interpreter usually doubles the length of time. The clinician should attend to his or her mode of speaking and should speak at a normal pace and in a normal voice, avoid jargon, speak in short sentences and wait for translation, ask only one question at a time, and, very importantly, address questions and comments to the patient rather than to the interpreter.

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RESOURCES

Diversity RX
http://www.diversityrx.org/

EthnoMed Home Page
Harborview Medical Center, University of Washington, Seattle, Washington
http://weber.u.washington.edu/~ethnomed/emedhp.htm

GLOBALRN

http://nurseweb.ucsf.edu/www/globalrn.htm

Hispanic Center of Excellence
http://riceinfo.rice.edu/projects/HispanicHealth/index.html

Pitkofsky & Associates
Health Care Diversity Consulting
http://members.aol.com/wrldview/

Resource Bibliography in Cross-Cultural Nursing
Melinda Mich and Noel Chrisman
University of Washington
Autumn, 1995
http://weber.u.washington.edu/~ethnomed/resbib.htm

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