

Towards Cultural Humility in Healthcare for Culturally Diverse Rhode Island

Jeffrey M. Borkan, MD, PhD, Kathleen A. Culhane-Pera, MD, MA, Roberta E. Goldman, PhD

Patients, physicians, and society clamor for accessible, affordable, high quality health care. Though variously defined, quality care may mean, “doing the right thing, at the right time, in the right way, for the right people—and having the best possible results.”¹ Quality health care is *effective, safe, timely, patient-centered, equitable, and efficient.*² Patient-centered care “is respectful and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions.”² To provide such care, physicians and ancillary staff must be culturally competent. Acquiring such competency may be daunting, given the range of ethnicities and groups in your practice area, not to mention local, familial, or individual variations. Where is the clinician to start? This article provides a general framework for achieving the competency, or as we prefer, the tools and the humility that are essential for delivering quality care.

Rhode Island has been described as a microcosm of the US population. In 2006, 23% of RI’s children lived in immigrant families, a percentage similar to that of the US (22%). About a quarter of these families are linguistically isolated; half of the children living in immigrant families are poor or low income; about half have parents with low education; almost a third have one or both parents with a college education or graduate degree.³ About 80% of Rhode Islanders are non-Hispanic White; 6.3% are Black; 2.7% are Asian; .6% are American Indian; and 11% identify as Hispanic or Latino of any race.⁴ Historically, many Rhode Islanders hail from English, Italian, Irish, Portuguese, and Cape Verdean ancestries. Portuguese and Cape Verdeans continue to migrate to the state, joined recently by immigrants from the former Soviet Union, Africa, Asia, Southeast Asia and India, and Latin America (particularly Colombia, the Dominican Republic, Puerto Rico, Mexico, and Guatemala). Between 1990 and 2000, the predominant regions of birth of immigrants were: Latin America (36.8%); Europe (32.9%); Asia (16.4%); and Africa (10.1%).⁴

CULTURALLY COMPETENT CARE AND CULTURAL HUMILITY

When physicians provide culturally competent medical care, they inquire about, respond to, and respect the patients’ beliefs and desires, regardless of the patient’s age, gender, religion, ethnicity, or language. (Other terms include cultural sensitivity, cultural responsiveness, or cultural appropriateness). Cultural humility is a life-long attitude and approach to cultural competence. We believe that healthcare professionals must be humble about their knowledge of patients’ beliefs and values, engage in self-reflection so that they are aware of their own assumptions and prejudices, and act to redress the imbalance of power inherent in physician-patient relationships.

Biomedicine tends to focus on the pathological processes of disease. Patients, in contrast, often focus on the psychological experience of illness, while the patient’s family and community focus on the patient’s sickness—the social determinants and ramifications of disease and illness. Culturally competent medical care requires that physicians understand cultural as well as social and psychological factors that influence how patients maintain health, treat disease, experience illness, and respond to suffering. Culture influences beliefs about nearly everything in the healthcare equation, from the understanding of bodily functions and disease etiology, to treatment choices.

CLASSIFICATION OF DISEASES

Since ethnic groups have differing classification systems for diseases, it is difficult to translate disease concepts across cultures. Entities that are recognized by certain ethnic groups and not others are often classified as folk illnesses or culture-bound syndromes. Such ailments have a defined etiology, course, and treatment, and include expressions of mental or social distress. For example:

One of our patients, Mrs. Yolanda Jackson, a 72-year-old African-American woman, has what she conceptualizes as high blood. At times,*

Mrs. Jackson can feel her blood rising up to her head. When she drinks pickle juice and vinegar, she can feel her blood return back to normal. Her 28-year-old European-American male physician believes she has hypertension and recommends a low salt diet, exercise, and medication.

“High blood” is a culture-bound syndrome while “hypertension” is a mainstream biomedical disease. Concepts of folk illnesses and biomedicine may be consistent, complementary, or contradictory. In this case, the two cultural systems may conflict due to their differences explanations of the disease (symptomatic or chronic) and the treatment (foodstuffs or medication). Mrs. Jackson and her physician could take steps to understand each other, compromise, and implement an approach that relieves both her illness and her disease.

THEORIES OF DISEASE CAUSATION

Etiologies typically fall into four categories, influenced by the cultural group’s concepts of the natural, social, and supernatural realms. Biomedicine emphasizes individual and natural causes, but patients may consider these other causes to be equally or more important.

1. Individual etiologies include behavioral risk factors for disease (e.g., lifestyle, diet, habits, and sexual behaviors) and presume the individual is responsible for the illness.

2. Natural etiologies include germs, environmental factors, humoral factors (hot/cold elements), and the heavenly bodies (moon, planets, constellations). Because these etiologies are seen as factors beyond human control, the individual has little personal responsibility for causing the illness.

3. Social etiologies arise from social interactions or conflicts (e.g., conflict between friends or family members; jealousy, envy, or hatred; giving someone the “evil eye”).

4. Supernatural etiologies reflect the culture’s religious beliefs. For example, an angry God may punish sinful thoughts or actions; *kharma* forces from previous

lives will influence events in this life; lack of respect for ancestral spirits can cause sickness. Prevention or cure is provided by religious prescriptions.

Mr. Eugene Schmidt, a 65-year-old third generation German American man, has lung cancer and wonders why it happened to him. His physician says it developed because he smoked tobacco for 50 years. His wife thinks God is punishing him, as he had turned away from the Catholic Church early in their marriage. His daughter admonishes him for not eating the vitamin supplements she had bought for him. His son encourages him to sue the ship building industry where he worked during World War II.

TYPES OF TREATMENTS

The patient, family, or community members may apply a variety of popular and lay treatments to relieve symptoms, cure illnesses, or prevent further harm; e.g., herbs, amulets and other protective clothing, rituals (including prayers and offerings), massage, nutrition, sleep, or exercise, or hygiene. Coining and cupping are common Southeast Asian lay practices to treat illnesses caused by the build-up of bad wind, or pressure. The healer first rubs the skin with a mentholated cream, then rubs a silver coin vigorously over the affected area to release the pressure or create suction with a cup, which relieves the illness. (The bruises from such treatments have occasionally been interpreted as marks of child abuse.)

Ana Soares is a 76 year old woman from Portugal who prevents getting colds and other respiratory diseases by ensuring that her head is covered when she goes from her hot kitchen to any colder environment, even if it is for just a minute. If she does get a respiratory infection, she treats it with a hot mixture of water, honey, and sage.

Sacred or secular healers who have acquired authority through inheritance, apprenticeship, religious position, or divine choice apply folk treatments. Healers include herbalists, bonesetters, traditional midwives, spiritualists, shaman, and injectionists. For example in Rhode Island's Latino communities, Puerto Ricans and Dominicans may consult an "espíritista" in

a local "botanica", herbal/spiritist shop and purchase herbs, or colored and scented lotions, liquids and candles. The colors and scents are associated with particular health or life circumstance properties, and are used to improve health, love, wealth, relationships, and luck, among other attributes.

INTERPRETATION OF BODILY SIGNS AND SYMPTOMS

Individuals declare themselves "sick" when they explain their signs or symptoms as abnormal. Socially, family members or healers or healthcare providers must concur before the patient can assume the sick role and legitimately withdraw from work and family responsibilities and receive assistance from others. Different interpretations of bodily signs and symptoms as normal or abnormal will influence this process.

Mr. Garcia Lopez, recently settled in the US from Mexico, was confused. His son was sent home from school with a draining ear, a common occurrence in Mexico, and not a cause for alarm. But then later the same month, his son was not permitted by school authorities to stay home after he was frightened (asustado) from a near-miss car accident, which could have made him vulnerable to many types of illnesses.

The significance patients attach to signs or symptoms of an illness is influenced by the individual's cognitive ideas or **explanatory models (EM)** about the sickness event.⁶ People's EMs can change as symptoms change, as response to treatment occurs, or

as the patient accepts other ways of thinking or others' experiences. The patient, family members, social network, and health care providers all have their own EMs for the sickness event, which may be congruent, complementary, or contradictory. When physicians understand these diverse EMs, they can respond to patients' needs, expectations, and fears, aim educational messages at patients' uncertainties, and negotiate diagnostic and therapeutic approaches.

A necessary skill in providing culturally competent care is eliciting and listening to patients' and family members' stories of their illness experiences, which includes the events, their models and beliefs about causation, their feelings about their disease, their quest for therapy, and their reactions to biomedical recommendations. (Table 1)

MEDICAL DECISION MAKING

Cultural beliefs, knowledge and experience, explanatory models, access, cost, and perceived efficacy influence medical decision-making. Ethnic identity—the extent to which individuals align themselves with a socio-cultural group—may influence people to seek healers or professionals from their ethnic background. When people relocate, their ethnic identity may be modified through acculturation. Acculturation can change a person's alignment from traditional healing practices to mainstream healing systems and can lead to intra- and inter-familial conflicts regarding treatments. The degree of social dissonance—the distance between the patient and the healer in terms of differences in ethnicity, socioeconomic class and all that encompasses,

Table 1: Eliciting the Patient's and Family's Story and Models

1. Would you please tell me more about yourself?
 2. How does this illness fit into or change your story?
- Illness/Problem**
3. What health problems or illnesses do you have, what do you think caused them, and what kind of care have you sought? (conventional medical care, complementary-alternative, traditional)? How have they been helpful? Not helpful?
- Impact of the Illness on the Individual**
4. How is this illness affecting your daily functioning and the things that are most important to you?
 5. What do you miss most from before you were ill?
 6. What do you think will happen in the future?
- Impact of Illness on the Family**
7. What changes have occurred in the family since the illness began? (daily routines, care, finances, etc.)
 8. How well do you feel the family is coping? Is there anything the family wishes they could do differently?

language, or religion—may become important. The greater the dissonance, the less likely the patient will choose the healer or adhere to treatment recommendations.

Patients can sequentially or simultaneously seek assistance from the three types of treatments (lay, folk, and professional sectors): a hierarchy of resort. People often begin with lay treatments in the form of self-help or family remedies. If lay treatments are insufficient, patients seek out folk healers or professionals. Patients may make decisions themselves, or may look to family members or social networks members for advice. Patients seek assistance from different traditions depending on the situation, the fit between the sickness and the healing approach, the perceived effectiveness of the therapies, as well as their ethnic identity and degree of acculturation. Physicians should inquire what treatments and healers patients have already received, as well as whom they will consult to make decisions.

HEALER/SICK PERSON RELATIONSHIPS

Every cultural system has expectations about the healer/sick person/family relationship. The social and cultural rules governing this relationship influence the style of communication, the appropriateness of certain discussions, the protocol about sharing or withholding information, and the amount of power or authority the healer exerts over the patient and family.

To care for patients from other cultures, physicians must be sensitive to cultural differences between them and their patients. Physicians must be familiar with general information about a cultural group, but they cannot assume their patients' beliefs and values based on the general cultural information. Rather than stereotyping, physicians can use general information about a group to generate hypotheses about an individual person or family, and then ask people about their lives, their expectations, and their desires.

CLINICAL APPLICATIONS

Over-use of stereotypes and generalizations can lead to *too little* care.

Mai Nguyen, a 29-year-old female refugee from Vietnam, came to a community health center for a complete physical exam before starting a new job, and had numerous

somatic complaints. She was hesitant to talk about emotional, familial, or intimate matters and refused a gynecological exam. Her young physician consulted colleagues who advised accepting her complaints as being consistent with Vietnamese "culture". However, after several encounters with the patient, the physician learned that the patient had escaped Vietnam in a small over-crowded boat and had undergone significant trauma and sexual abuse while at sea, and realized that her behaviors were not just "cultural". Indeed, her multiple somatic complaints were related to post-traumatic stress disorder and required social and psychiatric interventions.

Over-use of stereotypes and generalizations can lead *too much* care.

Moshe Kadosh, a 54-year-old Jewish immigrant to the United State from a village in Morocco, saw his primary care physician soon after arriving for complaints of sinus pressure, headache, and dizziness. The physician became alarmed when the patient described discussions with spirits, including hearing the voices of some of his ancestors and long-dead local holy men, and so referred him to a psychiatrist. After the initial visit, the psychiatrist postulated he was schizophrenic and admitted him to the inpatient psychiatry ward. Only after working with a psychiatry resident from the same country who interviewed him in his native language, did it become ap-

parent that he was not psychotic, but was only exhibiting some of his normal spiritual beliefs, as well as expressing his distress in culturally appropriate ways.

CULTURE OF BIO-MEDICINE:

Like all healing systems, modern biomedicine is influenced by historical, social, economic, political, religious, and scientific events. It has its own language, vocabulary, and concepts. It also has its own values, and each discipline (family physicians, surgeons, psychiatrists, etc.) are sub-cultural groups with variations on the general biomedical beliefs, values, and behaviors towards health and disease. As a sub-culture of Western society, biomedicine has values of the larger society, which specifically fit bio-medicine.

Dr. Jim Zedler, a new intern begins working up his first patient in the outpatient clinic of his academic health center. The patient is a 32-year-old married woman recently arrived from Africa who complains of diarrhea and lower abdominal pain, which although present for the last several months, have worsened in the past week. He completes his history and physical examination, and orders a broad series of laboratory and imaging tests. He becomes disappointed and frustrated when he is unable to provide a definitive etiology and a patho-anatomical diagnosis. Even worse, the woman's complaints of pain worsen. After several visits, he decides that the woman's pain is "in her head", a conclusion which angers her. After an assessment by his preceptor, it becomes clear that

Table 2: Working with Interpreters

1. Discuss expectations with interpreter before beginning, including first-person singular, verbatim translation.
2. Make sure everyone has been introduced.
3. Sit facing the patient, and speak to the patient, not the interpreter.
4. Use lay English terms and non-complex language structure.
5. Pause intermittently to allow interpretation.
6. Don't assume universal meanings to nonverbal gestures.
7. Periodically check the patient's understanding.
8. Do not expect interpreters to resolve conflicts or disagreements or to actively negotiate outcomes.

Cultural Humility (HUMBLE) Model

- H:** Be Humble about the assumptions you make about knowing the world from your patients' shoes
- U:** Understand how your own background and culture can impact your care of patients
- M:** Motivate yourself to learn more about the patient's background, culture, health beliefs and practices, as well as the unique points of view of their families and communities
- B:** Begin to incorporate this knowledge into your care
- L:** Life-long learning
- E:** Emphasize respect and negotiate treatment plans

the woman has lactose intolerance, which has been exacerbated by her recent dietary changes after moving to the US, and she is a victim of domestic abuse. The intern had not picked up on the cues and had considered both her domestic situation and her diet out of the realm of his investigation.

her as though staring, and they called her by her first name rather than calling her Grandmother in a respectful tone of voice. She always feels as though they don't really care about her and her sufferings.

TRANSLATORS

Professionally trained interpreters provide grammatically correct first-person verbatim translations for physicians and patients, including interpreting medical language into lay terms. Using family members as interpreters is particularly problematic. Differences in age and gender, may result in discussions about inappropriate topics (children hearing about intimate details of their parent's lives). Differences in language skills may mean the relative has inadequate knowledge of English medical terminology or medical terms in their own language. Seeking trained interpretation services over the phone is preferable in such cases. In addition, recent legislation in Rhode Island makes it illegal to use an individual under the age of 16 to interpret, although many immigrants expect their children to interpret for them. In general, physicians should huddle with the interpreter prior to the clinical encounter, clarify guide rules and expectations, ask for "word for word" translations, and listen to the interpreter's insights about cultural practices, meanings, or idioms. (Table 2).

SUMMARY

This article presents a framework for quality care that attends to culture and ethnicity. Tools and approaches for achieving cultural competency and humility are provided that may help improve the care of the patients, irrespective of their backgrounds or beliefs.

*All names used in this manuscript have been changed to ensure confidentiality.

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Jeffrey Borkan, MD, PhD, is Professor and Chair of Family Medicine, Memorial Hospital of RI, The Warren Alpert Medical School of Brown University.

Kathleen Culhane-Pera, MD, MA, is Adjunct Professor of Family Medicine and Community Health, University of Minnesota, and Associate Medical Director, West Side Community Health Services.

Roberta Goldman, PhD, is Clinical Associate Professor of Family Medicine, Memorial Hospital of RI, The Warren Alpert Medical School of Brown University.

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CORRESPONDENCE:

Jeffrey Borkan, MD, PhD
Memorial Hospital of RI
111 Brewster Street
Pawtucket, RI 02860
phone: (401) 729-2256
E-Mail: Jeffrey_Borkan@Brown.edu

Victoria BearClaw, 82-year-old Native American, feels insulted every time she attends the medical clinic in the city rather than on the reservation. The doctors and nurses talk quickly; they don't wait even a full second before she can reply, and then they're asking her another question as though she's dumb or can't hear. And then they don't really listen to her concerns as she tells the full story. Also, they look directly at