

Better communication with minority patients: seven strategies for achieving cultural competency

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Social inequalities add costs to the healthcare system and degrade the quality of care. Beyond socioeconomic indicators, cultural and ethnic differences present barriers to quality care. These barriers revolve primarily around beliefs that exist among certain populations and inadequate communication with those populations. This article offers a number of specific strategies for surmounting those barriers.

Health disparities occur when one group of people has a higher incidence or mortality rate than another, or when survival rates are lower for one group than another.¹ According to the National Institutes of Health, compared to whites, minorities “bear a disproportionate burden of disease, injury, premature death, and disability” in the US.² When it comes to cancer, the differences are stark.

The inequality of cancer care

African-Americans suffer the highest incidence and mortality rates from cancer of all racial/ethnic groups.³

- For prostate, lung/bronchus, colon/rectal, and stomach cancers in 2001, the age-adjusted incidence for black males was higher than for non-Hispanic white males.⁴
- African-American prostate cancer patients are more than twice as likely to die and more likely to be diagnosed at an advanced stage than their white counterparts.⁵
- Although white females have a higher incidence rate of breast cancer than African-American females, the latter have a higher breast cancer mortality rate.³

Among Hispanics:

- Overall, data show that Hispanics have lower incidence and mortality rates for cancer than African-Americans and whites.³
- Hispanic females experience the highest incidence rates for cervical cancer.³
- Hispanic females experience the second highest mortality rate from cervical cancer behind African-

- American women.³
- In 2001, the incidence rate of stomach cancer among Hispanic males and females was 63% and 150% higher than white males and females, respectively.⁶

Among other minorities:

- Asians/Pacific Islanders have the lowest overall cancer death rate among all racial/ethnic groups, but they have the highest incidence rate for liver cancer.
- Compared to rates in whites, liver cancer rates are 6–13 times higher for Vietnamese-Americans, Korean-Americans, and Chinese-Americans.¹¹

KEY POINTS

Minorities in the United States—in particular, African-Americans—suffer the highest incidence of and mortality rates from cancer.

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Even after adjusting for age, sex, median income, stage of illness, and insurance status (ability to pay), studies show that minorities experience health disparities.

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As minority populations continue to grow, health disparities will become even more costly, both socially and financially, and cultural differences will become more prominent.

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A number of strategies, detailed here, can facilitate and improve cross-cultural care.

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The growth of minorities

The American population is becoming increasingly more diverse. Between 1990 and 2000, the African-American,⁷ Asian,⁸ and Hispanic⁹ populations each became a larger proportion of the US population. Between 2000 and 2020, the Census Bureau projects:

- African-Americans will increase from 12.7% to 13.5% of the population
- Asians will increase from 3.8% to 5.4%
- Hispanics will increase from 12.6% to 17.8%¹⁰
- Non-Hispanic whites ("whites") will decrease from 69.4% of the population in 2000 to 61.3% by 2020.¹⁰

It's important to note that health disparities among minorities persist even after controlling for socioeconomic factors, including the ability to pay. For example, adjusting for age, sex, median income in the zip code of residence, and stage of illness, African-American Medicare patients with early-stage lung cancer had lower surgery and 5-year survival rates than white patients.¹²

Cultural competence can help

There is some evidence that culturally competent care and cross-cultural education can help reduce health disparities among minorities. Although links between language barriers and patient compliance rates have not been clearly established,¹³ research has shown that language concordance may lead to better understanding of diagnosis and prescribed medications among emergency room patients.¹⁴

There are misconceptions about the causes and symptoms of cancer among certain ethnic groups. For example, Hispanics are more likely than whites to think that sugar substitutes,

bruises from being hit, microwave ovens, eating pork and spicy foods, breast feeding, and antibiotics could cause cancer.¹⁵ Knowing that these attitudes and misconceptions may exist and engaging in a dialogue to allow patients to explain their beliefs may open the door for valuable patient education.

Generally, the quality of patient-doctor communication significantly influences the quality of care. Higher quality patient-physician communication during history-taking and discussion of a management plan can improve patient outcomes.¹⁶ So it's not surprising that language barriers between providers and patients directly affect quality of care. Although non-English-speaking patients do not comprehend diagnoses, prescribed medications, and care instructions as well as English-speaking patients,¹⁴ research has linked the use of trained interpreters to higher quality patient-physician communication.¹⁷ Language discordance between patient and provider is linked to lower patient satisfaction.¹⁸

But cultural barriers to care go beyond language discordance. Beliefs and experiences among certain ethnic populations influence their interactions with the healthcare system. Studies show higher rates of missed appointments and lower adherence rates among minorities.¹³ In one study, Hispanics were more likely than whites to believe that developing cancer is a death sentence and that there is very little one can do to prevent the development of cancer.¹⁵ The legacy of the Tuskegee Syphilis Study and the general history of segregation have caused distrust of the healthcare system among African-Americans.¹⁹ Cultural or religious practices can interfere with prescribed therapies¹⁹ and contradict bioethical and medical practice norms in the United States.²⁰

Governmental intervention

Federal and state governments have begun to address cultural com-

petency in healthcare. The Culturally and Linguistically Appropriate Services (CLAS) standards require individuals (including physicians) who receive Federal financial assistance from the Department of Health and Human Services to offer language interpretation, bilingual staff, and translated written materials to patients where appropriate. The Office of Minority Health Web site encourages all individual providers to use the standards. (For more information, see the Office of Minority Health Web site at www.omhrc.gov/templates/content.aspx?ID=2806 or call 1-800-444-6472.)

Recently, New Jersey and California passed legislation regarding cultural competence in healthcare. The New Jersey legislation requires each student of a medical school in the state to complete cultural competency instruction.²¹ The law also requires each physician licensed in the state who did not receive cultural competency training in medical school to receive such training as a condition of relicensure.²¹ The California legislation requires continuing medical education courses with a direct patient care component to include curriculum on cultural and linguistic competencies.²² Arizona, Florida, Illinois, and New York lawmakers are considering similar legislation.

Purchaser intervention

Large employers who purchase insurance for their employees have demonstrated significant interest in cultural competency as a solution to health disparities. The National Business Group on Health (NBGH) is an organization of Fortune 500 companies and public sector employers that provide coverage to more than 50 million US employees, retirees, and their families. For their members only, the NBGH created the Employer Toolkit: Reducing Racial and Ethnic Health Disparities.²³ Among other things, this toolkit identifies strategies to design culturally and linguis-

tically competent health and wellness programs at the worksite. It also provides information on educational programs about health disparities among minority employees.²³

Individual corporations have demonstrated considerable interest in the abilities of health plans to address health disparities and utilize culturally competent techniques. For example, 33% of employees at Verizon Communications are minorities.²⁴ The company provides healthcare coverage to 800,000 employees, retirees, and dependents and is now reviewing health plans' disease management programs, communication materials, collection of racial and ethnic membership data, racial and ethnic makeup of provider networks, and use of cultural competence to address healthcare disparities.²⁴

What can clinicians do?

More research is needed to understand which cross-cultural patient education techniques and teaching methods are most effective. But there are some things clinicians can do now to improve communication with culturally diverse patients and to improve chances of better diagnoses, adherence to treatment regimens, and outcomes. These techniques are our best opportunity to reduce health disparities among minorities:

Engage the concept of cultural competence.

The quest for improved cultural competence is not an admission of racism; it is a commendable effort to provide the highest quality of care possible to everyone. In addition to race and ethnicity, religion and generational differences also present challenges that can be engaged with cross-cultural techniques. For example, as the Baby-Boomer generation moves into retirement, the entire healthcare industry will have to respond to a group that has very different preferences and circumstances than the previous generation. Clinicians should also note

that awareness of cultural competence is just as important for an African-American doctor who grew up in suburbia and treats Cuban patients in an urban setting as it is for a Caucasian doctor who grew up in suburbia and treats African-American patients in an urban setting.

Engage tools that provide knowledge about cultural competence and cross-cultural care techniques.

There are a variety of tools clinicians can utilize to improve patient communication and to learn about cultural competence and cross-cultural techniques. Professional interpreting services are crucial to serving patients with limited English proficiency. See the box at right for more information.

Seek out community resources that can provide support to pertinent patient populations.

In some cases, a patient's unwillingness to undergo diagnostic procedures or take part in treatment decisions can pose significant obstacles to quality care. To mitigate these obstacles, physicians should seek out prominent social, civic, and religious organizations in the community. Faith-based organizations, local chapters of civic/community groups, or even a mayor's office may sponsor or support educational groups for many topics, especially cancer, or may be linked to such groups.

In some cases, non-profit organizations focus on support and education for cancer victims and high-risk populations. The RealMenCook Foundation (www.realmencookfoundation.org/index.htm) does just that. This organization provides free prostate cancer screening to minority men in inner-city communities in Los Angeles. While providing these screenings, it creates a relaxed atmosphere by playing music, distributing gift bags, and offering education about the disease. This organization has partnerships with faith-based organizations;

Pocket guides

- "Cultural Competence in Cancer Care: A Health Care Professional's Passport" from the Intercultural Cancer Council and Baylor College of Medicine.²⁵

- Cost: \$4.00

- http://iccnetwork.org/news/Pocket_Guide_Order_Form.pdf

- What Language Does Your Patient Hurt In? A Practical Guide To Culturally Competent Patient Care"²⁶

- Although not focused specifically on cancer patients, this publication is a comprehensive pocket guide that addresses cross-cultural issues from the aspect of race, ethnicity, and religious beliefs.

- Cost: \$30.00

- www.inter-faceinter.com

Online courses

- Courses for CME credit

- A Family Physician's Guide To Culturally Competent Care

- Cost: Free

- <https://cccm.thinkculturalhealth.org/default.asp>

- CME credits: Maximum of 9.0 category 1 credits toward the AMA Physician's Recognition Award.

- Quality Interactions

- Cost: Provided free to physicians through certain healthcare organizations such as Blue Cross and Blue Shield of Florida.

- www.qualityinteractions.org

- CME credits: Maximum of 2.0 category 1 credits toward the AMA Physician's Recognition Award.

Interpreter services

- Propio Language Services offers over-the-phone interpretation of more than 150 languages.

- www.propiospanish.com

community newspapers; local, state, and Federal political offices; and various community groups. Although a RealMenCook Foundation does not exist in every community, there are probably opportunities to find support through similar local organizations.

Engage the patient's family, when appropriate.

Although the confidentiality of the patient-physician relationship is a core tenant of the practice of medicine in the United States, that principle is not as strong in other cultures. One study found that compared to European- and African-Americans, Mexican- and Korean-Americans were less likely to believe that a patient should be told the diagnosis of metastatic cancer or a terminal prognosis or asked to make treatment decisions.²⁷ These findings suggest that doctors should consider asking their patients whether they wish to receive information and make medical decisions or they prefer their families to be involved in this process. However, cultural competence experts suggest, and the CLAS standards require, that patients who have limited English proficiency be communicated with through a trained interpreter, not a family member.

Acquire cultural competence through personnel.

Depending on the demographics of the population served and the size of the practice, physicians should consider hiring administrative personnel who are of, or have been immersed in, pertinent cultures and ethnicities. In addition to providing core administrative services, these employees could also help create a more welcoming environment, one that is more accessible to a particular population.

Coordinate with traditional healers.

Because some minorities use traditional healers while also receiving care from conventional sources,¹³ cultural competence researchers suggest that clinicians inquire whether their patients are utilizing such treatment. In that way, physicians can coordinate with al-

ternative care providers to ensure continuity of care and avoid complications due to incompatible treatment.¹³

Look to health plans for help.

To address concerns of members and employers regarding compliance with legal mandates (such as the CLAS standards previously mentioned), health plans have embarked on cultural competence initiatives to address health disparities.²⁸ Blue Cross and Blue Shield of Florida, for example, conducts disease management and outreach programs for minority communities and sponsors and participates in key minority community events. Blue Cross and Blue Shield of Florida also seeks to help its business partners increase their cultural competency by providing educational tools such as Quality Interactions, a case-based application that uses vignettes featuring minority patients. The tool provides feedback to users on the level of cultural competence they demonstrate during interactions with virtual patients. Blue Cross and Blue Shield of Florida is the first health plan to provide the program, without charge, to some of its network physicians. Providers who score adequately on a post-test are eligible for continuing education credits.

Conclusion

As the field of cultural competence and cross-cultural care evolves, more research is needed. There is little research linking cultural competence to outcomes and the reduction of health disparities, independent of confounding socioeconomic factors.¹³ Evaluation is also needed of cross-cultural education techniques to assess whether providers implement the lessons they learn and whether there is an impact on health outcomes and quality.¹⁹

However, cultural competence has shown potential in serving as a key factor in eliminating healthcare disparities. Furthermore, the demographic changes this country will experience, and the interests of governments and the private sector, are beginning

to demand more vigorous efforts to investigate the potential of cultural competence and to apply promising techniques. Cross-cultural education requires knowledge of communities in which a provider practices or trains. This information would include the social and historic context of the population, cultural and religious practices/beliefs, and disease incidence/prevalence.¹⁹ It's important for providers to understand the fluidity and diversity of culture, both within and among racial/ethnic groups, to avoid stereotyping and oversimplification, which could be counterproductive.¹⁹

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