

INVITED COMMENTARY

EDITOR'S NOTE: It is hardly news to physicians on the front lines of patient care that the cultural diversity of our patients is broadening daily. Those of us who want to provide sensitive, competent care to families from cultures other than our own are in urgent need of practical advice. In many health care settings today, this need is addressed by "diversity consultants" who put their "clients" through mind-numbing exercises. It is unusual to come out of such exercises with a practical strategy to use in the office or clinic. In this context, readers will find the article by Flores a much needed breath of fresh air. Although the author bases his recommendation on a firm theoretical foundation, the article is replete with usable, practical recommendations that any health care provider can immediately incorporate into his or her practice. The specific recommendations are targeted at those caring for Latinos, but the model of cultural competency he presents is widely applicable.

Thomas R. Welch, MD
Associate Editor

Culture and the patient-physician relationship: Achieving cultural competency in health care

The world's current population of almost 6 billion people inhabits 191 countries and speaks more than 6000 languages,¹ but little is known about the importance of culture in health care. Anthropological and cross-cultural studies have yielded key contributions about clinical aspects of selected cultural differences, such as patient belief systems and ethnomedical practices.²⁻⁴ The actual clinical ramifications of culture, however, have rarely been examined.

The purpose of this article is to describe how culture affects clinical care. Studies are presented that detail the impact of culture on health care processes, outcomes, quality, and satisfaction in order to provide a general framework for understanding the clinical consequences of culture. This is achieved through an in-depth focus on the culture of a single group, rather than a cursory survey of the cultures of multiple groups. Although the focus is

on Latinos, soon to be the largest minority group in the United States, the concepts that emerge apply to any cultural group. The following components of culture's effect on clinical care are examined: (1) normative cultural values, (2) language, (3) folk illnesses, (4) parent/patient beliefs, and (5) provider practices. The specific clinical impact of each of these components is examined, together with practical solutions to ensure that culturally sensitive care is provided. Finally, a model for cultural competency in health care is proposed, which can be used to guide clinicians in interactions with any cultural group.

From the Division of General Pediatrics, Boston University School of Medicine, the Division of Biostatistics and Epidemiology, Boston University School of Public Health, and the Pediatric Latino Clinic, Boston Medical Center, Boston, Massachusetts.

Supported by grants from the Robert Wood Johnson Minority Medical Faculty Development Program, the Institutional National Research Service Award-Health Resources and Services Administration, and the Department of Pediatrics, Boston Medical Center.

Presented in part as the keynote speech at the annual meeting of the Council on Medical Student Education in Pediatrics (COMSEP), Galveston, Texas, March 27, 1999; at the National Conference on Quality Health Care for Diverse Populations, New York Academy of Medicine, October 3, 1998; and as a workshop at the Pediatric Academic Societies' Meetings, San Francisco, California, May 2, 1999, and New Orleans, Louisiana, May 5, 1998.

Reprint requests: Glenn Flores, MD, Division of General Pediatrics, Boston Medical Center, 91 E Concord St, Maternity 419, Boston, MA 02118.

J Pediatr 2000;136:14-23.

Copyright © 2000 by Mosby, Inc.

0022-3476/2000/\$12.00 + 0 9/18/103352

OCR Office for Civil Rights

DEFINITIONS

Latinos

The term *Latino* denotes all persons living in the United States whose origins can be traced to the Spanish-

speaking regions of Latin America, including the Caribbean, Mexico, Central America, and South America. Although *Hispanic* is still the official designation used by the federal government, several authors^{5,6} have pointed out that this term places narrow and undue emphasis on the European influence of Spanish colonialism. *Latino* is a more inclusive term that does not de-emphasize the crucial roles of indigenous Indian cultures and African slaves in Latin American history.

Cultural Group

A *cultural group* is defined as individuals that share common beliefs, attitudes, values, and behaviors.⁴ However, as Pachter⁷ has stated, individuals subscribe to group norms to varying degrees. A patient's health beliefs and practices arise from a combination of normative cultural values together with personal experience and perceptions. Individuals in a cultural group do not think and act in the same manner.

DEMOGRAPHICS OF LATINOS IN THE UNITED STATES

Latinos will surpass African Americans as the largest minority group in the United States by as early as the year 2005.⁸ In 1996, the Latino population of the United States was >28 million, exceeding the total population of all but 6 Spanish-speaking countries.⁶ Almost 11 million US Latinos, or 39% of the American Latino population, are children.⁸ Latinos have one of the highest fertility rates of any ethnic group⁹ and triple the growth rate of the overall American population.⁶ Clinicians thus are increasingly likely to encounter greater numbers of Latinos in their practices.

Recent studies highlight that differences among Latino subgroups (such as Puerto Ricans, Cubans, and Mexicans) in sociodemographics, health status, and use of health services are

sometimes of equal or greater magnitude than differences among major ethnic groups.^{10,11} In the discussion of normative cultural values and folk illness beliefs, it is important for the clinician to be aware that such subgroup variation exists. Normative culture values and folk illnesses may also be influenced by such factors as a patient's socioeconomic background, the degree of acculturation, the country of birth, education, and English proficiency. However, at least for folk illnesses, evidence from several studies suggests that sociodemographic variables do not seem to have a significant influence on these beliefs and practices.¹¹

NORMATIVE CULTURAL VALUES

Normative cultural values are defined as the beliefs, ideas, and behaviors that a particular cultural group values and expects in interpersonal interactions. Five Latino normative cultural values and their clinical consequences are examined.

Simpatía

Simpatía means "kindness" in Spanish. In *simpatía*, a value is placed on politeness and pleasantness in the face of stress.¹² Avoidance of hostile confrontation is also an important component. In clinical settings *simpatía* includes the view that a physician with a positive attitude is the norm; it is expected that the physician will be conspicuously polite and pleasant. The relatively neutral attitude of many US physicians is often viewed as negative by the Latino patient. Lack of *simpatía* can potentially result in decreased satisfaction with care, an inaccurate history, nonadherence to therapy, and poor follow-up. For example, resentment toward a detached physician may cause the Latino patient to withhold clinical details, not adhere to therapy, not make follow-up visits, and not be satisfied with care. The clinician can

ensure *simpatía* by emphasizing courtesy, a positive attitude, and social amenities.

Personalismo

Personalismo can be translated as "formal friendliness."⁵ In *personalismo*, the Latino patient expects to develop a warm, personal relationship with the clinician.¹³ Such a relationship would be characterized by interactions that occur at close distances. Physical contact between the patient and physician would also be expected, including such gestures as handshakes, a hand on the shoulder, and even, in certain circumstances, hugging. The perceived absence of *personalismo* can potentially lead to an inaccurate history, noncompliance with therapy, dissatisfaction with care, and poor follow-up. For example, Latino patients might conclude that a physician does not really care about them because of the physician's failure to display adequate *personalismo*, resulting in patients holding back crucial details of an illness, not taking prescribed medications, not being satisfied with care, and never returning for subsequent medical visits. *Personalismo* can be achieved by decreasing the physical distance during interactions with patients, increasing socially appropriate physical contact, providing a business card or beeper number, and displaying an interest in the patient's life at each visit. For example, *personalismo* can be assured by routinely beginning each medical visit with a brief conversation about the patient's family, work, or school.

Respeto

Respeto literally translates as "respect." Appropriate deferential behavior is expected on the basis of a position of authority, age, gender, social position, and economic status.¹³ Health care providers are viewed as authority figures who must be shown *respeto*. Latino patients also expect reciprocal *respeto* from the provider, especially when the provider is younger than the patient. Demonstrating ap-

appropriate *respeto* may include a hesitancy to ask questions, because posing a question to an authority figure can be construed as disrespectful. The “nod of the head” in response to a physician’s instructions or comments may therefore represent a socially required gesture of respect, rather than understanding or agreement.⁷ The absence of *respeto* can potentially lead to inaccurate histories, medication errors, nonadherence to therapy, decreased satisfaction, and inadequate follow-up. For example, a Latino patient who is angry and resentful at not being shown proper *respeto* may withhold clinical information, be prone to medication errors or nonadherence because of communication problems, be dissatisfied, and not make additional medical visits with that particular physician. *Respeto* can be achieved by using Spanish terms of respect, such as *usted* (the polite form of “you”) rather than *tu* (the informal “you”), appropriate titles (*Señor* [Mr] and *Señora* [Mrs]), and formal greetings (*buenos días* [good morning] and *buenas tardes* [good afternoon]). It is also important to involve patients in medical decisions whenever possible. In addition, special attention should be devoted to eliciting the patients’ concerns.

Familismo

Familismo can be described as a collective loyalty to the extended family that outranks the needs of the individual.⁵ Important decisions are made by the extended family, not the individual alone. The 3 basic dimensions¹⁴ of *familismo* are: (1) familial obligations (providing material and emotional support to family members), (2) support from the family (the perception that family members are reliable providers of help and support in solving problems), and (3) family as referents (decisions and behavior should be based on pleasing and consulting with family members). *Familismo* can result in delay or deferral of important medical decisions to permit consultation with

the extended family. Clinical issues that can be affected by *familismo* include informed consent, intensive care unit choices such as intubation and extubation, and end-of-life decisions. Failure of the clinician to acknowledge *familismo* can potentially lead to unnecessary conflicts, dissatisfaction with care, nonadherence, and poor continuity of care. Clinicians can demonstrate appropriate respect for *familismo* by providing ample time and opportunity for the extended family to gather to discuss important medical decisions.

Fatalismo

Fatalismo, or fatalism, is the belief that the individual can do little to alter fate. In a study of adult attitudes toward cancer, Pérez-Stable et al¹⁵ found that Latinos were significantly more likely than whites to believe that having cancer is like getting a death sentence (46% vs 26%, respectively; $P < .001$), to prefer not to know if they had cancer (35% vs 23%; $P < .001$), to believe that there is little one can do to prevent cancer (26% vs 18%; $P < .001$), and to believe that cancer is God’s punishment (7% vs 2%; $P < .001$). *Fatalismo* can result in important adverse health consequences, including less preventive screening and avoidance of effective therapy for cancer and chronic diseases. For example, several studies of cancer in women have documented that Latinas present with more advanced tumors and delay seeking care for cancer-related symptoms.¹⁶⁻¹⁸ Clinicians may avoid the adverse consequences of *fatalismo* by emphasizing the importance of screening and prevention and by underscoring the efficacy of therapies for chronic diseases and cancer. For example, the culturally sensitive physician might achieve these objectives by using the patient’s own cultural beliefs and values, pointing out that “Perhaps God doesn’t want you to get sick and die yet,” or “You need to take care of yourself so that you can be there for your family.”

LANGUAGE

More than 31 million Americans are unable to speak the same language as their health care provider.¹⁹ In 1990 it was estimated that there were ~1.1 million Spanish-speaking children in the United States who had limited or no English proficiency.²⁰ Language problems can have a substantial impact on multiple aspects of health care, including access, health status, use of health services, and health outcomes.

Language Problems and Access to Care

Several studies have demonstrated that language problems can be major barriers to health care access for Latino children. Among Latino mothers surveyed in the waiting room of an emergency department, 35% cited staff not speaking Spanish as a major barrier to obtaining health care for their child in the past year.²¹ More than 26% of mothers of Latino children with asthma reported that language difficulties in talking to physicians were a major barrier to managing their child’s illness.²² Latino parents at a pediatric primary care clinic identified language problems as the single greatest barrier to health care access for their children²³; specifically, 15% of the 203 parents surveyed reported that the greatest obstacle was doctors and nurses who do not speak Spanish, and 11% cited a lack of interpreters. In addition, 6% of parents said that they had deferred a medical visit for their child because of language problems.

Language Problems, Health Status, Use of Services, and Health Outcomes

Limited English proficiency is associated with adverse consequences for health status, use of health services, and health outcomes. For example, children whose parents primarily or exclusively speak Spanish were significantly more likely to be in fair or poor health (by parental rating), less likely

Table I. Interpreter options available to the health care provider

Interpreter type	Training*	Cost*	Problems
Professional	1-4 y	Full time, \$16,000-66,560/y; contract work, \$10-32/h	Cost
Ad hoc	0-150 h	\$480-1500 (annual bonus), or \$1.00/h differential, or paid overtime	Loss of productivity while away from non-interpreter work, limited availability because of non-interpreter work
Telephone service	Already trained	Subscriber: \$200 initial fee; \$2.20-4.50/min; minimum monthly usage charge: \$50 Non-subscriber: \$4.15-7.25/min plus per call service fee: \$2.50	Requires minimum of 50 h/mo use, can be awkward, appreciation of non-verbal cues not possible
Family member or friend	None	None	Accuracy, confidentiality, avoidance of sensitive issues, disruption of social roles, medical terms may be incorrectly/not translated

*Selected data from Woloshin et al¹⁹ and Ginsberg et al.³⁴

to have a usual source of medical care, and less likely to have visited a health care provider in the past year, even after adjustment for relevant covariates.²⁴ Mexican-American children whose parents spoke English were 12 times more likely to have a regular provider than those whose parents spoke no English, regardless of insurance coverage.²⁵ Among Latino adults visiting several clinics in San Diego, monolingual Spanish speakers were least likely to have a regular source of care, to describe their health status as excellent, to be satisfied with care, and to have had a checkup, compared with both bilingual and monolingual English-speaking patients.²⁶ Lower rates of mammograms, Pap smears, and other preventive services have been found among Mexican-American women with limited English proficiency.²⁷ Among adult Latinos with asthma who were monolingual Spanish speakers, there was a greater likelihood of missing a follow-up appointment, of nonadherence to use of medications, and of making an emergency department visit among those whose physician spoke English only compared with those who had bilingual physicians.²⁸

Language Problems in Psychiatric Settings

In psychiatric settings, language problems for Latino patients have been associated with a greater likelihood of a diagnosis of more severe psychopathology, and of patients leaving the hospital against medical advice.^{29,30} Studies of doctor-patient encounters revealed that English-speaking patients are more likely than Spanish-speaking patients to establish a better rapport with the physician, to receive a better explanation of their therapeutic regimen, and to provide feedback to the physician.³¹ Latinos seen by bilingual physicians have been found to have a significantly greater recall of patient information than those seen by monolingual English-speaking physicians.³² Inadequate attention to language and cultural factors in the psychiatric evaluation of Latino children and adolescents may lead to misdiagnosis and treatment errors for at least 21 diagnoses in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, including mental retardation, autism, attention-deficit/hyperactivity disorder, separation anxiety disorder, and schizophrenia and other psychotic disorders.³³

Strategies for Overcoming Language Problems

Given that those with limited English proficiency are at risk for multiple adverse health consequences, what options to overcome language problems are available to clinicians? Table I summarizes the 4 main interpreter types and their associated training requirements, costs, and pitfalls.^{19,34} For patients with limited English proficiency, the most effective way to overcome language problems may be to have a clinician who is fluent in the patient's primary language. For example, adult Latinos with hypertension and diabetes who primarily spoke Spanish were found to be significantly more likely to have improved physical functioning, better psychologic well-being, better health outlooks, and less pain, if their primary care physician spoke Spanish fluently.³⁵

Effective Use of Interpreters

Selected guidelines that have been proposed for the proper choice and effective use of interpreters,^{5,7,36} supplemented by those that I have found useful, are summarized in Table II. Although studies have not examined the efficacy of these guidelines, they seem reasonable and are supported by clinical experience.

Table II. Guidelines for the effective choice and use of interpreters in clinical settings***Interpreter choice**

- Unless thoroughly fluent in patient's language, always use trained interpreter
- Avoid strangers from waiting room or untrained staff as interpreters because of potential problems with accuracy, confidentiality, and medical terminology
- Children should be interpreters of last resort because of problems with disruption of social roles, sensitive issues, and accuracy
- Adult relatives or friends brought specifically to translate are acceptable alternatives when trained interpreters are not available, but there may be problems with accuracy, confidentiality, medical terms, and disrupted social roles
- Always ask patient whether designated interpreter is acceptable

Interpreter use

- Clinician, interpreter, and patient/parent should be positioned in equilateral triangle so important nonverbal cues can be appreciated
- Speak to and maintain eye contact with patient/parent, not interpreter
- Ask interpreter to translate as literally as possible
- If mistranslation or misunderstanding is suspected, return to issue later using different wording
- Emphasize key instructions and explanations by repetition
- Use visual aids (charts and diagrams) whenever possible
- To verify quality and comprehension of translation, have patient/parent repeat information through back translation

At end of medical visit

- Interpreter should write lists of instructions for patient/parent, particularly for prescriptions and other therapeutic interventions
- Indicate to pharmacists that prescription instructions should be printed in the family's language
- Interpreter should always accompany patient/parent to schedule follow-up appointments with receptionist

*Includes information from Pérez-Stable,⁵ Pachter,⁷ and Putsch.³⁶

Few studies have examined the use and clinical impact of medical interpreters. An emergency department study indicated that interpreters are underutilized, despite the expressed needs of patients; most interpreters lack formal training; and patients' understanding of their conditions and therapy was poorest among those who desired, but did not have access to, interpreters.³⁷ Baker et al³⁷ found that among patients with limited English proficiency seen by providers with limited or no Spanish proficiency, 87% of patients who did not have an interpreter thought that one should have been provided. Only 12% of the interpreters were professionally trained. Among patients who desired but did not have access to an inter-

preter, only 38% said that their understanding of their disease was good or excellent, and 58% said their understanding of their treatment plan was good or excellent; both findings were significantly lower than corresponding rates for patients who had interpreters (57% had good/excellent understanding of their disease and 82% had good/excellent understanding of their treatment plan) or did not require interpreters (67% and 86%, respectively).

FOLK ILLNESSES

Folk illnesses are culturally constructed diagnostic categories commonly recognized by an ethnic group,

often in conflict with biomedical paradigms.^{4,7} The prevalence of folk illness beliefs varies, depending on such factors as ethnicity, national origin, region, and levels of acculturation. The clinical ramifications of the 3 Latino childhood folk illnesses most frequently encountered by clinicians are examined.

Empacho

Empacho is a condition in which it is believed that a substance (usually food or saliva) gets "stuck" to the walls of the stomach or intestines, causing an obstruction.⁴ It is thought to result from dietary indiscretions, including eating in excess, consuming spoiled food, eating at the wrong time, or combining inappropriate foods.⁴ Symptoms include vomiting, diarrhea, anorexia, bloating, cramps, and a stomachache.^{4,7,38} Treatment includes dietary restrictions, herbal teas, abdominal massage with warm oil, and popping the skin on the small of the back.⁴ The parents will frequently consult a folk healer (*santiguadora* in the Puerto Rican community and a *sobadora* or *curandero* in the Mexican-American community), who performs a special massage, recites prayers, and recommends dietary modification.

Most treatments for *empacho* do no clinical harm. However, multiple cases of lead toxicity have been documented among children whose *empacho* was treated with powdered folk remedies (called *greta*, *azarcón*, or *albayalde*) containing high concentrations of lead oxide.³⁹⁻⁴³ These lead oxide powders were used by 11% of mothers in one recent study at a California clinic.⁴⁴ *Empacho* may also be treated with a tea made from the leaves of wormwood, a cerebral stimulant that can be psychoactive and may, in rare cases, cause psychosis and premature death.⁴⁵

Other important clinical consequences of *empacho* were noted in a study of Puerto Rican families.³⁸ A survey of the parents of 63 children indicated that 90% knew of *empacho*, and 64% said that a child in their house-

hold had experienced it in the past. Among parents whose children had been afflicted with *empacho*, 77% took the child to a *santiguadora*, 58% used a home remedy, but only 37% made a visit to a physician. The physician was the first choice for treatment in only 30% of cases, and when asked which treatment option was most effective, 58% said the *santiguadora*, 37%, home remedies; and 5%, the physician. Indeed, 85% of those visiting a physician for *empacho* sought another treatment option afterward.

Pediatricians interviewed in this study noted that the symptoms of *empacho* overlap with several important biomedical conditions including gastroenteritis, formula sensitivity, milk allergy, obstruction, pyloric stenosis, appendicitis, and intussusception.³⁸

Mal Ojo

Mal ojo (evil eye) occurs when a person with “strong eyes” intentionally or unintentionally looks at a child.⁷ The illness is believed to occur because a spell has been placed on the child by an individual who secretly covets him or her.⁴⁵ The “strong eyes” are believed to “heat up” the child’s blood, resulting in fever, inconsolable crying, diarrhea, vomiting, aches and pains, and a gassy stomach.⁴⁵ Among one group of Mexican-American parents, *mal ojo* was the most frequently reported folk illness, with 70% saying that they had experience with it.⁴⁵ Treatment consists of taking the child to a folk healer for herbal remedies and ritual cures or sweeping the child’s body with an egg, a lemon, a chili pepper, or rue.⁴⁵

The symptoms of *mal ojo* overlap with serious biomedical conditions including bacteremia, sepsis, dehydration, and gastroenteritis. Some Latino parents place an amulet on infants, known as an *azabache*, which is worn on a necklace or bracelet and is believed to protect against *mal ojo*. Necklaces and bracelets can place infants at risk for strangulation and other accidents and present problems for

surgery and certain medical procedures, because the parents may insist that the *azabache* remain on as a source of protection. A safe, culturally sensitive alternative that is acceptable to most parents is to pin the *azabache* on the inside of a garment.

Mollera Caida

Mollera caida, or fallen fontanelle, is believed to occur when the breast or bottle is removed too rapidly from an infant’s mouth or when the infant is bounced or tossed around.⁴⁵ As a result, it is believed that the soft palate “sinks in,” leading to difficulties with feeding and swallowing. Other symptoms include fever, diarrhea, and fussiness. In one group of Mexican-American parents in Texas, more than half reported having had experience with *mollera caida*.⁴⁵ Treatment is aimed at “realigning” the fontanelle through such measures as pushing up the soft palate with the thumb, pulling the hair, sucking the fontanelle, or hanging the infant over a basin of water and tapping the feet.⁴⁵

The symptoms of *mollera caida* should alert the clinician to possible severe dehydration. In addition, treatments involving suction of the fontanelle or holding an infant upside down can be dangerous or fatal. There is a report of an infant’s death from complications of a subdural hematoma that probably resulted from treatment of *mollera caida*: the child’s grandmother had held the infant by the ankles with his head partially submerged in boiling water while shaking him and slapping his feet.⁴⁶

Culturally Sensitive Approaches to Folk Illnesses

A patient’s satisfaction with care, adherence to therapy, and continuity of care may depend on a clinician’s sensitive response to folk illness beliefs. A judgmental response to folk illnesses may lead to termination of future clinical encounters. A crucial step in achieving cultural competency is awareness of the existence of various folk illnesses within a patient’s cultural

group. This awareness is essential because folk illness symptoms often overlap with serious biomedical conditions, the first provider contact may not be with a non-biomedical practitioner, and some folk remedies may be harmful. Pachter⁴ suggests that clinicians can become aware of folk illnesses by sensitively talking to patients and staff members residing in particular ethnic communities: inquire about folk illness beliefs by explaining that you are aware that a given folk illness exists that doctors may not know about; ask whether the patient has ever heard of it, and if so, whether he or she (or his or her child) has it now.⁴

Because most folk remedies are harmless, instead of dissuading the patient from further use of these remedies, the clinician should emphasize the importance of using biomedical therapies in addition. When harmful folk remedies are encountered, the clinician should explain the potential harm and replace the folk remedy with another that fits into the patient’s belief system.⁴ An example would be to replace a tea containing wormwood with another harmless herbal tea, such as one containing mint.

PARENT/PATIENT BELIEFS

Patient beliefs can have a profound impact on clinical care. They can impede preventive efforts, delay or complicate medical care, and result in the use of neutral or harmful remedies.

Inaccurate parental beliefs have been shown to be associated with vaccination delays in children. In a study of factors associated with under-vaccination among poor, urban minorities, multiple logistic regression revealed that incorrect parental beliefs were significantly associated with delayed immunization status for Latino children at 3 months of age.⁴⁷

A study of Latino mothers in a California clinic⁴⁴ identified parental beliefs

that may lead to delays in seeking medical care, increased transmission of infectious diseases, and use of neutral or harmful home remedies. A hot-cold imbalance—including weather changes, walking in bare feet, getting wet, and consuming hot or cold food or beverages—was believed to be the cause of coughs by 80% of mothers, of fever by 43%, and of rashes by 34%. Conjunctivitis was more commonly believed to be caused by drafts and wind (by 53% of mothers) than by infectious agents (by 40% of mothers). Other believed causes of conjunctivitis included watching television too close to the screen, lack of sleep, and use of a heater. Diarrhea was much more commonly attributed to difficulties such as unsettled or decomposed food or dentition problems, rather than infectious causes. Most mothers in this study (81%) reported use of home remedies to treat their children's illnesses.⁴⁴ Home remedies were used by 51% of mothers for burns, 41% for coughs, 41% for rashes, and 31% for diarrhea. Potentially harmful home remedies that were given included, for fever, an enema of salt and oil; for conjunctivitis, instillation of drops of lemon juice or breast milk into the eyes, blowing cigarette smoke into the eyes, or washing the face with warm urine; and for minor wounds, application of spider webs, mud, lemon juice, or a mixture of bleach and baking soda.

Culturally Sensitive Approaches to Parent/Patient Beliefs

Strategies recommended for approaching folk illnesses would also be helpful in dealing with parent and patient beliefs. The sensitive, nonjudgmental clinician is able to learn about the parent's or patient's belief system and practices. Harmful remedies can be replaced with harmless ones consistent with the individual's beliefs. Medical treatment plans should be explained carefully, with special attention to the rationale behind therapeutic interventions.

PROVIDER PRACTICES

Clinicians sometimes provide a lower quality of care to patients from different cultures. A particularly dramatic example emerged from a study of analgesia administered to patients with long-bone fractures in an emergency department.⁴⁸ A statistically significant greater proportion of Latinos (55%) than whites (26%) received no analgesia. White patients were significantly more likely than Latino patients to be given oral analgesia and to receive both non-narcotic and narcotic forms of analgesia. When relevant covariates (including injury type, language, and insurance status) were adjusted for in multivariate analysis, Latinos had greater than 7 times the odds of receiving no analgesia, compared with whites.

Studies have also shown that there are ethnic disparities in vision screening and receipt of prescription medications. A nationwide study of vision screening at 102 pediatric practices⁴⁹ showed that Latino children (56%) were screened by pediatricians significantly less often than white children (66%, $P < .001$). Data from the National Medical Expenditure Survey⁵⁰ showed that among children aged 6 to 17 years of age who had made an outpatient physician visit, only 52% of African American and 53% of Latino children had received prescriptions, significantly less than the 66% of white children. These ethnic disparities persisted after adjustment for relevant covariates in multiple logistic regression. Statistically significant differences were also found among these groups in the mean number of prescribed medicines, with Latino (mean prescriptions = 1.5) and African American (1.7) children receiving fewer prescriptions than white children (2.4). In a study of preschool children hospitalized for asthma,⁵¹ investigators found that Latino children were 17 times less likely to be prescribed a nebulizer for home use at discharge, after adjustment for relevant covariates.

Clinician attitudes can be perceived as a barrier to health care by some ethnic groups. In a clinic for children with asthma, 31% of Latino mothers said that attitudes of physicians and nurses are a major barrier to managing their child's condition.²² Among Latino mothers at an urban primary care clinic, 11% said that they had deferred a medical visit for their child because the doctors and nurses did not understand Latino culture.²³ Lack of confidence in the health care staff was cited by 31% of Latino mothers in a pediatric emergency department as a major barrier to obtaining care for their child in the past year.²¹

The reasons that clinicians sometimes deliver lower quality of care to non-white ethnic groups have not been studied. Language problems have been suggested as a logistical difficulty accounting for ethnic disparities in vision screening.⁴⁹ In other studies, however, ethnic disparities persisted despite adjusting for the patient's language. Cultural differences may impede effective communication, leading to misunderstandings. Subtle or overt bias might be responsible in some instances, such as racial disparities in cardiac procedures.⁵²

Strategies for Altering Provider Practices that Affect Quality of Care

Recommendations mentioned earlier regarding normative cultural values and language problems should assist the clinician in the delivery of culturally sensitive health care. In addition, as part of institutional quality assessment, it would be useful to perform active surveillance for ethnic disparities in health and the use of services. Individual cases might then be examined to determine provider practices that might be responsible for differences in the quality of care. In settings in which clinical services are provided primarily or exclusively to a single cultural group, more patient-oriented surveillance techniques will be required to ascertain and address provider practices that affect the quality of care. For ex-

ample, in the Pediatric Latino Clinic at Boston Medical Center, which exclusively serves Latino children, we periodically survey parents regarding whether they have experienced problems with cultural issues, language, and lack of culturally sensitive health care providers.

A MODEL FOR CULTURAL COMPETENCY IN HEALTH CARE

Definition

Culture clearly affects clinical care. The studies cited document the impact that culture can have on outcomes, quality of health care, and satisfaction with care. A goal for the clinician, therefore, is to provide culturally competent health care in the patient-physician encounter. *Cultural competency* is defined as recognition of and appropriate response to key cultural features that affect clinical care.

How to Use the Model to Achieve Cultural Competency

A model of cultural competency is proposed, which can be helpful in clinical encounters with patients from any cultural group. The model consists of the 5 components that serve as the framework of this article: normative cultural values, language issues, folk illnesses, patient/parent beliefs, and provider practices. The clinician needs to be familiar with normative cultural values that may affect the health care of ethnic groups commonly encountered in the practice and to accommodate for such cultural values. The clinician can determine these cultural values by using a published reference,¹³ consulting with colleagues from other ethnic groups, and speaking to interpreters and community members from different ethnic groups.

The culturally competent clinician would use interpreter services for a patient with limited English proficiency, except when he or she is fluent in the

patient's primary language. Cultural competence requires knowledge and skills regarding the effective choice and use of interpreters (Table II). Essential components of culturally competent care also include ongoing efforts to increase the foreign language skills of staff and the English skills of patients with limited English proficiency.

To effectively approach folk illness beliefs and practices, the culturally competent clinician needs to be able to recognize those that are most commonly encountered in practice. Culturally sensitive methods are available for learning about folk illnesses.⁴ A brief but effective 4-step approach is to: (1) explain that you are aware that a given folk illness exists that doctors may not know about; (2) ask whether the parent or patient has ever heard of it; (3) ask whether the patient has the folk illness now; (4) ask what treatment the patient is receiving for the condition. The clinician should then suggest alternatives to harmful folk remedies, accommodate (nonjudgmentally) the folk illness beliefs and practices, and integrate the use of harmless folk remedies into the treatment plan.

The culturally competent approach to patient/parent beliefs is similar to the approach to folk illnesses. The clinician needs to identify the beliefs that might affect care in a similarly sensitive manner, suggest alternatives to harmful home remedies, and carefully explain the etiology and treatment rationale for a particular biomedical condition. Integration of harmless home remedies into the treatment plan should also be considered whenever possible.

The culturally competent clinician needs to maintain vigilance for ethnic disparities in screening, prescriptions, procedures, and health outcomes. When ethnic disparities are noted, the problem source should be identified, and the practices responsible need to be addressed. Regular monitoring by an institution's quality assurance board may be necessary to eliminate such ethnic disparities.

CONCLUSIONS

Culture can have important clinical consequences in the patient-physician relationship. Failure to consider a patient's cultural and linguistic issues can result in inaccurate histories, decreased satisfaction with care, non-adherence, poor continuity of care, less preventive screening, miscommunication, difficulties with informed consent, inadequate analgesia, a lower likelihood of having a primary care provider, decreased access to care, use of harmful remedies, delayed immunizations, and fewer prescriptions.

Recognition of and appropriate response to a patient's normative cultural values is important, because failure to do so can result in a variety of adverse clinical consequences. However, the culturally competent clinician needs to beware of the dangers of stereotyping. Among Latinos, for example, a wealthy Cuban American whose family has resided in the United States for many generations may have cultural values that differ strikingly from those of a first-generation Mexican American. Nevertheless, by using the 5-component cultural competency model, the clinician will be able to ascertain the unique cultural attributes of each patient and appropriately respond to the cultural values, language issues, folk illness beliefs and practices, patient/parent beliefs, and possible ethnic disparities in health and use of services.

The cultural competency model presented in this article can be used in a variety of settings including patient encounters, medical education, research, and advocacy. The model should assist the clinician in providing culturally competent care, regardless of the patient's ethnicity. The model provides a cultural framework for medical students, residents, and continuing medical education and can be particularly helpful in case-based learning. The model can serve as a research framework for both qualitative studies and health services research on culture. This model

can also be a helpful tool for physician advocates. For example, a cogent argument for instituting cultural competency initiatives on local, state, and federal levels can be made by demonstrating how the 5 model components affect access to care, health status, processes, outcomes, and satisfaction with care.

The studies described herein demonstrate the substantial impact language problems can have on multiple aspects of health care. Nevertheless, only 2 states in the United States (Minnesota and Washington) currently have Medicaid reimbursement for interpreter services. However, the Office for Civil Rights has issued a statement that recipients of federal financial assistance (ie, most health care institutions) have a responsibility, pursuant to Title VI of the Civil Rights Act of 1964, to provide limited English proficient (LEP) persons with a meaningful opportunity to participate in public programs.⁵³ In a recent Guidance Memorandum, OCR stated that "...where language barriers exist, eligible LEP persons are often excluded from programs, denied medical services or suffer long delays in the receipt of health and social services. Where such barriers discriminate or have had the effect of discriminating on the basis of national origin, OCR has required recipients to provide language assistance to LEP persons." The OCR further wrote that a recipient of federal financial assistance should be "...sufficiently organized so that interpreters are readily available during all hours of its operation." The OCR's statements, coupled with the failure of most state Medicaid programs to reimburse for interpreters, suggest that a crucial area for pediatric advocacy is the provision of adequate interpreter services and their coverage by Medicaid, managed care, and private insurance.

Because culture can have such a profound impact on clinical care, it would seem prudent to increase clinicians' exposure to cultural issues at various points in their training. Opportunities to enhance cultural training might in-

clude courses in medical school, lecture series during residency, and continuing medical education courses. The cost of the clinical consequences of overlooking a patient's culture should also be considered for managed care. Cultural competency training for staff and reimbursement for comprehensive, effective interpreter services would be cost-effective strategies that would enhance quality, beneficial outcomes, and satisfaction with care.

I thank Joel Alpert, Howard Bauchner, Jerry Klein, and Lee Pachter for helpful comments on earlier drafts of the manuscript.

*Glenn Flores, MD
Division of General Pediatrics
Boston Medical Center
Boston, MA 02118*

REFERENCES

1. The World Book Encyclopedia. Chicago (IL): World Book; 1998;12:62, and 1998;4:1097.
2. Harwood A, editor. Ethnicity and medical care. Cambridge (MA): Harvard University Press; 1981.
3. Kleinman A, Eisenberg L, Good B. Culture, illness, and care. Clinical lessons from anthropologic and cross-cultural research. *Ann Intern Med* 1978;88:251-8.
4. Pachter LM. Culture and clinical care: folk illness beliefs and behaviors and their implications for health care delivery. *JAMA* 1994;271:690-4.
5. Pérez-Stable EJ. Issues in Latino health care—Medical Staff Conference, University of California, San Francisco. *West J Med* 1987;146:213-8.
6. Aguirre-Molina M, Molina C. Latino populations: Who are they? In: Molina C, Aguirre-Molina M, editors. Latino health in the US: a growing challenge. Washington (DC): American Public Health Association; 1994. p. 3-22.
7. Pachter LM. Cultural issues in pediatric care. In: Behrman S, editor. Nelson's textbook of pediatrics. New York: Springer; 1992.
8. US Bureau of the Census. Statistical Abstract of the United States: 1997. 117th ed. Washington (DC): US Department of Commerce; 1997.
9. Mendoza FS. The health of Latino children in the United States. *Future Child* 1994;4:43-72.
10. Flores G, Bauchner H, Feinstein AR, Nguyen UDT. The impact of ethnicity, family income, and parental education on children's health and use of health services. *Am J Public Health* 1999;89:1066-71.
11. Flores G, Vega LR. Barriers to health care access for Latino children: a review. *Family Med* 1998;30:196-205.
12. Triandis HC, Marin G, Lisansky J, et al. *Simpatía* as a cultural script of Hispanics. *J Pers Soc Psychol* 1984;47:1363-75.
13. American Medical Association. Culturally competent health care for adolescents. A guide for primary care providers. Chicago: American Medical Association; 1994. p. 39-67.
14. Sabogal F, Marin G, Otero-Sabogal R, Marin BV, Perez-Stable EJ. Hispanic familism and acculturation: What changes and what doesn't? *Hispanic J Behav Sci* 1987;9:397-412.
15. Pérez-Stable EJ, Sabogal F, Otero-Sabogal R, Hiatt RA, McPhee SJ. Misconceptions about cancer among Latinos and Anglos. *JAMA* 1992;268:3219-23.
16. Daly M, Clark G, McGuire W. Breast cancer prognosis in a mixed Caucasian-Hispanic population. *J Natl Cancer Inst* 1985;74:753-7.
17. Samet JM, Hunt WC, Lerchen ML, Goodwin JS. Delay in seeking care for cancer symptoms: a population-based study of elderly New Mexicans. *J Natl Cancer Inst* 1988;80:432-8.
18. Vernon SW, Tilley B, Neale AV, Steinfeldt L. Ethnicity, survival, and delay in seeking treatment for symptoms of breast cancer. *Cancer* 1985;55:1563-71.
19. Woloshin S, Bickell N, Schwartz L, Gany F, Welch G. Language barriers in medicine in the United States. *JAMA* 1995;273:724-8.
20. Goldenberg C. Literary instruction for Spanish speaking children. *Language Arts* 1990;67:590-8.
21. Zambrana RE, Ell K, Dorrington C, Wachsmann L, Hodge D. The relationship between psychosocial status of immigrant Latino mothers and use of pediatric emergency services. *Health Soc Work* 1994;19:93-102.
22. Lewis MA, Rachelefsky G, Lewis CE, Leake B, Richards W. The termination of a randomized clinical trial for poor Hispanic children. *Arch Pediatr Adolesc Med* 1994;148:364-7.
23. Flores G, Abreu M, Olivar M, Kastner B. Access barriers to health care for Latino children. *Arch Pediatr Adolesc Med* 1998;152:1119-25.
24. Kirkman-Liff B, Mondragón D. Language of interview: relevance for re-

- search of southwest Hispanics. *Am J Public Health* 1991;81:1399-404.
25. Takata G. Differential access to health care of Latino children in the Hispanic Health and Nutrition Examination Survey [thesis]. Stanford (CA): Stanford University; 1991.
 26. Hu DJ, Covell RM. Health care usage by Hispanic outpatients as a function of primary language. *West J Med* 1986;155:490-3.
 27. Marks G, Solis J, Richardson JL, Collins LM, Birba L, Hisserich J. Health behavior of elderly Hispanic women: Does cultural assimilation make a difference? *Am J Public Health* 1987;77:1315-9.
 28. Manson A. Language concordance as a determinant of patient compliance and emergency room use in patients with asthma. *Med Care* 1988;26:1119-28.
 29. Alpert M, Kesselman M, Marcos L, Urcuyo L. The language barrier in evaluating Spanish-American patients. *Arch Gen Psychiatry* 1973;29:655-9.
 30. Baxter M, Bucci W. Studies in linguistic ambiguity and insecurity. *Urban Health* 1981;June:36-40.
 31. Shapiro J, Saltzer E. Cross-cultural aspects of physician-patient communication patterns. *Urban Health* 1981; Dec:10-5.
 32. Seijo R, Gomez H, Freidenberg J. Language as a communication barrier in medical care for Hispanic patients. In: Padilla AM, editor. *Hispanic psychology—critical issues in theory and research*. Newbury Park (CA): Sage Publications; 1995. p. 169-81.
 33. Cervantes RC, Arroyo W. Cultural considerations in the use of DSM-IV with Hispanic children and adolescents. In: Padilla AM, editor. *Hispanic psychology—critical issues in theory and research*. Newbury Park (CA): Sage Publications; 1995. p. 131-47.
 34. Ginsberg C, Martin V, Andrulis D, Shaw-Taylor Y, McGregor C. Interpretation and translation services in health care: a survey of US public and private teaching hospitals. A National Public Health and Hospital Institute Report. Washington (DC): National Public Health and Hospital Institute; 1995.
 35. Pérez-Stable EJ, Nápoles-Springer A, Miramontes JM. The effects of ethnicity and language on medical outcomes of patients with hypertension or diabetes. *Med Care* 1997;35:1212-9.
 36. Putsch RW. Cross-cultural communication. The special case of interpreters in health care. *JAMA* 1985;254:3344-8.
 37. Baker DW, Parker RM, Williams MV, Coates WC, Pitkin K. Use and effectiveness of interpreters in an emergency department. *JAMA* 1996;275:783-8.
 38. Pachter LM, Bernstein B, Osorio A. Clinical implications of a folk illness: *empacho* in mainland Puerto Ricans. *Med Anthropol* 1992;13:285-99.
 39. Bose V, Vashistha K, O'Loughlin BJ. *Azarcon por empacho*—another cause of lead toxicity. *Pediatrics* 1983;72:106-8.
 40. Centers for Disease Control. Lead poisoning from Mexican folk remedies—California. *MMWR Morb Mortal Wkly Rep* 1983;32:554-5.
 41. Trotter RT II. Greta and azarcon: a survey of episodic lead poisoning from a folk remedy. *Hum Organ* 1985;44:64-72.
 42. Baer RD, Garcia de Alba J, Cueto LM, Ackerman A, Davison S. Lead-based remedies for *empacho*: patterns and consequences. *Soc Sci Med* 1989;29:1373-9.
 43. Centers for Disease Control and Prevention. Lead poisoning associated with use of traditional ethnic remedies—California. *MMWR Morb Mortal Wkly Rep* 1993;42:521-54.
 44. Mikhail BI. Hispanic mothers' beliefs and practices regarding selected children's health problems. *West J Nurs Res* 1994;16:623-38.
 45. Risser AL, Mazur LJ. Use of folk remedies in a Hispanic population. *Arch Pediatr Adolesc Med* 1995;149:978-81.
 46. Guarnashelli J, Lee J, Pitts FW. "Fallen fontanelle" (*caída de mollera*): a variant of the battered child syndrome. *JAMA* 1972;222:1545-6.
 47. Wood D, Donald-Sherbourne C, Halfon N, et al. Factors related to immunization status among inner-city Latino and African-American preschoolers. *Pediatrics* 1995;96:295-301.
 48. Todd KH, Samaroo N, Hoffman JR. Ethnicity as a risk factor for inadequate emergency department analgesia. *JAMA* 1993;269:1537-9.
 49. Wasserman RC, Croft CA, Brotherton SE. Preschool vision screening in pediatric practice: a study from the Pediatric Research in Office Settings (PROS) Network. *Pediatrics* 1992;89:834-8.
 50. Hahn BA. Children's health: racial and ethnic differences in the use of prescription medications. *Pediatrics* 1995;95:727-32.
 51. Finkelstein JA, Brown RA, Schneider LC, et al. Quality of care for preschool children with asthma: the role of social factors and practice setting. *Pediatrics* 1995;95:389-94.
 52. Peterson ED, Shaw LK, DeLong ER, Pryor DB, Califf RM, Mark DB. Racial variation in the use of coronary revascularization procedures. Are the differences real? Do they matter? *N Engl J Med* 1997;336:480-6.
 53. Hayashi D. Guidance memorandum. January 29, 1998. Title VI prohibition against national origin discrimination—persons with limited-English proficiency. Available from: <http://www.hhs.gov/progorg/ocr/lepfinal.htm>.