

# Intercultural Competence in Health Care

## Developing Skills for Interculturally Competent Care

Rohini Anand and Indra Lahiri

**A** major challenge for today's health care providers around most of the world is that culturally diverse groups comprise the largest growing segment of the patient population. Individual health care choices and outcomes must be understandable to patients in terms of their own culture and experience. Thus, health care workers are faced with the need to develop intercultural competencies that allow them to recognize their own cultural norms, understand the patient's unique viewpoint, and effectively adjust their behaviors to maximize care.

While understanding the client's unique perspective is a challenge shared across industries, in health care, intercultural competence can be argued to be even more complex and challenging, primarily due to the intensely personal nature of the services offered, which often touch the core of patients' and providers' culturally influenced values, beliefs, and attitudes. Intercultural competence, also commonly referred to as cultural competence, may in the context of health care be briefly

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defined as the ability to deliver “effective, understandable, and respectful care that is provided in a manner compatible with [patients’] cultural health beliefs and practices and preferred language” (Office of Minority Services, 2000, p. 80865).

With global culture a reality in today’s health care systems and a clear mandate that interculturally competent care is a necessity for successful patient outcomes, how is it possible to learn about all the specific variations with regard to illness, health, care, communication, and other issues related to the delivery of health services? No one has a formula explaining all the variables for every culture. Attempting to provide training on specific cultures may be helpful, yet it is likely to backfire if the information is offered in a one-dimensional manner or if it is used to stereotype individuals.

The key to providing quality care to patients of all cultural backgrounds lies in developing skills to learn about cultural and personal beliefs in a respectful fashion. What are the questions that providers should be asking? What are the cues that a cultural clash may be occurring? How can care providers overcome cultural clashes? This chapter examines these issues and offers models and ideas for developing skills for interculturally competent care.

The field of medical anthropology is credited with shaping the discipline of inter-cultural competence in health care. Using ethnographic methods, medical anthropologists have studied relationships and interactions between care providers and patients, often with special emphasis on the physician-patient relationship. Medical anthropologists have often “described the traditional culture of Western medicine as being disease-oriented, focusing on biological concepts and processes, and largely discounting the importance of cultural and psychosocial factors to health” (American Institutes for Research, 2002, p. 6). This disease orientation is itself merely a cultural norm. By approaching medicine through only this norm and often discounting other cultural beliefs and approaches to health and illness, Western medicine has evolved into a service that inadvertently provides unequal treatment to patients whose cultural backgrounds differ from those of the majority of providers.

As the demographics of our world shift, with many countries experiencing global culture on a domestic level, intercultural competence is becomingly an increasingly critical skill, both to ensure quality care for all patients and to ensure the continuing economic viability of the industry. Indeed, Reynolds (2004) puts it succinctly when he says, “Cultural and linguistic barriers are posing a problem for an industry that is already financially strained. If strategies to provide more culturally appropriate care are not implemented, financial pressures will continue to rise, and quality of care will suffer” (p. 237).

## Overview of Business Case for Interculturally Competent Care

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Intercultural competence is a necessary component of any health care provider’s general competence. Not only are interculturally competent services being increasingly mandated at the federal and local levels, but cultural diversity among patient and patient populations is an ever-growing reality. Patient satisfaction, community support, patients’ willingness to seek treatment, and patient outcomes are all

dependent on culturally appropriate care and communication. The increasingly broad mix of cultures represented among health care patients and providers is evident with a simple review of recent statistics and projections:

In the United States alone:

- In 2006, not including people who identify as more than one race (who comprised 2% of the total U.S. population), African Americans constituted 12.4% of the total U.S. population, Latinos/Hispanics (who can be of any race) 14.8%, Asian Americans 4.4%, and American Indians or Alaskan Natives .8% (U.S. Census Bureau, 2006).
- From 2000 to 2050, White non-Hispanics will decrease from 69.4% of the total U.S. population to just over half (50.1%), while African Americans will increase from 12.7% to 14.6%, Hispanics (of any race) will increase from 12.6% to 24.4%, and Asians from 3.8% to 8% (no projections for American Indians and Alaskan Natives were provided) (U.S. Census Bureau, 2004).
- Nearly 55 million individuals, or 19.7%, speak over 30 languages other than English at home—an increase of nearly 23 million from 10 years before (U.S. Census Bureau, 2006).

Around the world:

- The world's population is aging: Between 2005 and 2050, the median age of the global population is expected to increase from 28 to 39, although developed countries across the globe have a significantly higher median age than do developing countries (United Nations Population Division, 2006).
- In developed countries, the current annual rate of population growth (excluding immigration) is less than 0.3%, while in the rest of the world, the population is increasing almost six times as fast. Because developed countries often have stronger economies and more job opportunities, an ever increasing number of young people from developing countries are migrating to developed countries, thus increasing cultural and ethnic diversity (McCarthy, 2000).

Given that people of color are often disproportionately affected by disease and health care problems, these statistics are significant. In fact, the impact of these demographic trends on health care quality is well documented. The *2004 National Healthcare Disparities Report* reveals that disparities associated with race, ethnicity, and socioeconomic status continue, especially with regard to patient outcomes and safety, timeliness, and patient centeredness (Agency for Healthcare Research and Quality, 2005). In 2001, the Commonwealth Fund also uncovered disparities, by race and ethnicity: “African Americans, Asian Americans, and Hispanics are more likely than whites to experience difficulty communicating with their physician, to feel that they are treated with disrespect when receiving healthcare services, and to experience barriers to care, including lack of insurance or a regular doctor. Moreover, a substantial proportion of minorities feel they would receive better care if they were of a different race or ethnicity” (Collins, 2002, p. v).

While health systems work to respond to the shifting populations among communities they serve, the public is becoming more involved in their own health decisions and therefore more demanding of individualized approaches to care. To compound matters, today's health care organizations participate in an extremely competitive market environment. Contrary to the economic model of most industries, wherein management decisions control the destiny of the organization within the marketplace, health care systems not only must satisfy their customers but also must adhere to guidelines set by third parties such as insurance companies and Medicaid, which apply pressure to keep costs down, in order to be paid for their services (Lahiri & Sedicum, 2000a, 2000b).

Thus, to meet the challenges of countless cultures merging into one health care arena in many parts of the world, health care systems must increase relationship-driven, individualized, and interculturally competent care while decreasing costs.

## Importance of Cultural Competence for Health Care Providers

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Prejudice can have a profound impact on the delivery of health care. If a provider is ethnocentric, his or her interactions, diagnosis, and treatment will be skewed by his or her biases. Intercultural competence is central to equalizing power dynamics in medicine that often lead to those with less power (such as those in a cultural, ethnic, linguistic, or economic minority) receiving a lower quality of care. As the American Institutes for Research (2002) point out,

Social issues such as stereotyping, institutionalized racism, and dominant-group privilege are as real in the examining room as they are in society at large. Therefore, the goal of cultural competence training in healthcare should be to guide physicians in bringing these power imbalances into check. This process, consisting of ongoing self-reflection and self-critique, requires humility. In fact, the concept of "cultural competence" may be better described as "cultural humility" (Tervalon & Murray-Garcia, 1998). (p. 22)

Often, when learning about cultural influences on approaches to health and illness, health care providers implicitly believe that they have a superior value system and the correct, most accurate approach to health care. For example, in some cultures, it is believed that when one talks about a death, it accelerates the loss of life. Many Western health care practitioners would view this as an erroneous belief. Similarly, in some cultures, the notion of affixing metal to a child's teeth and forcing the teeth to move would be considered cruel. Yet in the United States, this is a common treatment (braces) and viewed as standard practice.

Illustrative here may be an excerpt from an interview with a traditional healer of a Native American tribe (Lahiri, 2000):

Ogema, an Anishinaabe (Native American) healer and spiritual teacher explains his perspective on [the debate on integrating traditional and Western forms of

medicine], “Western science is trying to somehow legitimate traditional medicine when they do not even speak the same language as we do. The things that we consider proven beyond a shadow a doubt (just as much as they are convinced through their scientific procedures) are the same things they are saying need to be studied. Most Western physicians are not equipped to deal with our different reality, just as they have a reality we have difficulty with. (p. 1)

Medical ethnocentrism is a barrier to accessing health care because it inhibits a practitioner’s understanding of the patient’s beliefs and behaviors. This is especially true when these conflict with a provider’s diagnosis or treatment plan. Possible results of medical ethnocentrism are as serious as they are varied and can include exacerbation of a patient’s condition or even a patient’s death. For example, some patients may believe that to heal, they must show complete faith in God. For some, taking medication would be an indication of a lack of faith and therefore would actually cause them not to heal. If a provider does not know about or understand this belief, the patient’s noncompliance could lead to her or his death. If, on the other hand, the provider is aware of this belief, she or he can work with the patient to find a resolution that respects the patient’s belief system and also addresses her or his health issues.

Medical ethnocentrism on the part of the health care provider may cause patients to refuse to communicate beliefs or behaviors that they feel will cause a negative reaction in the provider, thus causing significant data to be lost. Providers may interpret situations using their own beliefs as a barometer and may be totally incorrect, or they may unknowingly prejudge based on their own implicitly held stereotypes and assumptions about a cultural group.

## Impact of Culture on Provider-Patient Relationships

Disparate treatment as a result of medical ethnocentrism has been shown to have a significant impact on quality of care (Institute of Medicine, 2002), specifically:

- Inaccurate diagnosis and treatment
- Exacerbated illnesses
- Noncompliance

In all of these cases, the quality of communication and the relationship between patient and provider is the key predictor of positive or negative outcomes. In fact, a great deal of attention has been paid to the lack of trust, understanding, and loyalty in the patient-physician relationship (Fredericks, Miller, Odiet, & Fredericks, 2006). Many times, these can be traced back to cultural differences between the health care provider and patient.

### *Case Study*<sup>1</sup>

Roberto, a terminally ill Latino, is referred to a hospice program. When the nurses visit his home, they are met by nine adults who appear to have come from all over the country. The adults all have various pieces of advice for the nurses. They

do not want the nurses to wear their hospice badges in the house. They also ask the nurse not to talk about death with Roberto but instead tell him that “he will be fine.” Roberto’s children are constantly asking him who he’d like to see and what he’d like to eat. The family members spend much of their time cooking his favorite foods and showing him pictures of family members who are unable to visit him.

### *Discussion*

Roberto’s hospice nurses may come from a cultural background that views full disclosure of their role as hospice care provider, as well as Roberto’s condition as terminal, as the morally appropriate behavior. They may feel that Roberto needs to know of his impending death in order to prepare for it and may be uncomfortable with what they perceive as dishonest and possibly disrespectful behavior.

Roberto’s family is likely to view talking about Roberto’s terminal condition as either unnecessary or unsupportive. They are likely to view their presence and behavior as providing Roberto with the information that he is not expected to live much longer. They may also feel that the kindest way to care for Roberto is by focusing only on the good: family, friends, loved ones, favorite foods, and perhaps music, flowers, and laughter.

Disclosure, then, is an example of an area where culture affects provider-patient relationships in both profound and challenging ways. To the provider socialized in a Western biomedical context, patient autonomy and self-determination are important. Telling the truth about the disease is seen as essential for patients to challenge the disease, be in control of the situation, and plan for the future. This is in sharp contrast with the cultures of others, where the patient is protected from bad news by the family. Patient autonomy is not seen as empowering but as burdensome. The provider, however, often feels that disclosure is necessary to allow the patient to make decisions about and to obtain consent for the treatment.

## **Cultural Barriers in Patient Care**

Cultural barriers between provider and patient may take a variety of forms. Some additional examples include the following:

- The patient’s level of comfort with the practitioner and fear of what he or she may find upon examination (e.g., the concern that the patient’s lifestyle and habits may not meet with the provider’s approval)
- A different understanding, on the part of the patient, regarding the role and function of the health care system and health care providers, which may vary greatly based on cultural context
- A fear of rejection of personal health beliefs. Patients may face providers who do not respect their beliefs and who may even challenge those beliefs. Given that many of these beliefs are rooted in the patient’s spiritual traditions as well as his or her cultural orientation, this is an extremely sensitive issue

- Differing expectations regarding the patient's ability to choose treatments. For example, the provider may feel that he or she has to lay out choices for the patient. If the patient sees the provider as an authority, having choices presented may be strange or unsettling for him or her

Understanding how powerfully cultural differences can affect the quality of patient care, with so many ways that cultural differences may arise, it becomes clear that understanding the patient's frame of reference is critical to providing quality health care services.

## Understanding the Patient's Frame of Reference

To meet the patient's expectations and to raise the chances of successful treatment, the provider must understand the patient's frame of reference. Different values to which the patient might subscribe are at the basis of the differing approaches to and expectation from health care providers.

### *Case Study*<sup>2</sup>

Thally, a 14-year-old Haitian immigrant who speaks a smattering of English, is referred to a mental health care provider, Donna. Her case report states that Thally was repeatedly scaring her ninth-grade classmates by telling them that she was possessed by a spirit and asking them to help her get rid of the spirit. Hospital authorities note that Thally refuses to eat or sleep. She sits on her bed, clutching her knees to her chest, and rocks back and forth. Although her parents have been informed of their daughter's illness and whereabouts, they do not come to see her in the hospital. They tell Donna on the phone that there is nothing wrong with their daughter. How might Donna familiarize herself with Thally and her parents' frames of reference, so that she can adequately evaluate the situation and develop a treatment plan?

### *Discussion*

Many Western-socialized health care providers, when faced with this situation, would fall into a trap of medical ethnocentricity, believing that there is no such thing as possession by spirits, and therefore Thally must be mentally ill. A useful approach for Donna might be to learn more about Thally's concerns. It would be most helpful if Donna could secure the help of an interpreter and ask Thally to explain what she is experiencing and what would help her. If Thally does not open up to Donna, she would do well to secure the advice of a person with expertise in Thally's belief systems. Perhaps a respected member of the Haitian community would be an appropriate intermediary in this case. Once Thally's experience and frame of reference are thoroughly understood, Donna will be in a position to develop a treatment plan that is appropriate within Thally's frame of reference. In many cultures, being possessed by a spirit may not be a cause for alarm or constitute

abnormal behavior. Or, there may be simple remedies that could help Thally to banish the spirit.

Similarly, Donna must also learn about Thally's parents' frame of reference, including their refusal to come to the hospital and their belief that there is nothing wrong with their daughter. Donna may have more success with Thally's parents by visiting them, along with an interpreter. Another option would be for Donna to ask the same trusted intermediary mentioned above to discuss the situation with Thally's parents.

We do not know whether Thally's family is in the country legally, and in some cases, illegal immigrants are fearful to talk with "officials" for fear of deportation. In some countries, mental institutions may be viewed as places of torture. There are many plausible reasons that Thally's parents may have for their behavior, based on their frame of reference and culturally based values.

## Different Approaches to Health and Their Impact on Treatment

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People have different "illness belief systems" or "a relatively coherent set of ideas regarding what causes illness and its course and treatment" (Chrisman, 1991). Chrisman (1991) organizes the range of illness causalities into four illness belief systems. This, he suggests, can be used as a starting point for understanding the patient's point of view. The four illness belief systems are germ theory, equilibrium, god- and spirit-caused illness, and sorcery and witchcraft.

It is critical that these belief systems be approached not just with respect but as truth. In other words, we cannot just acknowledge the belief and then try to make the treatment we want to use fit into the patient's belief structure. This only demonstrates our lack of understanding and will not help the patient. Instead, we must approach our treatment from the perspective of the patient, assuming the patient's belief is in fact the correct belief and working from that truth toward an optimal outcome.

Germ theory is the basis of Western medicine. It holds that tumors, abnormal cells, and chemicals are the causes of illness and disease. Germ theory is prevalent among most cultural groups across the United States and Canada, as well as many groups in Western Europe.

Equilibrium is a theory based on balance and holds that illness results when things are unbalanced. Chrisman (1991) advises Western clinicians to address this non-Western belief by suggesting that patients engage in activities or eat certain foods in moderation. The most common equilibrium beliefs are humoral pathology and harmony. The humoral pathology belief system maintains that the four humors—blood, phlegm, black bile, and yellow bile—must regain balance within one's body. When the humors are out of balance, illness is the result. The hot-cold system is one of the humoral pathology belief systems. According to this system, the body requires a balance of hot and cold. Medical conditions themselves are classified as either hot or cold and balanced by food and fluids (which are also classified as hot or cold) to restore balance. For example, a cold is treated with hot fluids but never with cold fluids, such as orange juice. Cancer, which is hot, should be treated



with cold remedies, while chemotherapy and radiation are heat producing and therefore compound the problem. Patients may therefore counter the treatment with fresh fruits and vegetables, which are cold.

Another equilibrium belief is harmony. In this belief system, health is brought about by harmony in a person's life, whereas being out of harmony causes illness. To become healthy, patients must first reestablish harmony and then treat the health condition specifically. Reestablishing harmony can be done through personal work, meditation and reflection, spiritual ceremony, or, in some instances, by visiting a medicine woman or man.

God- and spirit-caused illness theory attributes illness to divine causes. Sometimes in this belief system, dead ancestors are punishing or testing descendants for not honoring the family. In other situations, spirits may cause sickness and may need to be appeased before the patient can be cured.

Chrisman (1991) describes a fourth theory of sorcery and witchcraft as the cause of illness. Hexes, or evil eyes, may cause illnesses, in which case shamans or ceremonies can restore health by removing the hex.

These illness belief systems can have significant implications for health care. Sometimes a patient may believe that a physician can treat symptoms, but a traditional healer may be needed to eradicate the root problem before the sickness is cured.

### *Case Study*<sup>3</sup>

Alisa is a health care provider working with Yen, a Chinese woman who has recently been diagnosed with cancer. Yen speaks little English, and her husband translates for her. When her husband is present, Yen denies pain. When he leaves the room, she admits to having pain. Yen's husband indicates that he has very little faith in the U.S. medical community. Because he believes that pain medications interfere with the body's "natural healing process," he keeps her pain pills out of Yen's reach. Instead, he provides his wife with curative herbal teas. He also refuses to let Alisa tell his wife that she has advanced stages of cancer.

### *Discussion*

It is easy to see how this scenario presents challenges and perhaps some confusion or frustration for the health care provider. Is Yen in pain, or not? Is her husband preventing Yen from receiving the best possible treatment and causing her to endure pain because of his beliefs? Does Yen agree with the decision to replace pain pills with herbal teas? Should not Yen be told the truth about her cancer?

It is important that Alisa, the health care provider, does not make judgments hastily. It would be easy to assume that Yen is telling the truth about her pain when her husband leaves the room and that perhaps her husband is not translating accurately. However, we do know that Yen speaks very little English. She may be agreeing with Alisa that she is in pain because she does not understand. Yen may also hold the cultural belief that it is impolite to disagree and be trying to please Alisa by saying that she is in pain. Yen may also be agreeing with her husband out of a similar desire to please.

In many cultural belief systems, our thoughts and feelings play a crucial part in our healing. Therefore, Yen's husband's preference not to tell Yen about how advanced her cancer is may be a desire to support her in continuing to think positively about healing. Taking pain medications could also depress Yen and cloud her thoughts, so these, too, would interfere with healing.

The most helpful thing that Alisa could do would be to bring in an interpreter who is not related to Yen. Through the interpreter, Alisa could respectfully learn more about Yen's and her husband's belief systems. Together, they could then build a treatment plan that provides the best possible care and is comfortable within the framework of the patient's culture.

It is important that the provider listen and understand the patient's belief system to avoid stereotypically assigning beliefs to members of certain ethnic groups.

Frequently, "alternative" health beliefs may be subscribed to when biomedicine is not successful, when the treatment is too long or expensive, or when the problems are psychological. Often, "alternative" medicines are used simultaneously with Western medicine for the terminally ill.

Providers should think through how they will respond if there is a conflict between what they believe and what their patients believe. In some cases, the provider's and patient's beliefs may complement each other, yet in many cases, they may seem to contradict one another. Developing strategies for addressing these situations is critical for a culturally competent provider.

The provider who does not take the patient's beliefs into consideration when developing a treatment plan is likely to wind up with a noncompliant patient or to be dismissed. Listening to the patient's explanation of the cause of the illness without judgment might suggest whether the treatment will be successful or if an alternative treatment should be suggested (Harwood, 1981).

Different values systems may affect a variety of aspects of health care, such as the degree to which the family is involved in the patient's treatment. In collectivist cultures, for example, decisions are made by a family unit or other group, and the patient is not expected to decide on the treatment independent of the family's involvement. There might also be a preference for addressing important news to the family rather than to the patient alone.

It may be necessary for providers to work within the family hierarchy to ensure success of the treatment plan. Often a family member, perhaps the oldest male, might make decisions for the patient.

The gender of the provider might become an issue in the success of treatment. Patients from some cultures may value male opinions above those of female clinicians, while women from some cultures may be uncomfortable with a male health care provider.

There are often differing expectations of the provider's role and scope of responsibilities. The potential discrepancy between the provider's and patient's expectations can be compounded when the interaction takes place across cultures. While some may expect that the health care provider will offer holistic assistance, others will expect that the service will be more narrow and targeted. Yet others may not be satisfied with a visit to the doctor unless they receive an injection or a prescription. These differing expectations can result in misunderstanding and a breakdown of trust.

Personal history sharing may be an alien concept to patients from some cultures, and thus providers may not get the information they need for successful treatment. Many patients feel that certain health problems, particularly mental health concerns, should be dealt with within the family or community. Hence, if a provider is not seen as a part of the community, additional challenges may arise.

Attitudes toward seeking help from the health care system may vary, and as a result, providers may see a higher representation of chronically ill patients from some cultural groups. Some groups may mistrust the health care system, while others may rely on the family and turn to an outsider as a last resort. This is particularly true of mental health patients, where there may be a stigma associated with mental illness.

Patients may have different experiences around pain and what they label as a symptom based on their cultural framework. For some individuals, the tolerance for pain may be higher because of cultural norms. Hence, some patients may wait longer before they label pain as a symptom or communicate it to the provider. Similarly, what is labeled as a symptom in some cultures may be the norm in others.

## Conflicts Between Provider and Patient

Conflicts between a provider's and patient's worldviews can result in a misdiagnosis of the problem, an inadequate treatment plan, or noncompliance to essential treatment. Such a conflict can be resolved in many ways. Leinenger (1988) describes these interventions as different "modes of care."

One option might be cultural preservation, or maintenance of the patient's perspective. Often, traditional treatments can complement the Western medical treatment plan, and in such situations, it is important to collaborate. For example, drinking herbal teas is not in conflict with biomedical treatment. The provider will get better results by acknowledging the tea and recommending it in conjunction with her or his preferred approach.

Compromise and accommodation are also options for the provider to consider. In such situations, the provider can make changes to the treatment plan to accommodate the patient. When the patient's requests are not harmful to him or her, the provider should promote their use (Leinenger, 1988).

In some situations, the patient's worldviews may be in direct conflict with the provider's preferred treatment plan. In these situations, it is useful for the provider to educate himself or herself about the patient's frame of reference and reasoning. This could be as simple as reading about specific cultural beliefs online, although we strongly recommend that any reading or independent research be supplemented by respectful conversations with diverse members of the patient's cultural group, as well as the patient. Once the health care provider has truly understood the patient's position, she or he can introduce alternative treatments as necessary. Before the provider makes recommendations, however, it is necessary to evaluate the consequences for the patient and his or her family and balance that against the provider's illness theory, with the ultimate goal of the well-being of the patient.

Underlying all of these options is the importance of the provider listening to the patient's explanation of the cause of illness without judgment. Listening to the cause and understanding the preferred mode of treatment suggests whether the treatment will be successful and whether an alternative will be followed.

## Models for Interculturally Competent Care

There are several models for developing intercultural competence, three of which we will refer to in this chapter because we find them to be the most useful. These include Campinha-Bacote's (2002) culturally competent model of care, Milton Bennett's (1993) developmental model of intercultural sensitivity, and Darla Deardorff's (2006) process model of intercultural competence.

The culturally competent model of care, developed by Josepha Campinha-Bacote (2002), was developed specifically for the health care industry. In this model, cultural competence consists of several critical elements, including cultural awareness, cultural knowledge, cultural skills, and cultural encounters. In combination, these have the "potential to yield culturally responsive assessments which will in turn yield culturally relevant interventions" (Campinha-Bacote & Padgett, 1995, p. 33).

Cultural competence, in Campinha-Bacote's (2002) view, is a process, not an event, "in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of an individual or community from a diverse cultural/ethnic background" (p. 181).

Cultural awareness requires recognition of and sensitivity to the patient's perspectives, especially when the patients are from a different culture than the provider is. Exploring our own biases and prejudices, as well as developing a clear understanding of how these affect our interactions with culturally diverse patients, is the first step in developing cultural awareness. Campinha-Bacote (2001) makes a clear distinction between a "culturally sensitive" approach and a "culturally responsive" approach. She explains that "a culturally sensitive approach requires only an awareness of the values, beliefs, life ways, and practices of an individual, while a culturally responsive approach incorporates the individual's values, beliefs, life ways, and practices into a mutually acceptable treatment plan" (p. 11).

Cultural knowledge refers to the health care provider obtaining information about the other cultures' perspectives and beliefs about health and illness, whether this knowledge is gained through reading, academic pursuits, conferences, workshops, or talking with members of specific cultural groups. Campinha-Bacote (2002) cautions against stereotyping, pointing out that not all people from a given cultural background hold the same belief systems. Instead, she suggests that cultural knowledge can be used by health care professionals as a starting point in developing relationships with individuals from specific cultural groups and that through those relationships, relevant points about a patient's personal and cultural orientations will emerge.

Of course, each patient is an individual, with experiences, perceptions, and beliefs that may not be shared by his or her cultural group. It is therefore critical that health care providers learn how to gather information directly from patients through respectful and sensitive questions and conversation. These skills prevent cultural

knowledge from being applied stereotypically to all members of a cultural group. Campinha-Bacote (2002) refers to cultural skill as the process of learning how to gather information about a patient's culture. Campinha-Bacote suggests that conducting a cultural assessment (which is how she refers to the process of gathering information about the patient's individual beliefs, values, practices, and life ways) requires much more than a list of assessment questions, as some other theorists have suggested. She argues, instead, that the best way to elicit the needed information is through gaining trust and developing relationship, which is done through each provider's unique personal style. This style, of course, can and should be flexible to accommodate patients' cultural norms. The cultural assessment phase requires both awareness and knowledge to sensitively elicit information directly from the patient.

Cultural encounters, another component in Campinha-Bacote's (2002) model of cultural competence, refer to activities that allow the practitioner to experience a given culture firsthand. These may include spending time in an ethnic community, maintaining relationships with several members of a cultural group, or other similar firsthand activities. The purpose of cultural encounters is for health care providers to engage directly in cross-cultural interactions with diverse patients. It allows health care providers to check their own understanding of specific cultures and prevent stereotyping.

The developmental model of intercultural sensitivity, developed by Milton Bennett (1993), described also in Chapter 1 of this handbook and consisting of a continuum of six stages moving from ethnocentrism to ethnorelativism, is also particularly useful in the health care arena. The ethnocentric stages in Bennett's model are denial, defense, and minimization. As one develops intercultural sensitivity, he or she moves from ethnocentrism to ethnorelativism. The ethnorelative stages are acceptance, adaptation, and integration.

In the first stage, denial, an individual denies that cultural differences exist. For example, a provider in this stage is likely to presume that the patient shares the provider's illness belief system and therefore will not notice any cues that the patient is viewing her or his condition and treatment differently. This position may be more common among individuals who do not interact routinely with culturally diverse groups. In the second stage, defense, an individual recognizes that cultural differences exist but constructs defenses against the differences because they are threatening to her or his own reality and sense of self (e.g., a provider in this stage may have the point of view that "they are in the United States now; they must know that we don't have the evil eye here").

The third stage in Bennett's (1993) model is minimization. An individual in this stage acknowledges cultural differences but minimizes them, reasoning that human similarities far outweigh any differences. For example, a provider may concede that a patient views the cause of her or his illness differently yet concludes that, since the patient and provider both want the patient to get well, the cause of illness is irrelevant, and the course of treatment will be agreed on. The danger of this stage is that similarity is assumed rather than known, so that the provider may not check for agreement on the course of treatment and never find out that the patient has no intention of complying. In the fourth stage, acceptance, an individual recognizes and values cultural differences without evaluating those differences as positive or

negative. This stage moves an individual from ethnocentrism to ethnorelativism. First comes a respect for cultural differences in behavior and then a deeper respect for cultural differences in values.

In the fifth stage, adaptation, individuals develop and improve skills for interacting and communicating with people of other cultures. The key skill at this stage is perspective shifting, the ability to look at the world “through different eyes.”

The final stage of Bennett’s (1993) model is integration. Individuals in this stage not only value a variety of cultures but are constantly defining their own identity and evaluating behavior and values in contrast to and in concert with a multitude of cultures. Rising above the limitations of living in one cultural context, these individuals integrate aspects of their own original cultural perspectives with those of other cultures.

The major theme that emerges when studying intercultural competence in health care is understanding the patient’s worldview and perspective, which is addressed in Deardorff’s (2006) process model of intercultural competence (also discussed in Chapters 1, 3, 19, and 28, this volume). In fact, Deardorff created her model based on input from leading intercultural communication experts and scholars, and the only element of intercultural competence that 100% of the experts agreed on was understanding others’ worldviews and perspectives.

Deardorff (2006) organizes her model by four major components, each of which includes specific attributes, skills, and behaviors that comprise intercultural competence. The categories are as follows:

Attitudes

Knowledge and Comprehension and Skills

Desired Internal Outcome

Desired External Outcome

Attitudes include respect, which is defined as “valuing other cultures” (p. 256); openness, which refers to “withholding judgment” (p. 256); and curiosity and discovery, clarified as including tolerance of ambiguity. Thus, for a health care provider, these attitudes would allow one to appreciate and accept different illness belief systems, an integral first step to providing culturally competent treatment.

Knowledge and comprehension in this model include cultural self-awareness, deep cultural knowledge, and sociolinguistic awareness. The skills in this stage of the model include listening, observing, and evaluating, as well as analyzing, interpreting, and relating. Hence, in the realm of health care, a person with these skill sets would be adept at learning about patients’ cultures and would therefore be more agile in her or his ability to provide appropriate care.

The desired internal outcome is an “informed frame of reference shift,” which requires adaptability, flexibility, an ethnorelative view, and empathy. This would mean that a health care provider would have the requisite liveness to provide whatever the patient needs.

The desired external outcome refers to “effective and appropriate communication and behavior in an intercultural situation” (Deardorff, 2006, p. 256), which is the ultimate goal in the health care arena, providing interculturally competent care.

Deardorff’s (2006) model is useful for a variety of reasons. It reflects the most current thinking of today’s leading intercultural competence scholars versus being the theory of only one or two experts, as is usually the case. Her model also remains flexible so that, as the world and our view of it changes, the model can be adapted as well. It emphasizes that developing intercultural competence is an ongoing process that one never finishes completely and also encompasses more than just behaviors or skills, pointing out that our attitudes and even emotional responses play critical roles in intercultural competence.

## Conclusion

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Intercultural competence in health care, defined as the ability to deliver “effective, understandable, and respectful care that is provided in a manner compatible with patients’ cultural health beliefs and practices and preferred language” (Office of Minority Services, 2000), is indispensable in today’s health care industry. Not only does the provider’s level of intercultural competence directly affect patient outcomes, but the health care organization’s level of intercultural competence is directly related to its continuing financial viability as an organization.

For providers, the key to providing quality care to patients of all cultural backgrounds lies in developing skills to learn about cultural and personal beliefs in a respectful fashion. Through case studies and discussion, we have provided examples of the kinds of questions that providers should be asking, as well as some cues that a cultural clash may be occurring and ideas on how care providers can overcome cultural clashes.

For health care systems, the key to remaining financially viable and providing interculturally competent care lies in developing and implementing long-term strategies and systems that support both providers and patients. For example, health care professionals would do well to examine their policies and practices, forms, meals, and so on to ensure that patients from all walks of life will feel welcomed and nurtured. They must also examine the ways that they recruit, select, manage, develop, and support their staff to ensure that staff is given the skills and tools they need to provide interculturally competent care and that they are held accountable for doing so.

Together, providers and patients co-create interculturally competent health care that is respectful and effective. Only through these partnerships can we ensure optimal patient outcomes.

## Notes

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1. From Anand (2001, p. 33). Used with permission.
2. From Anand (2001, p. 123). Used with permission.
3. From Anand (2001, p. 111). Used with permission.

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