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## Patient Centeredness, Cultural Competence and Healthcare Quality

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### Abstract

Cultural competence and patient centeredness are approaches to improving healthcare quality that have been promoted extensively in recent years. In this paper, we explore the historical evolution of both cultural competence and patient centeredness. In doing so, we demonstrate that early conceptual models of cultural competence and patient centeredness focused on how healthcare providers and patients might interact at the interpersonal level and that later conceptual models were expanded to consider how patients might be treated by the healthcare system as a whole. We then compare conceptual models for both cultural competence and patient centeredness at both the interpersonal and healthcare system levels to demonstrate similarities and differences. We conclude that, although the concepts have had different histories and foci, many of the core features of cultural competence and patient centeredness are the same. Each approach holds promise for improving the quality of healthcare for individual patients, communities and populations.

### Keywords

cultural competence; patient–physician relationship; quality of care

## INTRODUCTION

Cultural competence and patient centeredness are approaches to enhancing healthcare delivery that have been promoted extensively in recent years. As they have gained recognition and popularity, however, considerable ambiguity has evolved in their definition and use across settings. Proponents of patient centeredness speak of cultural competence as merely one aspect of patient-centered care, while proponents of cultural competence often assert the converse. The purpose of this paper is to present and compare the ideals of patient centeredness and cultural competence, to define their similarities and differences, and to discuss their implications for improving healthcare quality at the interpersonal and health system levels.

## THE EVOLUTION OF PATIENT CENTEREDNESS

### Early Conceptions of Patient Centeredness

Originally coined by Balint in 1969 to express the belief that each patient “has to be understood as a unique human-being,”<sup>1</sup> patient-centered medicine began as a descriptive account of how

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physicians should interact and communicate with patients. In 1984, Lipkin and colleagues described the patient-centered interview as one which “approaches the patient as a unique human being with his own story to tell, promotes trust and confidence, clarifies and characterizes the patient’s symptoms and concerns, generates and tests many hypotheses that may include biological and psychosocial dimensions of illness, and creates the basis for an ongoing relationship.”<sup>2</sup> According to Lipkin, practitioners who are patient centered have specific knowledge (e.g., define countertransference, identify different types of interview questions), attitudes (e.g., unconditional positive patient regard, willingness to join with patients as partners) and skills (e.g. elicit patient’s “story” of illness, overcome barriers to communication).<sup>2</sup>

Levenstein and colleagues subsequently described the patient-centered clinical method as one in which the physician aims to gain an understanding of the patient as well as the disease—as opposed to an approach focusing strictly on the disease—through a process of addressing both the patient’s and the physician’s agendas—as opposed to addressing only the physician’s agenda.<sup>3</sup> Later, Stewart outlined 6 dimensions of patient-centered care: 1) exploring the illness experience, 2) understanding the whole person, 3) finding common ground regarding management, 4) incorporating prevention and health promotion, 5) enhancing the doctor–patient relationship, and 6) being realistic about personal limitations.<sup>4</sup>

More recently, Mead and Bower proposed a similar conceptual framework with 5 dimensions: 1) adopting the biopsychosocial (as opposed to narrowly biomedical) perspective; 2) understanding the patient as a person in his or her own right, not merely as a body with an illness; 3) sharing power and responsibility between the doctor and the patient; 4) building a therapeutic alliance; and 5) understanding the doctor as a person, not merely as a skilled technician.<sup>5</sup> Noticeably absent from this framework is any mention of disease prevention or health promotion. Mead and Bower focused their framework of patient centeredness as a style of interaction and communication with patients, while Stewart construed patient centeredness as a more comprehensive approach to patient care.

Summarizing patient centeredness most succinctly, McWhinney described the patient-centered approach as one where the “physician tries to enter the patient’s world, to see the illness through the patient’s eyes.”<sup>6</sup> This notion of “seeing through the patient’s eyes” has become perhaps the most concise description of patient centeredness, and has led to several outgrowths of the early patient-centered movement. It may have been, by sincerely looking through the patient’s eyes, that it became clear there is a great deal more to fix in the healthcare system than the interaction style of its practitioners.

### **Expansion of the Scope of Patient Centeredness**

The Picker-Commonwealth Program for Patient-Centered Care was begun in 1987 to promote a patient-centered approach to hospital and health services focusing on the patient’s needs and concerns. Seven dimensions of patient-centered care were identified: 1) respect for patients’ values, preferences and expressed needs; 2) coordination and integration of care; 3) information, communication and education; 4) physical comfort; 5) emotional support and alleviation of fear and anxiety; 6) involvement of friends and family; and 7) transition and continuity.<sup>7</sup> The Picker-Commonwealth Program clearly went beyond the more narrow interpretation of patient centeredness as a guide for individual practitioners interacting with individual patients, and moved towards the consideration of patient centeredness as a comprehensive way of delivering health services. Figure 1 details the key features of patient centeredness within organizations and interpersonal interactions between patients and providers.

The shift in focus of patient centeredness is later reflected in the National Library of Medicine's MED-LINE subject heading (MeSH) definition of patient-centered care, introduced in 1995, which states, "Design of patient care wherein institutional resources and personnel are organized around patients rather than around specialized departments." Most notably, the Institute of Medicine (IOM) endorsed patient-centered care as one of six aims for health system improvement in the groundbreaking 2001 report, "Crossing the Quality Chasm." The IOM defined patient-centered care as "care that is respectful and responsive to individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."<sup>8</sup> Further descriptions of patient-centered care in the IOM report draw on the earlier Picker-Commonwealth dimensions described by Gerteis and colleagues, and include the dimensions of coordination and integration, the provision of information and education to patients, attention to physical comfort, emotional support, and involvement of family and friends.<sup>7</sup>

It is worth noting, both from a semantic and substantive point of view, that there are a variety of terms used to describe patient centeredness. The term "patient-centered interview" describes the original model of interaction and communication between patients and providers. Patient-centered communication is often used to describe patient-practitioner interactions as well, but could include other modes of communication. For example, patients may experience patient-centered communication when attempting to interface with the health system; patients may have the ability to e-mail their practitioners if they prefer, to have the phone answered by a pleasant and responsive receptionist when they call their practitioner's office and receive timely returned phone calls. Similarly, written communication, such as signage and patient education materials, may be patient centered to the extent that they meet patients' needs, are written in a way that patients can understand, and enhance patients' understanding and ability to participate in medical care.

Patient-centered care is not limited to communication and often focuses on other aspects of care such as convenience of office hours, ability to get appointments when needed, being seen on time for appointments and having services near one's place of residence. The term "patient-centered access" distinctly does not include the interpersonal aspects of care and is more clearly focused on the delivery of health services such that patients can secure services when and where they are needed.<sup>9</sup> Patient-centered outcomes refer to the measurement or consideration of outcomes that patients might care about, but which have traditionally been ignored by the medical establishment, such as patient satisfaction, quality of life and functional status.<sup>10</sup> The terms "patient-centered approach" and "patient centeredness" are the most broad and vague, since there is no particular content specified.

Finally, because of the number of ways patient centeredness has been construed, it is also worth noting that there is >1 model of care that can be regarded as antithetical to patient centeredness. Some have contrasted patient-centered medicine with care that is focused on disease rather than on people, or so-called illness-oriented medicine.<sup>1</sup> This has led to a greater focus on the biopsychosocial model, health promotion, attention to physical comfort and coordinated transition between care settings. Others have argued that patient centeredness is at one end of a continuum, with "doctor-centeredness" at the opposite end.<sup>11</sup> This has led to a greater focus on the provision of same-day appointments and patient-provider e-mail correspondence. Still others have identified medical paternalism as the opposite of patient centeredness, because it may fail to acknowledge the preferences, needs and values of individual patients.<sup>12</sup> This has led to a greater focus on the provision of information and education to patients. In short, it is fair to say that any of these alternative conceptions of patient-provider interactive styles are *not* patient centered and that patient centeredness could be envisioned as a strategy to correct for all of these tendencies in medicine simultaneously.

## THE EVOLUTION OF CULTURAL COMPETENCE

The rise of cultural competence in healthcare has been somewhat less prominent but more precipitous than that of patient centeredness. The term “cultural competence” did not begin to appear consistently in the healthcare literature until the early 1990s. By May 2007, >1,000 articles mentioning the terms “cultural competence” or “cultural competency” in their titles or abstracts had been published in medical and nursing journals, more than three-quarters of them since 2000. Within the last 10 years, myriad programs addressing cultural competence in healthcare have been developed,<sup>13</sup> national standards for health systems have been published,<sup>14</sup> a recurring national conference devoted to the issue has been established ([www.diversityrx.org/CCCONF/](http://www.diversityrx.org/CCCONF/)) and federal mandates to increase cultural competence have been issued.<sup>15</sup> The primary impetus for the cultural competence movement of the last decade has been the demonstration of and publicity surrounding widespread racial and ethnic disparities in healthcare.<sup>16,17</sup> But the principles of cultural competence are rooted in efforts that precede the high visibility the issue has received in recent years.

### Early Conceptions of Cultural Competence

For decades, healthcare leaders and educators have recognized that cultural and linguistic barriers between healthcare providers and patients might interfere with the effective delivery of health services. Advocacy for greater attention to these barriers gave rise to programs and curricula bearing the monikers cross-cultural medicine, cultural sensitivity, transcultural nursing and multicultural counseling. Programs largely focused on populations “whose health beliefs may be at variance with biomedical models.”<sup>18</sup> Although the principles underlying these programs were acknowledged to be universally applicable, the targeted groups included primarily immigrant populations with limited English proficiency and limited exposure to western cultural norms. Programs sought to bridge the “cultural distance” that existed between healthcare providers and these immigrant patients, focusing on the appropriate use of interpreters and “cultural brokers” and on learning the history and cultural norms of different minority populations.

A number of frameworks and guidelines were proposed to help healthcare practitioners consider patients’ cultural context and conduct cultural assessments.<sup>18–21</sup> These models acknowledged that, while awareness of and respect for different cultural traditions were valued, familiarity with all cultural perspectives a healthcare provider might encounter in clinical practice was impractical. Additionally, viewing patients as members of ethnic or cultural groups, rather than as individuals with unique experiences and perspectives, might lead providers to stereotype patients and make inappropriate assumptions about their beliefs and behaviors. To account for these concerns, approaches to cross-cultural healthcare incorporated a balance, between acquiring some background knowledge of the specific cultural groups encountered in clinical practice, and developing attitudes and skills that were not specific to any particular culture but were universally relevant. As outlined in the late 1970s and early 1980s by pioneers in cross-cultural medicine—including Berlin and Fowkes, Kleinman and colleagues, and Leininger—these “generic” attitudes and skills included: 1) respecting the legitimacy of patients’ health beliefs and recognizing their role in effective healthcare delivery; 2) shifting from a paradigm of viewing patients’ complaints as stemming from a disease occurring within their organ systems to that of an illness occurring within a biopsychosocial context; 3) eliciting patients’ explanations of the illness and its perceived causes (patient’s explanatory model of illness); 4) explaining the clinician’s understanding of the illness and its perceived causes (clinician’s explanatory model of illness) in language accessible to patients; and 5) negotiating an understanding within which a safe, effective and mutually agreeable treatment plan could be implemented.<sup>18,19,22</sup> Essentially, this individualized approach

entailed clinicians' seeing the illness experience through patients' eyes, helping patients to see the process through the clinicians' eyes and reaching common ground.

Inherent in early formulations of cross-cultural healthcare was the importance of recognizing that both patients and providers brought cultural perspectives to the encounter. As such, healthcare providers were encouraged to acknowledge and explore their own cultural influences, including those acquired through their training in western biomedicine and entry into the health professions. This included reflecting on the privilege and power associated with their status as professionals. This process of critically questioning and deconstructing the "medicentric" perspective was considered central to the ability to deliver effective care across cultural boundaries.<sup>22</sup>

It should be readily apparent that many of the principles of cross-cultural care were the same as those for patient-centered care. These included respect for patients as individuals; engagement of patients as partners; effective communication of illness models and treatment goals; and holistic consideration of the sociocultural context and consequences of patients' illness experience. Just as patient centeredness was construed as one end of a continuum (with doctor centeredness on the other end), cultural competence was also characterized in terms of continua ranging from ethnocentric to ethnosensitive<sup>23</sup> or from cultural destructiveness to cultural proficiency.<sup>24</sup>

### Expansion of the Scope of Cultural Competence

From its roots in early models of cross-cultural healthcare, cultural competence expanded in the late 1980s through the 1990s in 3 ways. First, the populations to whom cross-cultural care was applied expanded from primarily immigrants to essentially all minority groups, particularly those most affected by racial disparities in the quality of healthcare. Second, the conceptual purview of cultural competence expanded beyond culture per se and encompassed issues such as prejudice, stereotyping and social determinants of health. Finally, as occurred with patient centeredness, the scope of cultural competence expanded beyond the interpersonal domain of cross-cultural care to include health systems and communities.

This expansion in scope was driven largely by accumulating research demonstrating that racial and ethnic minority groups received lower quality healthcare than the majority population, even after accounting for differences in access to care.<sup>16,17</sup> Studies further suggested that social and cultural barriers between healthcare providers and nonimmigrant people of color might be affecting the quality of care.<sup>25-27</sup> The expansion of the population base for whom cultural barriers were now felt to be a potentially important issue, and the urgency to address documented racial inequities, gave rise to an explosion of new interest and activity in cross-cultural healthcare, which adopted from other disciplines the more modern label of cultural competence.

Proponents of cultural competence acknowledged that the principles and approaches of cross-cultural healthcare were in and of themselves necessary but not sufficient to address racial disparities in healthcare quality. The observed inequities were not yet fully explicated, but few disagreed with the notion that while cultural barriers might be contributing, other factors also needed to be considered. For instance, some minority patients might distrust healthcare providers or institutions, possibly related to historical or ongoing experiences of discrimination. Providers might harbor either overt or unconscious biases about people of color that influence their interactions and decision-making. Champions of the cultural competence movement took these issues on, incorporating into their training programs a wide-ranging set of issues: the concepts of race and class and their impact on health and healthcare experiences; the relevance of trust in patient-provider relationships and the historical contributors to potential distrust among certain minority populations; the importance of social factors, including support

systems and literacy; and reflection on one's own racial attitudes and stereotypes. While some of these issues might be seen as overlapping with a liberally interpreted definition of culture, most would not consider them to represent "cultural" barriers per se. In fact, some consider addressing these issues under the rubric of "cultural" competence to be dangerously dismissive of the interpersonal and institutional racism that they more accurately reflect.<sup>28</sup> Nevertheless, all of these efforts were generally folded into cultural competence programs. Cultural competence, therefore, grew from the relatively focused set of principles that defined cross-cultural healthcare, into a concept encompassing a broad array of topics relevant to racial and ethnic disparities in healthcare quality.

Several different models have been proposed to describe cultural competence in health care. Nearly all of them include dimensions of knowledge (e.g., understanding the meaning of culture and its importance to healthcare delivery), attitudes (e.g., having respect for variations in cultural norms) and skills (e.g., eliciting patients' explanatory models of illness). Many aspects of the cultural competence formulation are also central aspects of patient centeredness; some have consequently argued that the essence of cultural competence is a "patient-centered approach."<sup>29</sup>

Pioneers of the cultural competence movement recognized that disparities in healthcare quality may result from cultural and other barriers not only between patients and healthcare providers but also between communities and health systems. Most of the American healthcare infrastructure was developed in the pre-Civil Rights era and is therefore at risk of propagating "institutionalized" discrimination against people of color. Even modern health systems were largely designed with the majority population in mind. These realities, coupled with the increasing racial and ethnic diversity in the United States, have made changing health systems to accommodate the preferences and values of diverse populations an essential part of the cultural competence agenda. One of the earliest proposals for more culturally competent systems of care was outlined in a monograph by Cross and colleagues.<sup>24</sup> They defined cultural competence as "a set of congruent behaviors, attitudes and policies that come together in a system, agency or amongst professionals and enables that system, agency or those professionals to work effectively in cross-cultural situations." They described the culturally competent system as: 1) valuing diversity, 2) having the capacity for cultural self-assessment, 3) being conscious of the dynamics inherent when cultures interact, 4) having institutionalized cultural knowledge, and 5) having developed adaptations to diversity.<sup>24</sup>

Methods of operationalizing these principles of "system-level" cultural competence have included efforts such as the National Standards on Culturally and Linguistically Appropriate Services in Health Care (CLAS Standards), which include recommendations such as having healthcare practitioners, leaders and staff that are ethnically similar to the community served; collecting and tracking data on quality of care, stratified by race; and engaging communities in the design and delivery of healthcare facilities and services.<sup>14</sup> Many have based arguments for these changes not only on the moral imperative to reduce healthcare disparities but on the "business case" for catering to an ever-expanding segment of the healthcare market.<sup>30</sup> Key features of cultural competence within healthcare organizations and patient-provider interactions are detailed in Figure 2.

In summary, the cultural competence movement grew out of early efforts to bridge the divide between the largely biomedical, white, middle-class American cultural perspectives of clinicians, and the perspectives of patients, mainly immigrants, whose experiences and language put them at a substantial cultural distance from American healthcare. Cultural competence evolved from these efforts into an all-encompassing approach to address interpersonal and institutional sources of racial and ethnic disparities in healthcare. Though

the concept of cultural competence has changed over time and continues to evolve, it has always contained at its core the principles of patient-centered healthcare delivery.

## **PATIENT CENTEREDNESS AND CULTURAL COMPETENCE: OVERLAPPING AND DISTINCT CONTRIBUTIONS TO HEALTHCARE QUALITY**

Apparent from the evolution of patient centeredness and cultural competence is the fact that both began as guides for interpersonal interaction and later expanded to consider health systems. Because frameworks for understanding quality in interpersonal interactions are substantively different from frameworks for quality in health systems, we consider each separately while comparing patient centeredness and cultural competence at both levels.

### **Interpersonal Interactions in Healthcare**

The ability or preparedness of healthcare providers to engage in effective interactions with patients depends in large part on the providers' knowledge, attitudes, skills and behaviors (Figure 3). While the features of patient centeredness and cultural competence in Figure 3 are not intended to be a comprehensive account of all important facets, they are representative of the respective traditions.

At the core of both patient centeredness and cultural competence is the ability of the healthcare provider to see the patient as a unique person; to maintain unconditional positive regard; to build effective rapport; to use the bio-psychosocial model; to explore patient beliefs, values and meaning of illness; and to find common ground regarding treatment plans. The patient-centered model additionally includes a detailed set of knowledge and skills that healthcare providers should possess in order to accomplish these tasks, such as understanding the stages and functions of a medical interview and attending to patients' physical comfort. While such detail is generally not explicit in accounts of cultural competence, most of these additional characteristics of patient-centered care might be endorsed as traits of a culturally competent provider.

Patient centeredness has not been directly responsive to racial and ethnic disparities in healthcare, but it has the theoretical potential to reduce such disparities because it addresses some of the hypothesized mechanisms by which patient race/ethnicity impacts healthcare providers.<sup>31</sup> For example, provider decision-making appears in some cases to be biased by patient race.<sup>31,32</sup> Since patient-centered care aims to equalize power between patients and providers, it is possible that disparities in clinical decisions would be reduced by increasing patient involvement. Providers also display differential interpersonal behavior, characterized by more affective distance (less warmth, empathy, respect), when interacting with people of color.<sup>31,33</sup> Here too, patient centeredness emphasizes fostering these positive qualities within all patient-practitioner encounters.

In addition to the core features that cultural competence shares with patient centeredness, it has been suggested that the culturally competent healthcare provider exhibits other, distinct qualities, such as understanding the meaning and importance of culture, and effectively using interpreter services when needed (Figure 3). Just as proponents of cultural competence might embrace most aspects of patient centeredness, it is likely that proponents of patient centeredness would also embrace these additional features of cultural competence. Because cultural context and effective communication are relevant to the care of patients in general, not only people of color, cultural competence has the capacity to enhance patient centeredness and improve quality for all patients.

## Healthcare Quality at the System Level

Elements of patient-centered and culturally competent health systems include structures and processes intended to improve patient-centered outcomes and promote equity (Figure 4).<sup>34, 35</sup> Again, these features are not intended as an exhaustive catalog but rather as representative facets of the respective traditions.

The features of patient-centered and culturally competent approaches to quality in health systems do not overlap as substantially as at the interpersonal level. The overlapping features include the general endorsement that services should be aligned to meet patient needs and preferences; that healthcare should be available in communities and convenient to patients' homes; that educational materials should be tailored to patients' needs, health literacy and preferred language; and that information on performance should be publicly available (though the sort of information varies slightly in that patient centeredness calls for general information to be recorded and available and cultural competence standards call for race/ethnicity-specific data to be recorded and available).

Patient-centered health systems offer additional features, such as the ability to get same-day appointments and maintaining continuity and secure transitions across healthcare settings. There are likewise features of culturally competent health systems that are not explicitly mentioned in accounts of patient centeredness, such as an emphasis on a diverse workforce that reflects the patient population, and partnering with communities in setting priorities and planning. In examining the distinct aspects of cultural competence at the system level, it is clear that these features hold promise for enhancing patient centeredness. For instance, the use of community health workers might help healthcare systems reach out and bring care to the patient, rather than always relying on the patient to come to the system for care. Likewise, the distinct aspects of patient centeredness have the potential to improve care for people of color and to reduce disparities in care. Enhancing provider availability might improve care most dramatically for minority groups who tend to be disadvantaged in terms of access to care. Some patient centeredness initiatives, however, if not crafted carefully, might actually increase disparities. For instance, promoting provider availability through e-mail contact or web portals might disproportionately benefit patients with easy access to and familiarity with computers, and thereby exacerbate disparities for low-income and minority patients on the less fortunate side of the "digital divide." This highlights the wisdom of integrating patient centeredness and cultural competence when considering initiatives to promote quality of care.

## CONCLUSION

Patient centeredness and cultural competence are movements in healthcare that have garnered a great deal of attention and momentum in the last decade. Both aim to improve healthcare quality, but the emphasis of each is on different aspects of quality (Figure 5). The primary aim of patient centeredness has been to individualize quality, to complement the healthcare quality movement's focus on process measures and performance benchmarks with a return to emphasis on personal relationships and "customer service." As such, patient centeredness aims to elevate quality for all patients. The primary aim of the cultural competence movement has been to balance quality, to improve equity and reduce disparities by specifically improving care for people of color and other disadvantaged populations. Because of these different emphases, patient centeredness and cultural competence have targeted different aspects of healthcare delivery. Despite these different focuses, however, there is substantial overlap in how patient centeredness and cultural competence are operationalized, and consequently in what they have the potential to achieve. Individualizing care must take into account the diversity of patient values and perspectives; to the extent that patient-centered care is delivered universally, care should become more equitable. Conversely, attending to the specific needs of people of color and other disadvantaged populations must take into account the wide range of worldviews



within a given group, and the multifaceted nature of “culture;” to the extent that cultural competence enhances the ability of health systems and providers to address individual patients’ preferences and goals, care should become more patient centered.

Because the cultural competence and patient-centered care movements both aim to improve healthcare quality in similar ways, one might reasonably ask whether it is better to keep the movements separate or to combine efforts into a single agenda. While many features are similar, important aspects of each remain that have not been formally adopted by the other. Since these nonoverlapping features also have the potential to improve healthcare quality, we suggest that the concepts should remain distinct, at least in the short term. While the concepts remain distinct, however, efforts to incorporate them into provider practices and health systems should occur in concert. Separating patient centeredness and cultural competence initiatives will duplicate effort, since so many of the principles are the same. In addition, as mentioned above, efforts to enhance patient centeredness, without adequate attention to the needs of minority and other disadvantaged groups, have the potential to exacerbate existing disparities in care.

A variety of specific recommendations can therefore be made. Healthcare organizations and providers should adopt principles of both patient centeredness and cultural competence jointly, so that services are aligned to meet the needs of all patients, including people of color and other disadvantaged groups, whose needs and preferences may be overshadowed by those of the majority. Health services researchers should develop measures of cultural competence and patient centeredness and explore the impact of their unique and overlapping components on patient outcomes. Medical educators should partner with social scientists, anthropologists and researchers to develop and evaluate educational programs to improve the patient centeredness and cultural competence of health professionals. Those responsible for ensuring health system quality should employ measurement of both patient centeredness and cultural competence as part of the process of delivering high-quality care. Finally, all patients should take advantage of every opportunity to provide feedback (e.g., participate in surveys and focus groups) to improve the design and evaluation of healthcare systems that reflect patients’ diverse needs and preferences.

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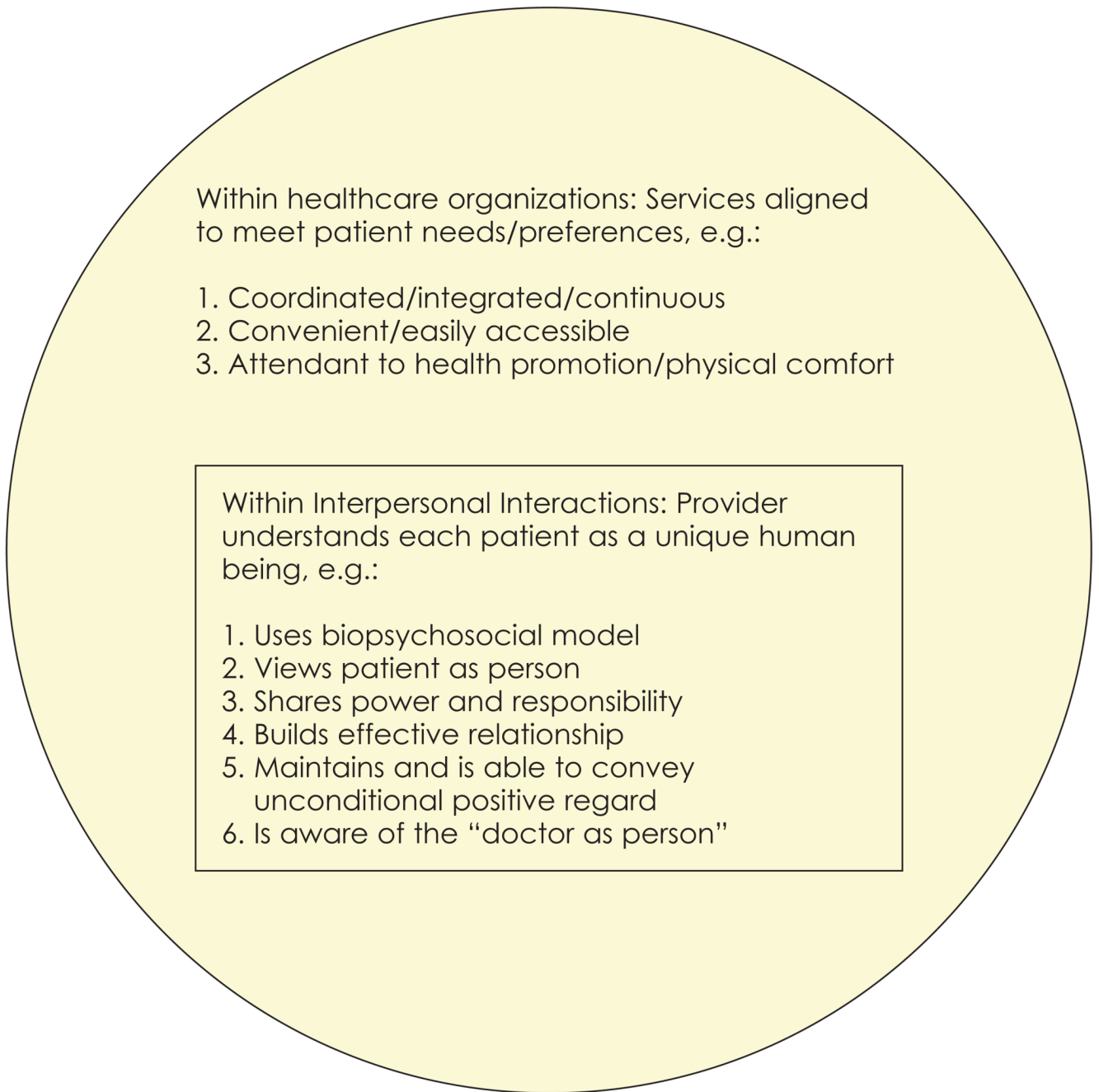
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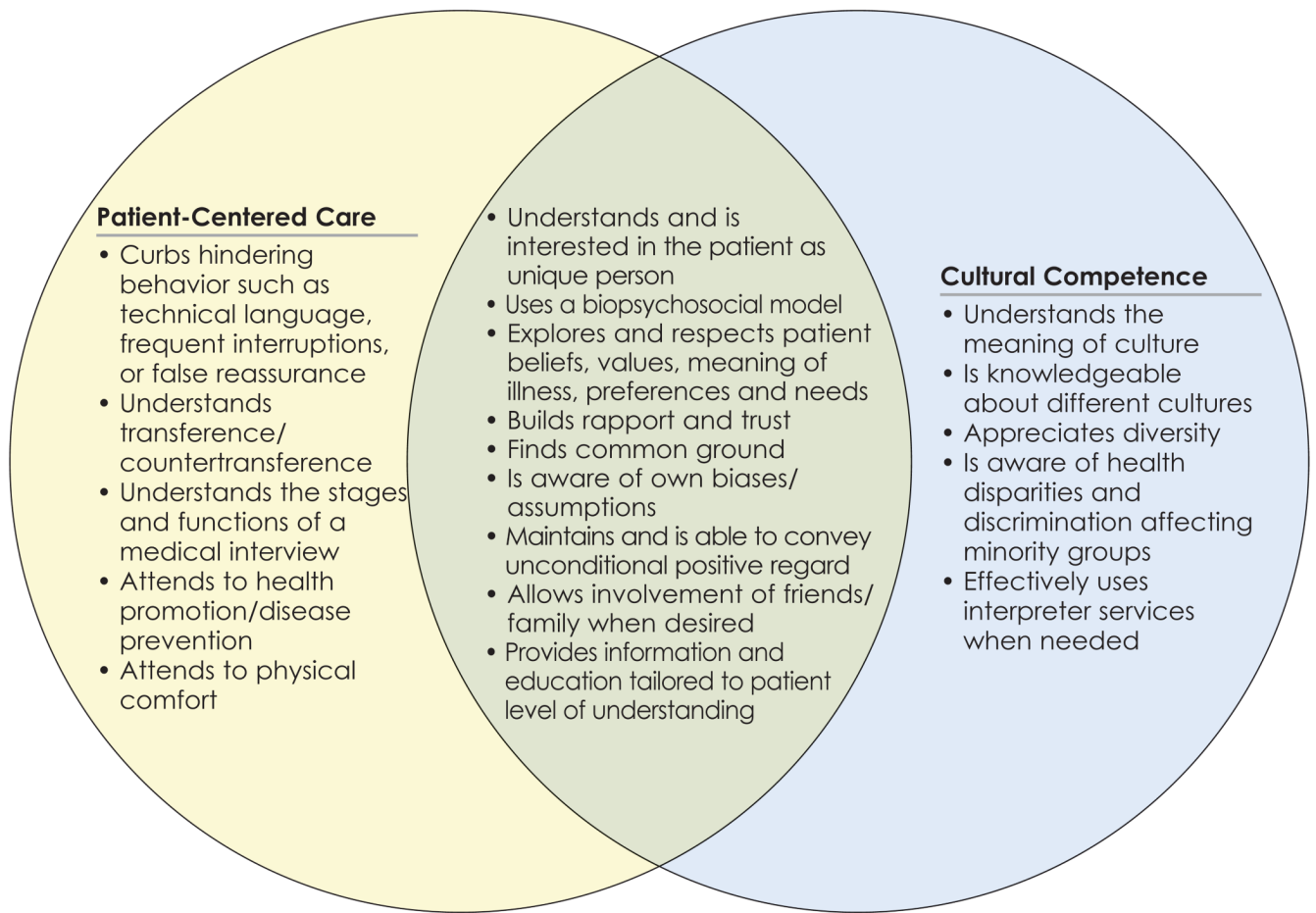
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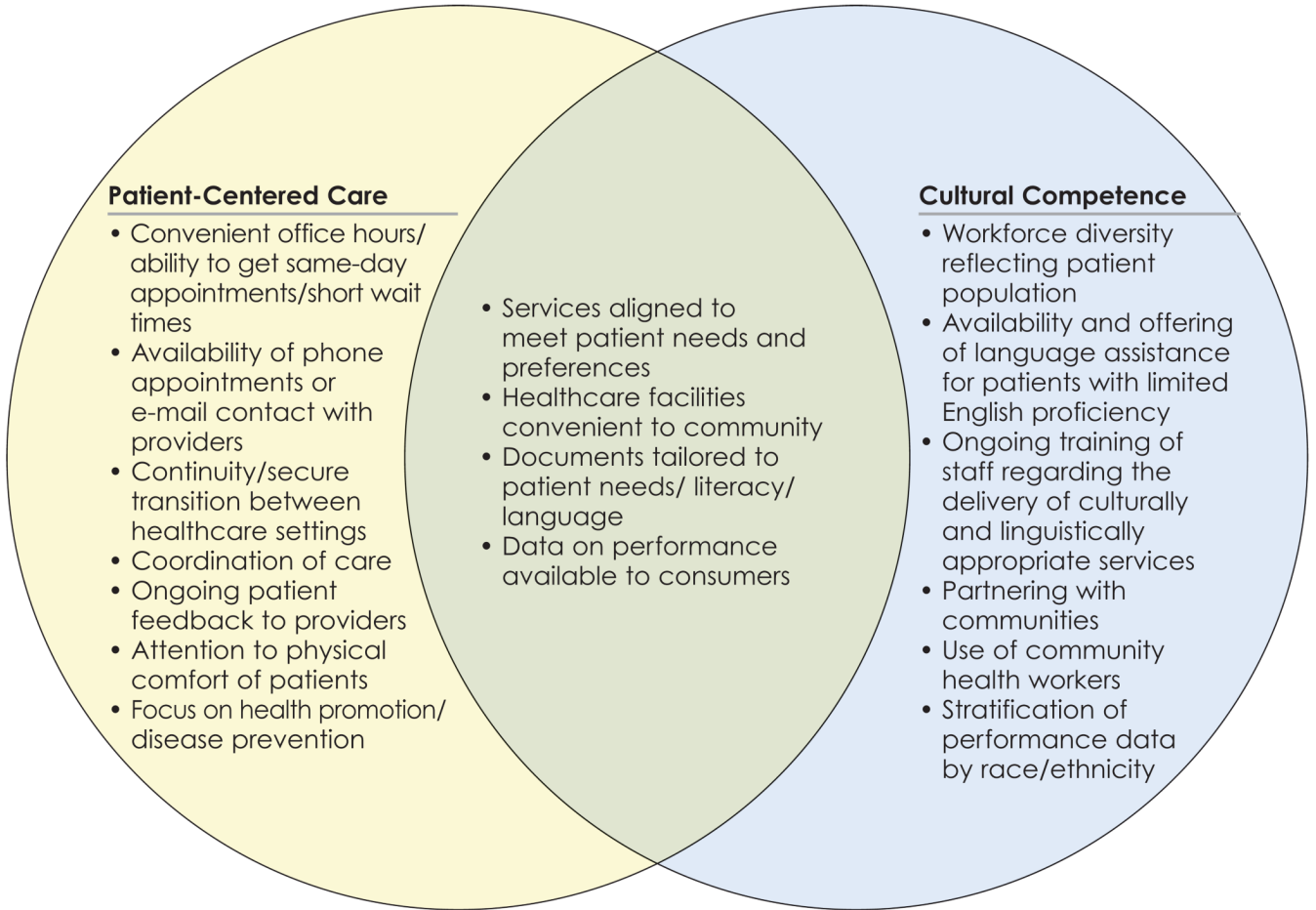
**Figure 1.**  
Key features of patient centeredness



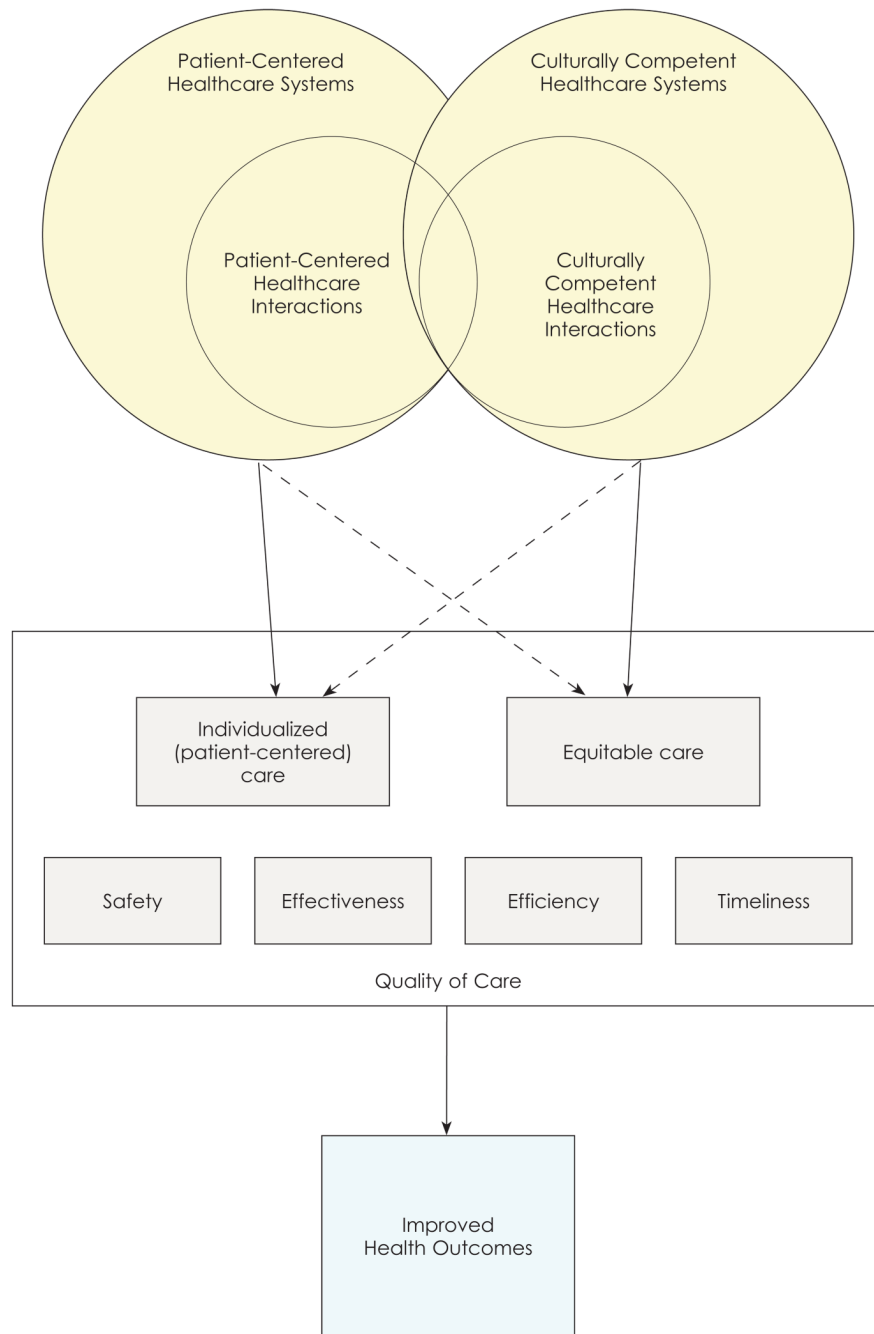
**Figure 2.**  
Key features of cultural competence



**Figure 3.**  
Overlap between patient-centered care and cultural competence at the interpersonal level



**Figure 4.** Overlap between patient-centered care and cultural competence at the health system level



**Figure 5.** Patient centeredness, cultural competence and healthcare quality