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Cultural competence in clinician communication

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Abstract

1. To define cultural competence.
2. To understand the need for cultural competence.
3. To understand the changing child demographics of the United States.
4. To understand the process of becoming a more culturally competent clinician.
5. To learn tools and techniques that help achieve cultural competence.

Keywords

cultural competence; diversity; health disparities; self-awareness; self-reflection

Introduction

In teaching cultural competence, I sometimes encounter hesitance as demonstrated by comments that suggest the content is something that cannot be taught or learned. In other words, some clinicians are just more sensitive than others when it comes to issues of cultural differences. And indeed, there are some instances in which we preach to the choir, if you will, regarding attitudes toward cultural competence. However, there are skills that can be imparted to help all clinicians regardless of attitudes. As Dr. Joseph Betancourt concludes, we would not accept substandard competence in other areas of clinical medicine; cultural competence should not be an exception (1).

The take home message of this review article is that skills can be acquired, practiced, and honed on the journey of becoming a more culturally competent clinician. I will review the evolution and benefits of cultural competence in pediatric practice, as well as provide examples of questions that can be asked to provide more comprehensive care to the patient and their family.

Evaluation of cultural competence can be achieved in several ways. For example, evaluations and/or satisfaction surveys from patients, families, and staff, otherwise known as 360 degree evaluation, in a busy pediatric practice can provide useful feedback that prompts change in behavior. Observation, one of the best tools for evaluating clinician behavior, can be performed using either with standardized patients or real patients. Observed role plays with standardized patients is something we do at the medical school to provide students with formative feedback to improve their interviewing skills. Observation of real patients or unidentified standardized patients, similar to the observation model used in education, captures clinician behavior real-time when functioning under pressure.

The landscape

The Institute of Medicine issued its landmark report around health disparities in 2002 referencing inequities in adult healthcare services. Pediatrics is no exception to the health disparities landscape, many health outcomes being complicated by childhood poverty. Classic examples of pediatric health disparities include immunizations, asthma, and teen pregnancy.

Although health disparities and cultural competence are often used interchangeably, cultural competence is one vehicle - along with increased access, insurance coverage and others - that can improve health outcomes through improved communication, increased trust and understanding between patient and clinician.

What is cultural competence?

Culture is defined as patterns of human behavior that are part of a racial, ethnic, religious, or social group. I might add there are other social groups that can be defined by age, generation, ableness, body image, mental illness, etc. Characteristic behaviors can include thoughts, language, customs, beliefs, and institutions. For example, I do not think anyone would deny that adolescents are their own culture—subculture—characterized by how they communicate, how they wear their clothes, types of music they listen to, and what they value.

Some of the variance across cultural groups can be affected by immigration, family structure, educational attainment, and socioeconomic status. The importance of educational attainment as an influence on socioeconomic status cannot be overstated and is highly predictive of health outcomes for children.

Cultural competence, therefore, is an acknowledgement and incorporation of, on the part of clinicians and healthcare systems, the importance of culture, the assessment of cross-cultural relations, vigilance towards the dynamics that result from cultural differences, the expansion of cultural knowledge, and the adaptation of services to meet culturally unique needs. Some of my colleagues have stated that they interact with all patients in the same manner. Indeed, being culturally competent would imply that you not treat patients the same, given what cultural dynamics they bring to the healthcare encounter.

Cultural competence is a concept that has slowly come to medicine, although upon review of the literature, one can see this concept has been discussed in the nursing and psychology literature extensively. Cultural competence terminologies have evolved over the last two decades, from cultural awareness to cultural sensitivity to cultural competence. Other terms such as cultural effectiveness and cultural humility are currently being used. Regardless of the term used, we recognize the principles of cultural competence most often when they are absent. These principles include *empathy*, *curiosity*, and *respect*, with which comes a heightened understanding and appreciation of the social context of the patient.

The term, “cultural competence”, which I will use for the purposes of this discussion because it is a familiar term to most clinicians, falsely implies some endpoint that can be reached. The exact opposite is true; you never become, “competent.” Cultural competence is a process, built upon by asking questions of the patient and family, but also of yourself.

Why is cultural competence timely and crucial?

Wherever you may be, you are in the midst of observing a rapid change in the demographics of the child population of the United States. New York is one of several states that has stood apart in terms of patterns of immigration over the last century. The immigrant child population is the fastest growing portion of the child population. In contrast to the White European and English speaking immigrant populations that migrated to the United States in the early 20th century, now families from the Caribbean, Africa, and Asia constitute significant immigrant groups.

Noteworthy is the ever-growing Latino population. Immigrants from Mexico and Central America are settling and raising their families here, and similar to other immigrants, come looking for greater economic opportunities or seeking safety from war conflict. It is estimated

that by the year 2020, Latino adolescents will be the largest minority youth population and approximately 40% of all youth will belong to a minority group.

Given the change in the cultural makeup of the United States, we as healthcare clinicians are being challenged like never before to provide cross-cultural care that is sensitive, effective, and meets the needs of the patient and family. Cross-cultural care requires that clinicians be open and seek to understand the various dynamics that play into the patient-clinician encounter such as: 1) variation in the perception of illness; 2) diverse belief systems around health; 3) differences in help-seeking behaviors; and 4) preferences in approaches to health care.

Therefore, cultural competence is not a question of, “doing the right thing.” It is an important vehicle for patient satisfaction and safety, and improved health outcomes.

The cultural divide

One of the first challenges for culturally competent practice is acknowledgement that medicine is its own culture, often at odds with the cultural orientation of patients we serve. Western medicine puts a high priority on concepts like individualism, emphasizing that the individual has control over his/her health. Western medicine also endorses that diseases have specific causes, that there be one system of care to address the disease, and that patients adapt to the system. Specific to pediatrics, we may have particular assumptions about family dynamics and how families mobilize on behalf of their children to make healthcare decisions.

In contrast to the culture of Western medicine, patients’ cultural norms demonstrate more community than individual orientation, conceptualize things as being beyond their control, see disease as a result of misfortune or imbalance, and may use other treatments in combination with or to the exclusion of Western medicine. In order to bridge this gap, the onus is on the clinician to ask questions that uncover these orientations to health and illness such that they can be integrated into the caretaking of the patient and family and negotiated, if possible, when it comes to making healthcare decisions.

What does it take to be a culturally competent clinician?

As I alluded to in the previous section, cultural competence involves empathy, curiosity, and respect. While being aware of the history and health beliefs/practices of a particular cultural group can provide a foundation for understanding, this knowledge needs to be carefully balanced to avoid stereotyping and accommodate diversity within groups. Resources such as *Working with an Interpreter: Stronger Outcomes Tips* at www.massgeneral.org/interpreters/working.asp and additional links cover general information regarding various racial/ethnic groups. In addition to these broad strokes, there is an important role for asking questions, to acknowledge and create deeper understanding of how the many layers of culture interact within the patient and family to influence health care.

Before beginning the process of engaging with the patient, we have to have an idea of our own positioning which comes with self-reflection. There are five key goals to engage in this process of becoming culturally competent.

- The first is the capacity for being self-aware. In other words, are you aware and mindful of your own cultural beliefs, values, and behaviors? How do these affect your interactions with patients? If you cannot manage your biases for the sake of the patient, do you recognize that limitation and defer to a colleague? A classic example is counseling around reproductive health choices including abortion. If such counseling is not congruent with a clinician’s beliefs, then he/she should facilitate linking the patient with someone who can do such counseling.

- The second is being aware and accepting of cultural differences. This is self-explanatory and implies developing a value for diversity.
- The third is understanding the dynamics of difference. This is a particularly important point for physicians, given how much power is bestowed upon us by our titles, white coats, etc. If we believe in a particular treatment for a patient, and they do not agree based on cultural difference, because of our power, we may not respect and work with that difference. Sometimes we “work” the patient to fit into what we think is best for them.
- The fourth is assessing cultural knowledge. Our cultural knowledge is shaped by interacting and integrating lessons learned from those colleagues and patients with whom we interact. We also have to be aware of our limits and know when to ask for help with particular populations we may be less familiar with in order to determine core principles for a particular culture.
- And finally, to be a cultural competent clinician we have to be able to adapt to diversity. How do we adapt to the needs and preferences of our patients? Are we open to different approaches to the same problem?

The surprises and challenges of cross-cultural communication

When we work with patients and families, we need to be open to what they tell us. Cultural competence is not only a practice to engage in when the patient speaks a different language or looks different than we do, but should be engaged with *every* patient. Some of the most surprising instances of cultural disconnects are with those patients and families who look like us.

As an African-American clinician, I have experienced colleagues referring African-American adolescents to me assuming that I will automatically bond with them. Though African-Americans in America may have common experiences, I bring my own orientation to clinical encounters. My orientation may or may not be congruent with the orientation of the patient. Regardless of our shared skin color, we may not have the same values, perspectives, or choices.

Given the challenges in our everyday practices, how do we negotiate across cultures with families? First steps are to recognize our biases in a particular situation. Are we able to sidestep the bias or do we need to refer on? If we can sidestep the bias, how do we create time and space to reassess that bias and from where it originates? How do you organize these efforts for your office team? With self-reflection, can we change how we engage with patients and families?

What are the key questions we need to ask?

1. Exploring the meaning of illness

Patients may hesitate to offer their beliefs and fears, which can be overcome through respectful questioning (Table 1). We can save time during the encounter by having the patient help set the agenda for the visit and therefore, get their needs met. We can also bridge a gap by recognizing the role of complementary and alternative medicine, which may shed more light on a patient’s explanatory model for health or illness. The next three patient examples, all of which are real, are meant to highlight how asking or not asking these questions can help or hinder a patient-clinician interaction, respectively.

- *A 17-year-old African American girl is coming in for what looks like a well child check. While doing a psychosocial assessment, she appears agitated to you. After some time, she expresses to you that she wants birth control pills.*

This is a case of asynchronous agendas. The patient's agenda here is very well defined, basically to not be or become pregnant. What we come to find out with asking more of a psychosocial history is that her 2 older sisters were adolescent parents and that she is eager to avoid the same outcome. She was seeking birth control at this visit and had specific ideas about what method she wanted and why. Questions to elicit the patient's agenda such as, "*How can I be most helpful to you?*" at the beginning of the visit could have set the frame for the visit and increased her satisfaction with the visit.

- *A 15-year-old White girl and her mother come in for consultation regarding general body aches and sleep disturbance. The patient had already seen various specialists and thankfully, had a relatively benign workup. The mother had consulted family members, friends, and neighbors regarding what could have been wrong with her daughter. In particular, the girl's aunt seems to have had quite a bit of say regarding potential causes and non-medical treatments for the patient's problems.*

The clinician, in this case, had to negotiate with more people than were actually present in the room at the time of the visit. Being respectful and listening to the ideas of the family were important to establishing rapport with this family. Questions such as, "*Have you used non-medical remedies or treatment for your problem?*" can help open the door to a comprehensive conversation about how patients help themselves.

It also gave the clinician a sense of their openness to complementary and alternative medicines. Some of the therapies that were proposed and accepted by the family included melatonin/valerian root for sleep disturbance, peppermint for stomach upset, and yoga for general conditioning. Also continued biofeedback therapy, which the family was already engaged with, was encouraged. Asking about and coordinating care with complementary and alternative medicine clinicians or traditional healers in the community can be validating to a family and encourage a non-mutually exclusive approach to a health condition.

- *A Chinese father brought in his 9-month-old son for a well child visit. The baby had been doing well. The baby's grandparents, though, had been putting pressure on the father to start feeding the child eggs. The clinician summarily told the father that eggs are not recommended until 12 months of age because of risk of food allergies. She suggested the father use her as the scapegoat with the grandparents for adhering to this recommendation.*

This case encompasses the issue of who advises a parent about their child's health. Even though we pediatric clinicians see ourselves as the pillars of prevention and health, there are many other influences at play in the daily lives of our families, like grandparents. There is a missed opportunity here in terms of inquiring about the cultural importance of eggs in to this Chinese family's diet. Questions like, "*Tell me why this is important to you and your family*", open a dialogue to increase understanding of this family's explanatory model for health. Instead, this clinician forecloses the conversation with no guarantee that the father is onboard with the recommendation or that the father will again disclose the family's health beliefs.

2. Social context "review of systems"

As we know, the social context of our patients can very much affect their health and presentations to us. Poverty, again, is one of the most significant barriers to health and access to healthcare. Also from the Carrillo reference, highlights questions we can ask in the clinical encounter regarding resources, change in environment, social supports, and literacy that can open the dialogue (Table 2). If we understand these social factors, we appreciate the challenges our patients encounter and compensate for them in our counseling and treatment. Four actual patient cases follow here.

- *A 7-year-old boy has just been diagnosed with ADHD. His mother is eager to have him on medication because of the pressure she is getting from his school. Unfortunately, she has switched jobs and in between insurance plans. The out-of-pocket cost for a 30-day supply of stimulant medication would be \$200 for the month between this visit and when the mother would potentially have her new insurance plan.*

The clinician in this case was able to uncover that finances were an issue for this family and would impact the family's ability to purchase and therefore be adherent with the medication regimen. In light of this, frank discussion around how much the family could afford was possible. The mother agreed to the idea of purchasing the medication for 2 weeks until she met her next pay period. Also being able to consult social workers or community health workers to do outreach to a family can increase access to services as well as increase understanding of the challenges families may face.

- *A 12-year-old girl with sickle cell disease who emigrated from Jamaica is having adjustment reaction issues and conflict with her mother. Her mother who is now an illegal alien, has had a dramatic change in her earning potential in comparison to their middle class lifestyle in Jamaica. The family emigrated for better healthcare for the girl.*

This patient, as is the case with many immigrant children, was in between two worlds. She was mourning the loss of the life she had in Jamaica, at the same time being confronted daily with the unpredictability of her family life in a new country. Her mother had to work jobs that paid "under the table", which sometimes meant her mother needing to move away for months at a time and leaving the patient with other family members. Questions like, "Tell me what brought you to this country" and "What was life like for you in your country?" elicit information regarding place and family of origin, changes in socioeconomic status, and acculturation issues. Or, as in this mother's case, just letting the patient tell their story answered many of the questions encompassed here.

- *A 19-year-old African American young man is dealing with the second recurrence of his cancer. He is admitted to the hospital. Both parents are vigilant and at the bedside. There are various family members and church members who come to pray for him. The number of visitors became more of an issue as the patient became neutropenic and needed isolation.*

It is clear that for this family, their spirituality is very important. They are connected to their church and appreciate the prayers that the congregation has for them. Apart from his family, spirituality is important for this young man also. He had taken on many active roles in the church including maintaining the church property and helping some of the more elderly parishioners. These parishioners, in turn, visited for the sake of laying on of hands to facilitate prayer and healing of the patient. Questions like, "Who is your support?" would uncover this family's religious beliefs and connectedness to their church community. This understanding would also help anticipate the expectations of the patient and family around visitation.

- *An 8-year-old boy and his 6-year-old sister are brought in to the doctor's office for rashes. Their mother is from Puerto Rico and the family moved several years before for better economic opportunities. The mother speaks Spanish only. There is no interpreter, but the clinician attempts to communicate with the patient.*

Every patient has the right to be understood. This was a very awkward situation in which the clinician did not speak Spanish and instead was gesticulating and yelling to get his points across. The mother was concerned and it was not clear by the end of the encounter that she understood what the diagnosis was, what the treatments were, or how they were to be used. This opens the window for medical error. Knowing the language the patient speaks, preferably

before the visit, can allow for planning for an interpreter and developing a working scheme with the interpreter. The use of family members as interpreters should be avoided despite being convenient. Family interpreters may not be able to interpret medical terminology and may hinder open communication on the part of the patient or themselves, knowingly or unknowingly.

This was a case of language being a barrier, but literacy can be a barrier in any language and should be considered when counseling and giving patient instructions. In those cases, pictures and diagrams can be a helpful way of overcoming the barrier.

3. Cross-cultural negotiation

Part of what we have to do in the course of the encounter is to negotiate a treatment plan for the patient. This final case, experienced by the author, exemplifies differences in explanatory models for illness, the influence of family members, and the need to bridge the gap. Table 3 includes action steps that you can implement in order to create shared understanding and agreement, or at the very least an acknowledgement of clinicians' and families' boundaries.

- *A 5 year-old African-American boy with sickle cell disease who is non-adherent with his prophylactic medications. His mother thought the medications made him sick because once he stopped taking them, he had no further hospitalizations for his painful crises. When encouraging the mother to reconsider his prophylactic medications, she hesitated to make that decision without her own mother, the child's grandmother. A family meeting was arranged.*

The mother's explanatory model is that the prophylactic medications used for sickle cell disease bring on the pain crises. Therefore, the family did not give the patient the medications to avoid this perceived consequence. And as luck would have it, the patient did not have pain crises during that period of being off the medication, thus reinforcing the explanatory model.

This patient's mother was not comfortable with the idea of making a decision regarding medications for her child without her mother's input and approval. The maternal grandmother clearly had an important role in terms of brokering power around medical decision-making. She also was a caregiver for the child and would be the main person responsible for administering his medications.

The family meeting gave the medical team a chance to re-explore with them their conceptualization of how sickle cell works and to reorient that within the biomedical framework. Mutual understanding was accomplished and all family members present actively agreed to restart the prophylactic medications. The team would not have made progress with the non-adherence issues without involving the maternal grandmother very early on in the negotiation process.

This case was unhindered by real conflict, time pressure, or imminent health risk. Difficult negotiations are often characterized by apparent absolutes on the part of clinician, patient/ family or both. Even what appears to be absolute can be relative and leave room for negotiation and compromise. Involving a family's traditional healer, religious or community leader can help broker a difficult negotiation as well.

At the systems level

There are potential cultural competence interventions at the systems level as well. We can demonstrate our value for diversity in our hiring practices of clinicians and office staff. We can support cultural competence training of our office staff to enhance the quality of care provided at every point of the patient encounter. Our educational materials and posters on

display can have diverse models and be in different languages. Techniques like culturally competent health promotion, interpreter services, training and accommodations, like time and space for self-reflection, can communicate a value for diversity within the practice or service.

Summary

In this article, I have reviewed the definition and need for cultural competence given the ever changing childhood demographics in the United States. Indeed undergoing the process of becoming a culturally competent clinician is to have the fundamental attitudes of empathy, curiosity, and respect that are constantly being reshaped by self-reflection. Clinicians can develop their skills in cultural competence by incorporating questions regarding the meaning of illness, social context “review of systems”, and negotiating explanatory models and treatment options into their interviews with patients, whether they be sick or well. We can further solidify our commitment to culturally competent practice by diversifying our staff, and ensuring that our office environment and protocols are inclusive and respectful of other cultures.

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References

Suggested references: The references below provide further information regarding: 1) census data; 2) racial/ethnic disparities; 3) standards for culturally competent care; 4) frameworks for negotiating cross-cultural care; and 5) clinical examples

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References

Websites Resources: These resources provide guidance around understanding the community in which you practice and how to facilitate cross-cultural and cross-lingual clinical encounters

1. Culture Clues at <http://depts.washington.edu/pfes/cultureclues.html>.
2. CulturedMed at <http://culturedmed.sunyit.edu/>.
3. DiversityRx at www.diversityrx.org/.
4. The Manager's Electronic Resource Center at <http://ethnomed.org/>.
5. National Center for Cultural Competence at <http://www.georgetown.edu/research/gucdc/nccc/>.
6. U.S. Department of Health and Human Services. *National Standards for Culturally and Linguistically Appropriate Services in Health Care. Final Report. 2001 Mar.* at <http://www.nhmamd.org/pdf/CLASfinalreport.pdf>.
7. Working with an Interpreter: Stronger Outcomes Tips at www.massgeneral.org/interpreters/working.asp.

References

Evaluation Tools: These resources provide tools to evaluate providers, offices, and larger health systems on cultural competence practices.

1. Cultural Competence Health Practitioner Assessment at <http://www11.georgetown.edu/research/gucchd/nccc/resources/index.html>.
2. Cultural-Competency Organizational Assessment – 360 (COA 360) at <http://apps2.jhsph.edu/coa360/aboutcoa360.html>.

Table 1
Exploring the meaning of illness

<p>Explanatory model</p> <p>What do you think has caused your problem? What do you call it?</p> <p>Why do you think it started when it did?</p> <p>How does it affect your life?</p> <p>How severe is it? What worries you the most?</p> <p>What kind of treatment do you think would work?</p> <p>The patient's agenda</p> <p>How can I be most helpful to you?</p> <p>What is most important for you?</p> <p>Illness behavior</p> <p>Have you seen anyone else about this problem besides a "physician"?*</p> <p>Have you used non-medical remedies or treatment for your problem?</p> <p>Who advises you about your health?</p>

From material cited in Carrillo JE et al. Cross-cultural primary care: a patient-based approach.

* Note: Any medical or nursing clinician can be referenced here i.e. nurse practitioner, physician's assistant, nurse, etc.

Table 2
Social context “review of systems”

Control over environment

Is money a big problem in your life? Are you ever short of food or clothing?

How do you keep track of appointments? Are you more concerned about how your health affects you right now or how it might affect you in the future?

Change in environment

What is your country (city, town) of origin?

What made you decide to come to this country (city, town)? When did you come?

How have you found life here compared to life in your country (city, town)? What was medical care like there compared with here?

Social stressors and support network

What is causing the most difficulty or stress in your life? How do you deal with this?

Do you have friends or relatives that you can call on for help? Who are they? Do they live close to you?

Are you very involved in a religious or social group? Do you feel that God (or a higher Power) provides a strong source of support in your life?

Literacy and language

Do you have trouble reading your medication bottles or appointment slips?

What language do you speak at home? Do you ever feel that you have difficulty communicating everything you want to say to the doctor or staff?

From material cited in Carrillo JE et al. Cross-cultural primary care: a patient-based approach.

Table 3
Negotiation

Negotiating explanatory models

Explore patient's explanatory model

Determine how the explanatory model differs from the biomedical model and how strongly the patient adheres to it.

Describe that biomedical explanatory model in understandable terms, using as much of the patient terminology and conceptualization as necessary.

Determine the patient's degree of understanding and acceptance of the biomedical model as it is described.

If conflict remains, reevaluate core cultural issues and social context (for example, bring in family members or maximize interpretations).

Negotiating for management options

Describe specific management options (tests, treatments, or procedures) in understandable terms.

Prioritize management options.

Determine the patient priorities.

Present a reasonable management plan.

Determine the patient's level of acceptance of this plan (do not assume acceptance – inquire directly).

If conflict remains, focus negotiation on higher priorities.

From material cited in Carrillo JE et al. Cross-cultural primary care: a patient-based approach.