Abstract

This work will discuss culturally sensitive areas of medical practice and suggest the implementation of certain procedures or mentalities that health care providers should maintain to ensure culturally competent care. It will focus mostly on the Latino community when giving concrete examples, as that is the ethnic population with whom I have most extensively worked, through volunteering for the local, free clinic, HealthFinders, in Dundas, MN. These suggestions were created with the challenges I have experienced or observed while interning at the clinic. However, through other shadow experiences and research I feel many of these suggestions could be generally applied to all health care institutions.

The guide will be structured so that suggestions are given in the order you would spatially experience a medical appointment: first the reception area, next the exam room, then places outside the exam room such as the x-ray room and finally suggestions for important interactions beyond the clinic. Within the exam room section, a recommendation to include a cultural competency course in medical school will be described. Before this spatial examination of a medical clinic however, some suggestions will be made in reference to health care organizations because many of the changes needed, will have to come from this higher authority. In general, I hope to paint the reader a picture of a culturally sensitive clinic as I suggest changes that could be the basis for standardized procedures across the nation.

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1 Throughout this work the words Latino and Hispanic will be used interchangeably to refer to the Spanish-speaking populations within the United States.
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Introduction

The implementation of intercultural medical practices nationally, is vital to ensure quality of care to patients in the United States. The steady increase of immigration worldwide indicates that inevitably health care providers will be interacting with patients who speak different languages and hold varied cultural beliefs, values and understandings (McFarland, 2002). Some opponents to prioritizing the development of intercultural medical practices argue that this may dissuade patients from learning how to live in the United States without extra services, such as interpretation. Although this may be a legitimate concern to contemplate, the scope of this work does not touch on this topic. Rather than focusing on ways to motivate cultural populations to adapt so they may live in the American society without needing additional help, it focuses on the reality of our diverse population. To illustrate this reality, knowledge about the Latino population will be used. Thus, reality presents us with the dilemma, that as of 2000, more than 28 million Latinos lived in the United States and 9 million of this population spoke Spanish at home or said that they spoke English “not well” or “not at all” (U.S. Census Bureau’s 2000 census). Communication is a vital component of healthcare and its realization through specific languages is subject to unwritten rules understood by the people of the culture in which the language was acquired. The improvement of communication, through procedures such as interpreter services, will be a major component of this work, but will not be the only intercultural practice emphasized.

To show how this belief in the right to adequate communication in healthcare has been reflected in our society, the creation of policies and other national programs that promote access to language services will be quickly discussed. In 1964, Congress enacted Title VI of the Civil Rights Act to prevent discrimination on the basis of national origin. According to Title VI, health providers that receive federal funds, including Medicare and Medicaid, must provide language assistance to people who speak little or no English. In August 2000, President Bill Clinton signed Executive Order 13166 directing federal agencies to help recipients of federal funding comply with Title VI. The Department of Justice and the Health Care Financing Administration (now the Center for Medicare & Medicaid Services) took further steps to achieve compliance, including informing state Medicaid directors that federal funds were available to help. At the same time, providers began to face additional pressures to address language barriers from accrediting bodies, such as the Joint Commission for the Accreditation of Health Organizations (JCAHO). Hablamos Juntos: Improving Patient Provider Communication for Latinos is a national program of the Robert Wood Johnson Foundation (RWJF), the first national effort to help health care organizations meet the challenge of providing language services and signage. It ran from October 2001 through June 2006. The program focused on developing “affordable models of innovative language services,” which included interpretation of spoken encounters and translation of written documents, and it also focused on developing “interpreter services, informational materials in Spanish and easy-to-understand signage to post with health facilities.”

Nonetheless, adequate communication is only one component of culturally competent care which is what intercultural medical practices strive to achieve. Cultural competency is “a concept that goes beyond awareness and sensitivity to include the possession of cultural knowledge and respect for different cultural perspectives, and having the ability to use these skills effectively in cross-cultural situations” (Judy Ho, 2006, p. 172). This means that health care providers must not only be aware of their own biases and be sensitive to other culture’s differences, but must learn about the values and beliefs of other cultures and apply that knowledge when working with a patient with a different cultural background. Not only will culturally competent care facilitate communication with the patient and the
creation of the patient-provider relationship, but it will “lead to greater patient satisfaction, improved clinical outcomes and greater cost efficiency” (Galanti, 2008, p. 2).

Intercultural medical practices that promote culturally competent care can also be seen to improve patient-provider relationships between a patient and provider of the same culture. Many of the practices that will be suggested in the paper strive to improve “patient-centered care” regardless of the culture of the patient. Communication skills are vital to any relationship, no matter who the interlocutors are, and should be stressed, if not to improve culturally competent care, then to improve patient-centered care which is a current emphasis of medicine in the United States.

Health Care Organization

All systematic changes start at the level of the health care organization. Each organization has a mission statement, and if culturally competent care is not part of this statement, the employees of this organization may not strive to provide culturally competent care. Beyond the inclusion of culturally competent care in the mission statement of the organization, below are some suggestions on how to educate employees on what is culturally competent care and how to motivate them to provide culturally competent care.

Procedural Suggestions:

- Require culturally-specific nursing interventions as part of nursing care plans.
- Bring physicians into the planning process.
- Link language services to quality improvement and patient safety. It is vital that interpreters be trained.
- Clearly define procedures within a health care organization for developing written materials in other languages.
- Adapt information systems that enable patients' language preferences to be collected routinely.
- Engage executive-level leaders early so that new language services become an organizational priority and part of mainstream operations.
- Do not assume that patients do not speak English.
- Create durable structures in order to embed language services within the health care system. It is not enough just to hire an interpreter; the real goal is to make changes in organizational culture and to develop an interpreter infrastructure across communities.
- Post information at nursing stations on how to contact an interpreter or cultural resource person.
- It should not be assumed that any Spanish-speaking individual can interpret in a health care encounter. Test for proficiency before hiring interpreters or using bilingual employees to interpret. Many people who speak Spanish are "heritage speakers" who learned Spanish at home and may not be fully proficient, particularly in medical Spanish.
- Train bilingual staff to serve as interpreters and post a list of staff that indicates who can provide interpretation services from different units.

Cultural Education and Awareness Suggestions:

- Create a bulletin board in the break room that with information about different cultures and health beliefs.
- Create a cultural questions box for nurses to post questions that could be discussed at staff meetings.
• Organize potlucks in which each person brings something from his or her own culture, and describes any associated traditions or significance.
• Make cultural issues a regular topic for discussion at staff meetings.
• Have resources easily available for staff to access cultural information.
• Survey and interview patients regarding how well their cultural needs were met. Add a category regarding cultural competent care to patient satisfaction surveys.

Suggestions on How to Motivate Staff:
• Have monthly meetings with staff to communicate any comments or concerns.
• Make cultural competence policy part of the job description and thus part of the yearly evaluation.
• Publicly recognize clinicians that provide culturally-competent care. If a nurse’s name is specifically mentioned by a patient in the cultural competency category of the patient satisfaction surveys, he or she could receive a small reward.

Reception:
The atmosphere of the lobby or reception area is very important as it is the first environment that the patient interacts in and consequently, bases their first impressions upon. The following suggestions aim to make the reception area more welcoming in order to lessen the distress a patient may be experiencing due to their health status or complications they may have communicating with health care workers in English.

Suggestions:
• Have signs and forms in multiple languages reflecting the populations served. These signs and forms could be nationally used and distributed.
• Have books and magazines in multiple languages.
• Do not put religious icons up on the wall.
• Educate staff on cultural competence.
• Allow for flexible scheduling in clinic.
• Provide on-site continuing education on cultural diversity issues. Including ethnic food might make it more fun.
• Make cultural assessments part of the intake form. This information could be included on the charge sheet to help ensure that the information gets passed on from one shift to the next.
• Having signs available behind the receptionist desk with common receptionist questions to, at the very least, ascertain what language the patient speaks. Interpreters by speakerphone will be easier to contact if you already know what language you are looking for.
• To overcome problems with illiteracy, have buttons at the desk that say these questions so that patients can listen and answer yes or no. Receptionist should be taught to understand these words in a minimum number of languages.
• Instead of buttons, a website could be created that could be used by everyone that has all of these questions recorded. This way if an interpreter is not immediately available they have some way to initiate communication.
Exam Room:

Currently in medicine there is a focus on patient-centered care. This model requires that the physician provide healthcare according to the preferences and values of the patient. If language or cultural beliefs act as barriers preventing adequate communication in the consultation, care cannot be provided according to these values and preferences, and the patient-provider relationship essential to medical care cannot be properly developed. Thus, cultural competency and the use of interpreters are an integral part of patient-centered care.

Many healthcare providers and patients agree that cultural competency and the use of interpreters are vital to patient-centered care. This is shown in a study conducted by Wirthlin Worldwide in 2001 (Wirthlin Worldwide, 2001). In this study, Wirthlin Worldwide carried out a telephone survey of approximately 1,000 physicians, nurses, health care executives and pharmacists who cared for Latino patients and 500 adults whose primary language was Spanish. As detailed in the Wirthlin Worldwide report, researchers found that:

- 94 percent of provider respondents regarded patient-provider communications as very important to quality care.
- 68 percent of provider respondents regarded helping Spanish-speaking patients better use and benefit from the health care system as a top priority.
- 68 percent of Spanish-speaking respondents said that positive outcomes were more difficult to attain when providers neither spoke Spanish nor offered interpreters.
- 65 percent of Spanish-speaking respondents were concerned about using an interpreter because they believed the interpreters would not explain things to them clearly, omit information or disregard their privacy, among other reasons.
- 19 percent or 1 in 5 Spanish-speaking respondents reported being sick, but decided not to visit a doctor because the doctor didn't speak Spanish or have an interpreter.

Patient-centered care must be culturally competent care

In order to achieve the goal of providing patient-centered care, we must focus on improving two aspects of medical care: communication skills and cultural competency. The Wirthlin Worldwide study illuminates the importance of communication, since patients will avoid seeking medical care if they feel the use of an interpreter is necessary and there is no interpreter available. In addition to a focus on communication, patient-centered care must also be culturally competent care, as culture clearly influences an individual’s values and preferences. The Hablamos Juntos: Improving Patient Provider Communication for Latinos, a national program funded by the Robert Wood Johnson Foundation, found that providing interpreter services may not be enough to improve patient outcomes. Patients speaking little or no English may still suffer a lack of continuity of care, redundant services and miscommunication as they move from one provider setting to another. The implication of this finding would suggest that improving the patient-provider relationship by training health care providers in culturally competent care will build trust with patients and motivate them to continue care.
Main Suggestion: Cultural Competency Course

Cultural competency training would inform doctors of the unsaid communication rules of various cultures and the beliefs and values of these cultures. Cultural competency training could be a semester long course required for medical students that would focus on intercultural communication skills and basic knowledge about the cultural populations found in the United States. The intercultural communication skills portion of the course would also focus on the proper use of an interpreter. My experience as a volunteer interpreter, and the experience of the eleven interpreters that will be discussed in the section on the role of the interpreter below, has shown that many providers do not know how to work with the interpreter while providing medical care. For example, many medical providers forget to make eye contact with their patients when they are working with an interpreter. This may be because they are either referring to the interpreter who will translate to the patient what they say, or because they are writing notes while they speak. Not making eye contact in many Hispanic cultures would not be understood and they would be influenced to pay more attention with the interpreter and thus the patient-provider relationship would not be able to develop. Patient-centered care requires that a physician maintain eye contact, as it shows that they are attempting to establish the patient-provider relationship. ²

Communication Component of the Cultural Competency Course

This section focuses on the role of a medical interpreter, the problems that doctors and patients encounter as a result of language barriers and gives general suggestions for communication skills that should be practiced in medical care.

Interpreter

The use of an interpreter not only facilitates intercultural medical practice, but can also influence whether a patient of another culture will seek medical care. Thus, in this section I will discuss the role of the interpreter in the exam room and the conflicts that arise between executing this role and following the suggested guidelines for medical interpreting.

Guidelines describe the medical interpreter as a language conduit that facilitates communication between health care providers and patients of different cultures. The interpreter is expected to be “invisible.” That is, they should not draw any attention to themselves and should literally translate what either party says without adding, deleting or changing any content. This prescribed invisible role conflicts with the actual role that interpreters have in medical interactions, creating a tension (Angelelli, 2004, p. 129). The actual role of the interpreter becomes visible not only because literal translation is impossible and thus interpreting involves subjective decision-making on how to best translate what is said, but also because the physician and patient many times rely on the interpreter as a cultural guide. The concern that if the medical interpreter does not literally translate the words of the doctor or patient important information will be lost is not realistic.

² Of course, certain cultures do not understand eye contact to mean that the physician is paying attention to the patient. They might view eye contact as rude. Knowledge of which cultures do not value eye contact would be gained in the cultural knowledge portion of the cultural competency course suggested.
Before we address this concern, however, we should discuss what the role of the interpreter is. According to the eleven medical interpreters that Claudia Angelelli interviewed in her ethnography on a bilingual hospital, the role of an interpreter encompasses more than just literal translation, as suggested by the prescribed invisible role. The following list enumerates the various tasks these interpreters believe a medical interpreter role has:

- **Educate the patient:**
  - About the protocol of the American system of medicine that revolves around time constraints and require that:
    - The patient is kept on track.
    - The patient is instructed to give brief answers and not tell stories.
    - Appointments requiring interpreters should be scheduled far apart enough to allow the interpreter sufficient time to explain concerns.
  - That it is completely normal to ask the doctor questions in the United States.
    - At the clinic where I interned, a Colombian nurse explained that Latino patients view the doctor as an authoritative figure and that asking questions is a sign of disrespect.

- **Provide a source of comfort by:**
  - Helping establish good rapport between the patient and medical provider.
  - Helping develop the partnership between the medical provider and the patient that facilitates effective communication. This bond motivates the medical provider and patient to work as a team towards their goal of health.
  - Putting themselves in the shoes of the patient. This empathy should help the interpreter translate the concerns of the patient more accurately.
  - Using a tone of voice that is caring to build trust, which will help the interpreter convince the patient that the doctor’s instructions are valuable.
  - Adjusting their language register to the educational level and regional variety of Spanish of the patient. The interpreter, however, should start out explaining things in the most polite manner possible instead of using slang terms they feel the patient would understand immediately. This way they avoid offending a patient with their assumptions.

- **Broker differences in social levels.**
  - Some interpreters were concerned that medical providers could not relate to their Hispanic patients because their educational and socioeconomic backgrounds were so different.

- **Focus on smoothing the interaction by:**
  - Translating what a doctor says in a culturally-polite fashion, not translating rude words and by not communicating any frustration a doctor might show through his or her tone.
  - Informing the doctor if the patient is confused by reading the tone of the patient to see whether or not they truly understand the doctor’s instructions.

- **Act as a cultural source for the doctors by:**
  - Instructing doctors on culturally-appropriate manners of communication.
According to the above list of tasks, medical interpreters are visible participants of the intercultural medical interaction. The tasks that the medical interpreter role encompasses cause them to be visible. For example, they are required to expand upon a patient’s description of their illness if it has cultural implications. Many times doctors might ask the interpreters to describe certain aspects of the patient’s culture to help them understand the patient’s behavior and diagnose them more accurately. Interpreters are called upon to explain medical terminology, the purpose of medical practices and medical equipment to patients. They are also paraphrase what the patient says in order to save time if the patient is distracted and telling a story that only vaguely relates to the health concern.

It is clear that the interpreter becomes a conspicuous part of the medical interaction, but it is also evident with the rising number of citizens that only speak Spanish that interpreters are a necessary tool for medical care. Thus, the next step is figuring out how to incorporate the interpreter into the patient-provider relationship without weakening it. One possibility is training for doctors working with medical interpreters.

**Language Barrier Problems**

Problems that language barriers create for patients:

- Are not fully aware of existing services or how to use them.
- Have difficulty making medical appointments.
- Reduce patients' compliance with medication regimens and limit their participation in medical decision-making.
- Are less likely to receive preventive care.
- Receive less detailed information about rehabilitation therapy.
- Understand less about using their medications.
- Are unable to communicate adequately with health care providers and ancillary staff at all points within the health care delivery system.
- Are less satisfied with their health care experiences, making them less likely to keep subsequent appointments and more likely to visit the emergency room.

Problems that language barriers create for medical providers:

- Make an accurate diagnosis.
- Meet informed consent requirements.
- Explain care option to patients, which may lead them to offer fewer options.
- Convey health care information and education.
- Convince patients to comply with a treatment regimen.
• Impair the development of respect, trust and understanding between patient and provider.

**General Communication Skill Suggestions**

• Avoid using idioms.
• When discussing test results do not say “positive” or “negative” because they can be confused with lay understandings of the terms.
• Pay attention to patients’ nonverbal reactions.
• Always ask the patient if they have any concerns regarding your recommendations.
• Set up a schedule for updates on the patient’s conditions.
• Inquire about the needs and concerns of your patients.
• It is better to ask open ended question with patients than yes and no questions.
• Match your approach to the desires of your patient. Some will prefer shared decision-making and others won’t.
• Some patients expect a more personal relationship with their physicians.
• Encourage patients to ask questions. For example, assume they have questions and ask “what questions do you have?”
• Ask patients what they know about their condition.
• Ask patients about their religious and ethnic background and tell them why you are asking. For example, asking because maybe someone cannot be put on heparin because they cannot consume any products made from a pig.
• Use professional, trained interpreters. Use telephone interpreters if live ones are not available.
• Understand that lack of eye contact means different things in different cultures.
• Avoid using gestures since they can mean different things in different cultures.
• People of lower socioeconomic status often have present time orientation and thus may need additional teaching regarding preventive medicine and the outcomes should be attached to things that they value.

**Cultural Component of Cultural Competency Course**

The portion of the cultural competency course offers general suggestions on how to conduct culturally competent care with limited cultural knowledge, describes what cultural information would help doctors provide culturally-appropriate care, and offers practical suggestions of how to provide medical care according to the cultural knowledge learned.

**The 4 C’s of Culture:**

The key to developing cultural competency is asking the right questions to understand the patient’s point of view. In her book, *Caring for Patients from Different Cultures*, Geri-Ann Galanti suggests a mnemonic to ask the types of questions called “The 4 C’s of Culture.” The four questions medical providers should ask include:

1. What do you call your problem? (What do you think is wrong?)
2. What do you think caused your problem?
3. What have you done to cope with your problem?
4. What concerns do you have about your problem? What concerns do you have about my recommended treatment?

Why a physician should be knowledgeable of other cultures

America can be described as a mixed salad in reference to its diverse population (Lassiter, 1995, p. xi). This metaphor attempts to communicate that in the United States many times cultural populations do not assimilate themselves into society. Instead of merely “melting” into the United States popular culture, they resist acculturation and strive to maintain their beliefs and traditions. Physicians should be informed about the various cultural populations in the United States in order to combat the negative effects of stereotypes. For example, if a physician thinks that all Hispanic patients will eventually develop diabetes, this bias might cause a physician to misdiagnose a disorder with similar symptoms. However, at the same time physicians must be aware that individuals will adhere to the beliefs of their culture in varying degrees and they may do so according to the situation. Of course, knowledge about different cultures can be acquired through reading books, but the physician must develop awareness, sensitivity and skills through acting out scenarios in training and practical experiences with culturally diverse patient populations. There are also certain elements that will affect the health behavior of any individual, regardless of cultural background, that health care providers should keep in mind, such as acculturation, generational level, socioeconomic level, psychological state, and situational factors (unemployment, poor housing, and family disorganization). The following list highlights components of health, illness behaviors and attitudes about illness that are strongly influenced by an individual’s culture. It is important that the doctor be aware of the influence of culture on these health-related elements.

Aspects of health, illness behavior and illness attitudes that culture can influence:

- Health preservation
- Health prevention
- Illness
- Treatment
- Coping styles
- Belief about important life events such as death and dying.
- Traditional folk health care systems
- “Hierarchy of illness resort”—process of help seeking when ill before they see a health professional.
- Culture influences symptom meanings and consequently the manner in which health problems are treated: Gastrointestinal problems are significant for Italian and Mexican Americans and weight loss and fever for some Hispanic groups (Lassiter, 1995, p. xii).
- Compliance
- Decision making
- Self-care
- Pessimism
- Pain Tolerance
- The primary decision-maker or the caretaker are pre-determined roles in some cultures. Such as the Hmong culture that may defer decision-making power to clan leaders.
- The accepted mainstream goal of self-care may not be expected of the patient in some cultures (Lassiter, 1995, p. xii).
- Illness is punishment for sin or a result of a curse or an indication of weakness and this will all affect the patient’s health behavior.
- Ideas related to death and dying can affect the grieving process—if death is viewed as punishment for sins they might avoid seeking professional treatment.

**Cultural Profile: Mexican American Example**

In the suggested cultural competency course, cultural profiles of each cultural population in the United States would be studied. For the purpose of this guide we will focus on the Mexican American culture as an example, but this information should also be known about other cultures. Below is one cultural profile of Mexican Americans. In the course, the various categories listed below would be discussed in regards to the other cultural populations studied. Some categories are: country of origin of the culture, reasons for immigrating to the United States, communication style specific to the culture, and cultural beliefs regarding family, socialization patterns, religion and health. Under each section suggestions for how to provide culturally competent care in regards to these topics will be listed. These suggestions will not be limited to the Mexican American culture, but will at times reference other cultures. These extra suggestions represent some of the helpful knowledge I have learned about other cultures through my research and my internship at the clinic.

**Location:** of the country of origin of the culture.

**Population in the United States:** This category could include where higher concentrations of this cultural group can be found in the United States. For example, for Mexican Americans it would Los Angeles. Many times they live in “crowded Hispanic sections” of towns and this voluntary segregation helps maintain group identification through helping to maintain language culture and traditions (Lassiter, 1995, p. 172).

**History of Immigration:** Between 1810 and 1910 many Mexican Americans immigrated to the United States to take advantage of rapid economic development there and many also came to escape the Mexican Revolution of 1910. In the 1960s, the Chicano movement fought against some of the inequalities that Mexican Americans endured, such as limited educational opportunities and low wages. Currently, the practice of illegal immigration of Mexican Americans to the United States and the policies regarding this practice are heatedly debated the country.

**Forms of communication specific to that culture:** Most Mexican Americans speak Spanish. They communicate with the use of touch. Sometimes it just signifies how close the interlocutors are, but sometimes it means something more. For example, if they believe in the evil eye, a pat on a child’s head not only shows admiration, but will dispel the evil (Lassiter, 1995, p. 172). Their verbal expression is strong and usually accompanied by a strong facial expression and body language.
**Socioeconomic status:** Unfortunately, most are not very educated and many times the lack of American citizenship acts as a barrier to educational opportunities. Also, many lower socioeconomic status families resist acculturation and show stronger ethnic identification (173).

**Family:** Some of subcategories below will change between cultures, such as the Godparents section.

- **Traditional family:** Significant family members include the extended family, rather than only the nuclear family. The extended family acts as a support system and is considered more important than any one member. It has been patriarchal, patrilocal and patrilineal. The cultural pattern of machismo makes the male dominant and the female subordinate in the family.

- **Modern Family:** The family is becoming more nuclear, but many times extended family members live close by.

- **Child Rearing:** Parent’s relationship with children is more important than with each other. Also, children spend more time with adults, including grandparents and uncles and aunts, and thus are not as active as other children.

- **Godparents:** In Spanish it is called the *Compadrazo* System and includes the *padrino* and the *ahijado*. Many times godparents are considered extended family members and contribute economically to the family.

- **Discipline:** Fathers are strict with their children after puberty and siblings are segregated by gender. Although good behavior and obedience are stressed, personal achievement and self-reliance are not enforced. This is one of the reasons Latino children I have worked with don’t seem to value education.

**Suggestions:**

- Respect family dynamics.
- Ask the patient at the beginning of the consultation if there is anyone they would need to consult with if they need to make any medical decisions. Males are traditionally the authority figure in many cultures and often act as spokes persons for the family and make decisions for the family.
- Do not impose the value of independence upon those who do not want it. In some cultures, decisions are made by the family, not the individual. Many times these cultures value interdependence over independence.
- Involve the family in patient care if they want. However, emphasize self-care when the patient desires it or when it is necessary for physical recovery.
- When appropriate, patient education should involve all family members because they might help with care of that person.
- Show family members that you care about their loved one.
Ask your patients how much they know about their condition. Family members may try to protect them from a negative diagnosis/prognosis.
If your patient comes from a culture that practices sexual segregation, do your best to assign female caregivers to female patients.
Be especially sensitive to the needs and feelings of circumcised women whenever possible.
Realize that domestic violence is an extremely complicated issue for women from many other countries. This sometimes is further complicated if the women are undocumented.
Try to maintain the modesty of women whenever possible.
When a patient gives you an inappropriate gift, try to refuse it graciously. This practice is normal in many Latin American countries. If possible, try to accept gifts and share them with other staff.

Socialization Patterns: Mexican Americans often have the following characteristics:

- Machismo and male dominance
- Female submissiveness
- Generational interdependence
- Strong sense of family loyalty
- Fatalism: There is only so much good in the world. They have an external view of control; the individual is at the mercy of their environment.
- Honesty and dignity
- Personalism: a focus on relationships rather than tasks (175)
- Their sensual nature may make them perceive Americans as distant, cold and insensitive.
- Present time orientation: value needs of the present, which may include family or friend needs and not work goals. This also makes them late to appointments.

Religious beliefs and practices: They are predominantly Roman Catholic, but traditional native views believe in a reciprocal relationship between humans and gods. Some also believe that humans have multiple animistic centers. One animistic force is *tonalli*, which is located on top of the head and can determine a person’s temperament, future behavior, and fate (Lassiter, 1995, p. 176). The Aztec believe in the loss of *tonalli* through the fontanel. *Tonalli* is one of the three souls and is thought to be located on the top of the head. The loss of *tonalli* is diagnosed by doctors as dehydration. The folk cure for this illness is gravity, turning the baby upside down, or pressing upwards on the palate of the baby’s mouth. The concern is that folk beliefs might cause a delay in bringing in the infant for professional care and this could be fatal for an infant with dehydration.
Suggestions:

- Ask about food preferences and religious diet restrictions during the admission interview.
- Involve the patient and/or family in choosing meals when possible.
- Take ethnic diets into account with patients with special dietary requirements. Heart-healthy ethnic recipes are available online.
- If your patient comes from a culture or religion that forbids shaving, or cutting hair, do not do so without discussing it first with the patients.

**Chief complaint of health providers working with the cultural population:** A macho male is not supposed to show weakness and thus hides discomfort or pain longer than women or children. They may self-report pain more than other cultural groups, but they can endure it longer and this endurance is considered admirable, courageous, and self-sacrificing. Some Mexican Americans understand pain as punishment for sin that manifests itself as family misfortunes and cannot be explained by medical reasons.

The value that Mexican American culture places on enduring pain illustrates one way that pain treatment is complicated by cultural responses to it. Treatment of pain is important because pain can interfere with the healing process and it can compromise the immune system. The following are some tips for overcoming some of these cultural difficulties:

- Do not base your assessment of pain based on their expression of pain because culture can influence how much or how little a patient will express their pain.
- Anticipate a patient’s pain needs because cultural factors may deter from asking for pain medication.
- Address the type of concerns a patient has about their pain. Is it the sensation or the significance of the pain that worries them most?
- If alternative forms of pain medication are available, ask the patient what they would prefer.
- Address the patient’s concerns about addiction and explain the importance of pain medication to healing.
- Give clear directions on the use of pain medication and explain the reasoning for it.
- Examine your own biases and make sure they do not affect your response to patients in pain.

**Culturally Based Health Beliefs and Practices:** Many Mexican Americans see health as a harmonious relationship between social and spiritual realms. This means disruptions in social relations and any behaviors that conflict with social norms could hurt your health. They believe that illness can be caused naturally (*males naturales*) or it results from witchcraft or supernatural causes (*mal puesto*). Witchcraft illnesses can be cured by a traditional religious healer (*un curandero*). Many believe in a hot-cold dichotomy that evolved after Hippocrates’s humoral pathology was brought to Mexico by *conquistadores*, or Spanish conquerors. Health maintenance depends on the balance of hot and cold factors (Lassiter, 1995, p. 177). One area of health that is tends to abound with cultural beliefs is pregnancy. Pregnancy is considered a hot condition in cultures, like many Asian and Hispanic cultures, that practice a system of hot/cold body balance. However, it is important to realize that
most pregnancy taboos originated because of the desire to control the outcome of the pregnancy (Galanti, 2008).

**Suggestions regarding beliefs about birthing practices:**

- Physicians should carefully assess the pregnant woman’s diet to make sure she is getting enough protein because foods that are high in protein may be perceived as “hot” and thus avoided by the pregnant woman. The same is true for prenatal vitamins. If prenatal vitamins are considered to be too “hot,” they can often be neutralized by taking them with a “cold” beverage.
- Be aware that prenatal care may be avoided because many women see pregnancy as a “normal” condition and thus not requiring the assistance of a physician.
- Be aware that some cultures dictate stoicism during labor; others allow free expression of pain.
- If the husband seems unwilling to be in the room with his wife, do not force him to be because in many cultures, female relatives are the preferred labor partner.
- In some Southeast Asian cultures, surgery, like a c-section, may be avoided due to the beliefs of the patient. Hmong and Somali patients.
- Do not be surprised if patients may want to keep the umbilical cord or the placenta. This is a normal practice in the Hmong and Navajo culture.
- Patient education may be necessary when some women may want to postpone breastfeeding because they believe that colostrums is bad for the baby.
- Compromise when possible when a woman wants to practice a post-partum lying-in period. Many Asian, South Asian, and Hispanic women may practice a post-partum lying-in period in which they are to rest, stay warm, and avoid bathing and exercise. This practice may have health risks.
- Do not be concerned if Southeast Asian women do not appear to be bonding with their infant, as long as they hold and feed the baby properly. If they are not fussing over the infant, follow their lead. You should do this as often that is possible without inflicting harm to health.
- Be prepared to compromise. For example, rather than tell a mother not to use a bellyband on her child, make sure it is clean and not too tight.

**Folk Practitioners:** *Curanderos* use prayer and pledges (*mandas*) to supernatural forces to cure infirmities. *Yerberos* are herbalists. *Sobadoras* are masseuses that correct the musculoskeletal system. *Albolarios* are witch doctors. *Parteras* are midwives.

**Suggestions regarding Traditional Medicine:**

- Ask about unfamiliar markings on a patient’s body rather than assuming that they are a sign of abuse or a symptom of a disorder.
• Be sure to give clear instructions on the use of medications; nonadherence may simply reflect a lack of understanding.

• Allowing your patient to continue to use traditional remedies will help you gain their trust and increase the chances they will listen to you when you tell them that something is harmful. Many traditional remedies are helpful, and many of those with no proven scientific benefit are at least not harmful.

• It is important to ask respectfully if a patient is seeing a traditional healer. It is common for individuals to seek out multiple health care practitioners for the same problem without sharing this information with their medical practitioners because they fear offending the doctor, or being judged by them, or because they don’t think the information is important.

• You can say something along the lines of: Many of my patients also see traditional healers who prescribe herbal remedies, or use home remedies that have been passed down for generations. Often they can be effective, but sometimes they can cause problems, especially when mixed with other treatments. That is why it is important that I know everything that you’re taking to treat this or any other problem (Galanti, 2008, p. 221). An attitude of respect, rather than derision, is crucial.

• Collaboration between physicians and traditional healers is often in the best interests of the patient.

• Be aware that not everyone will adhere to traditional health care practices.

• Respect your patient’s beliefs, even if they conflict with your own and those of biomedicine.

Health seeking behaviors of Mexican Americans: These behaviors describe what actions a Mexican American might take if they feel unwell. They are listed in chronological order of when they would commonly occur. It is important for doctors to understand this process, as it guides them in what questions they might want to ask a Mexican American patient. Such as the simple question, “what have you done to get better thus far?” Typically these behaviors relate to the hot-cold illness model.

1. Bed rest
2. Taking aspirin
3. Using home remedies
4. Consulting family and the lay referral network
5. Consulting a folk practitioner
6. Seeing a medical professional (178)

Cultural dietary patterns: Mexican American food is highly seasoned and spicy. Corn and beans are eaten a lot. Although we see meat in a lot of “Mexican” food in the United States, this food is not considered “traditional” because meat is expensive and the poor in Mexico did not eat a lot of meat because they could not afford it. There are no food taboos for Roman Catholics.

Morbidity and Mortality: The Mexican American population experiences a high incidence of diabetes mellitus; even higher than in Mexico (Lassiter, 1995, p. 179). Obesity is a risk factor for Mexican Americans regarding chronic diseases such as hypertension, heart disease and cancers of
the breast and colon. They also experience a high incidence of cysticercosis or intestinal tapeworm disease among Mexican-American immigrants.

**Beliefs about death and dying:** Their beliefs stem from Roman Catholic beliefs that consider death the will of God. Sometimes grief manifests itself in Mexican American patients as somatic complaints. They can view death as respectful or humorous, as some of the practices of Day of the Dead show.

**Suggestions regarding the issue of Death:**

- It is important to discuss with the patient to whom they want information about their condition to be given—privately and at the beginning of the consultation—because in some cultures it is common to withhold a negative diagnosis/prognosis from the patient. Should the physician speak directly to a family member or to them? How much does the patient want to know about their condition? With whom does the patient want the physician to speak to for decisions regarding the treatment? American culture values individualism and autonomy, so we do not consider the possibility of not fully informing the patient. In cultures that value the family over the individual, such as Mexican Americans and Korean Americans, they believe this information should be withheld from the patient. In many Asian countries, including Japan and China, physicians reveal a cancer diagnosis to the family and they get to decide whether or not they will tell the patient (Galanti, 2008, p. 167). In the Hmong culture, telling a patient they are going to die would curse them. In the Navajo culture, they believe that saying something can make it happen, so they might not want to hear that they are dying.

- When raising the subject of hospice care, make sure the patient understands that care can be provided in the patient’s home. This will allow family members to care for their loved one.

- Be aware that cultural and religious influences play an important role in determining whether or not a family member is willing to remove life support. These influences can include the belief that only God can make that decision, the belief that suffering is an opportunity to show courage and faith in God, the need to show filial piety, and distrust of the white medical establishment.

- Be aware that many cultures have beliefs regarding the moment of death; these beliefs may include whether or not someone should remain at the bedside and what needs to be done to free the individual’s soul.

- Health care providers can play an important role in assisting families when the patient is close to death by trying to accommodate cultural practices regarding how the body should be prepared after death.

- Be aware that there are cultural variations in the expression of grief, as well as attitudes toward organ donations and autopsies.

- Be aware that traditions regarding disposal of the body relate to both environmental conditions and beliefs regarding the afterlife.
• Be aware that numbers may have significance for people; 13 as unlucky by many Americans and many Asians associate 4 with death. Room 4 would then be room of death.

**Physical assessment:** Mexican Americans may be shorter than non-Hispanic whites, with shorter legs and longer trunks.

**Places outside of the exam room in the clinic**

**X-ray room suggestions:**

• Have a small room attached to the x-ray room where patients can change into their gowns. Many cultures require that women dress modestly and they would not approve of women walking in hospital gowns from the exam room to the x-ray room.

• The extra changing room should be clean and not used as a storage room. Unidentifiable medical supplies or technological equipment can be scary to any patient regardless of their culture, especially in vulnerable situations where they are changing into revealing hospital gowns.

**Laboratory area:**

• If patients are brought to a special area to perform laboratory tests make sure there are comfortable chairs available for the patient and a few more chairs for accompanying family members. Many patients from cultures that value interdependence within the community versus independence of the individual will bring their family members to medical appointments for support. We want family members to feel comfortable too because they strongly influence the behavior of the patient regarding medical care.

• Have pamphlets explaining the purpose of various laboratory tests in various languages. Getting poked with a needle can be scary even if an interpreter tells you what the nurse is doing and why. Sometimes it helps to learn about the test to calm anxiety.

**Clinic Area for Height and Weight Measurements:**

• Have signs in different languages that give the directions normally given to take the height and weight of a patient. This way if the only available interpreter is an interpreter over speakerphone, the nurse can point to these directions and use body gestures to direct the patients through the

**Room Dedicated to Cultural Issues**

No one can deny that the United States population is diversifying. This means that many different cultures will be coming into contact and many of these cultures will not assimilate into the “melting pot.” Rather businesses will have to adjust in order to provide culturally competent services. Medicine will need to adjust accordingly as well. I suggest that beyond the addition of permanent interpreter there should be a separate office that is in charge of diversity issues. This will alleviate some of the pressure from the interpreter to provide support, as this office should be devoted to cultural issues. This separate room where people can discuss cultural issues with a permanent employee would
help build trust with multicultural patients. A nonmedical environment may also make them more comfortable discussing concerns.

**Beyond the Clinic**

This section focuses on medically-related activities that diverse patient communities might struggle with and thus require some system to help them. Some recommendations for how a medical care institution may make medically-related activities outside of the clinic more culturally accessible include:

- Research how to make appointment reminders or scheduling more culturally appropriate.
- Advertising to show that the clinic serves multicultural populations.
- System for contacting interpreters.
- A community informant or system that keeps the health care institution informed about the needs of the community and its general ethnic composition and activities of any sort.
- An educational workshop on how the pharmacy works. Especially, on how refills work.
- Connections to other healthcare programs. This area may be more relevant for the HealthFinders clinic than for other health care institutions because they are a free clinic. There are certain things they can’t do, and so they contact other programs that provide certain free or reduced-price services.

**Connecting to the community**

HealthFinders clinic is connected to an umbrella group called “Growing up Healthy” that tries to foster communication between healthcare providers and other community programs. They have meetings where the administrators of these community programs come together. The problem with these meetings however, is that the administrators are not always able to relay the information they learn from these meetings to their employees who work with their clients. Information sometimes gets stalled at the top. I learned this information from a friend that is working with the program right now and she also informed me that her boss in this program is trying to get a grant that would fund efforts to find a better way to relay information through organizations.

The main point is that an organization should get to know other partner programs and the community in general to make better use of their resources. Sometimes organizations take on things that they aren’t equipped to do and other organizations are. It is important to understand the limitations and the strengths of other organizations. Bottom line, connecting to the community and patients provides support for your organization’s mission and financial resources. Being connected to your community is what ensures success.

Many different healthcare businesses, such as Allina and Fairview, further increase the United States’ tendency towards isolation as the systems do not communicate with each other and many times the communication within these systems is not very good either. For example, when I shadowed in the Fairview system at a regular clinic and then in the emergency department of a hospital, I learned that
they both had different electronic medical record systems and that because of this they could not access information in the other system. The point of electronic medical record system is not only to save trees, but also to enable better communication. With different systems, the files still need to be sent between clinics in paper form. This is not helpful for the emergency department, which usually needs background information on a patient very fast. This inability to communicate within a single organizational network makes it impossible to communicate between organizational networks nationwide. If local networks cannot communicate within themselves, how do we expect to communicate nationally between networks? National communication would have many benefits such as faster spread of new medical findings which could help decrease medical costs.

Thus, it would be more sensible if there was some type of standard national electronic record system that enabled the transfer of records quickly from clinic to clinic. Of course healthcare businesses may not want to support this idea because this makes it easier for patients to switch systems. The deterrent of paper records might keep some patients within a system.

It seems that not only would culturally competent care be provided with the hiring of more interpreters and the implementation of cultural competency courses in medical school, but better communication between health care institutions regionally and nationally would help facilitate spreading cultural knowledge.
Bibliography


