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Appreciating our Similarities and Differences

Introduction to Culturally Competent, Patient-Centered Health Care

By Gail Price-Wise, S.M.

Cultural competence in healthcare is the ability of organizations and practitioners to build effective relationships with patients of different cultural backgrounds in order to produce a positive health outcome. Often when people are first learning about cultural competence, they think their only job is to find out about the holidays, customs, religion, food, health beliefs and practices, etc. of the specific populations with whom they are working. This is very important information, but it's NOT the only component of cultural competence and it is not the most important part.

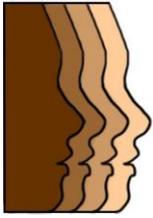
Cultural competence has three components:

- Managing Our Prejudices
- Communicating Across Cultures
- Understanding Specific Populations

A good place to start on the journey to becoming culturally competent is to look within. Everyone experiences automatic thoughts and feeling about others based on race, ethnicity, accent, religion, sexual orientation, age, socio-economic level, physical presentation (clothing, body type, tattoos etc.) and other factors. When you have an immediate reaction to someone, it's often because that person reminds you of someone you have known in the past, someone you've seen on TV, or someone your mother told you about. Your reaction may have nothing to do with the individual sitting in front of you. Unconscious biases are closely related to the many stereotypes that are widely shared: one group might be associated with street crime; another with stealing money on Wall Street; a third with alcoholism. If you meet someone who fits the stereotype, it is easy to think, "Aha! See..... They really are that way." The reality is that stereotypes are true of some people within a group and untrue of others in the same group. "Managing Your Prejudices" begins with a willingness to recognize the human tendency to think "those people" are all the same, and to remind yourself that it's not true. "Those people" are not all the same. Each is a unique individual. It is difficult to control thoughts and feelings but, as responsible human beings, we can learn to *manage our prejudices* so they do not affect the way we treat others.

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The second kind of cultural competence is about listening and speaking effectively – *communicating across cultures*. This kind of cultural competence has a goal – the two people will exchange information they need from one another. A culturally competent person will ask himself, “What message do I need to convey? What information do I need from the other person? What words should I use? What words might be considered offensive? How do I make the other person comfortable to ask questions, or to tell me he has a different point of view?”

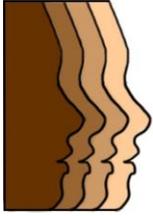
Managing our prejudices and communicating across cultures do not require any special knowledge of the particular culture one is dealing with. Without knowing anything about the other person’s culture, one can be culturally competent by managing one’s prejudices, asking open-ended questions, showing respect, and speaking in a way that does not presume that the other person shares one’s own values or experiences.

Only the last component of cultural competence, *understanding specific populations*, requires prior knowledge about particular cultural groups. Having specific knowledge about different cultures is useful but it has a pitfall. It can lead to stereotyping. There is great diversity in any racial or ethnic group. Education, income level, residing in a rural vs. urban environment, whether one has traveled, and other personal life experiences can influence one’s cultural identity, beliefs, and practices as much as one’s race, ethnicity, religion, or country of origin.

Rationale for Cultural Competence

Providing culturally competent, patient-centered healthcare is essential for reducing disparities in morbidity and mortality. In order for patients to be healthy, patients and providers must do the following:

1. Patients of all cultural backgrounds must be willing and able to come for preventive and therapeutic services. Both clinical and non-clinical staff have a role in creating a comfortable environment for patients of diverse backgrounds. Patients who are uncomfortable vote with their feet by simply not returning.
2. Clinical and non-clinical staff that have contact with patients must recognize how conscious and unconscious prejudices may affect their ability to put the patient at ease.
3. The provider must help the patient to give a complete and accurate history so that she can make an accurate diagnosis. Diagnostic errors are made more frequently when the provider has failed to get a full history.

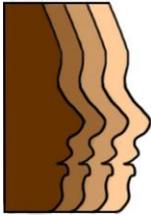


4. The provider must recognize how conscious and unconscious prejudices can influence the diagnostic and treatment plan. Studies have shown that providers may be less likely to order certain tests or particular medications for racial and ethnic minorities.^{1 2}
5. The provider and patient must negotiate a treatment plan that the patient understands and is motivated to follow. The provider must set the tone for open communication so that the patient can express any concern or confusion regarding the treatment plan.
6. The provider must ensure that the patient fully understands the treatment plan by asking the patient to explain it in his or her own words or by having the patient actually demonstrate what must be done at home. Patients across all cultural groups often fail to take medications correctly or otherwise follow a treatment plan but compliance is especially poor among patients with language barriers and those with limited health literacy.
7. Clinical and non-clinical personnel must ensure that the patient receives the necessary support at home to make health-related changes in behavior. Medical advice regarding changes in diet, exercise, smoking, sexual behavior, and substance abuse is often ignored. Support services can be helpful.
8. Clinical and non-clinical personnel must establish policies and procedures to meet the needs of patients of diverse cultural backgrounds, and those with limited English proficiency and health literacy.

Further it is essential for clinical and non-clinical staff to work together as a team, in a congenial and mutually-supportive environment that celebrates the cultural diversity of the staff. Poor teamwork and low employee morale reduces the quality of services.

Cultural Difference and the Patient-Provider Relationship

Cultural differences can affect the quality of the patient-provider relationship. Some studies have shown that patients' trust, satisfaction, and utilization of services are higher when the patient and physician share the same race or ethnicity. Other studies, however, have found no significant effect associated with racially concordant physician-patient relationships.^{3 4} One study found that White doctors spend more time speaking with White patients than Black patients and their speech is slower with a more positive emotional tone.⁵ This is not the overt racism of slavery or segregation. It's much more subtle. It has to do with whether people perceive themselves to be personally



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similar to one another and simply whether they like each other.⁶ Not surprisingly, patients are able to accurately perceive whether their providers like them, which can impact patient satisfaction and adherence.^{7 8} For this reason, it is important for providers to acknowledge and manage their biases regarding different groups of people. They should be honest with themselves about their biases and proactively learn about the positive qualities of individuals who do not fit negative stereotypes.

A good patient-provider rapport may not follow ethnicity, and in fact one study showed that Hispanics were more likely to report being treated with *disrespect* if the provider was Hispanic than non-Hispanic.^{9 10} The authors of this Hispanic study did not discern what country the patients and providers were from and whether they were of European, African, or indigenous descent. Hispanics are heterogeneous. There is racism and classism throughout Latin America, and tension between some countries. This likely affected how patients experienced their encounters with the physicians. Similarly, there are inter-ethnic tensions and military conflicts throughout much of the world that affect how immigrants feel about each other in the United States. People from the same region may or may not be comfortable with one another.

Encouraging studies have shown that providers who use patient-centered communication can create a good relationship with the patient, regardless of race and ethnicity.¹¹ Patient-centered communication is characterized by physician open-ended communication, relationship building, and more psychosocial content.

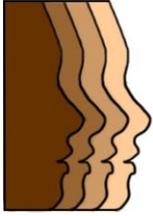
Communicating Across Cultures: Asking Questions

There are many tools in the literature to guide healthcare providers in patient-centered communication. The questions below are a combined adaption of Kleinmans' Eight Questions¹², and the ETHNIC mnemonic developed by Levine, Like, and Gottlieb¹³.

- Explanation
- Treatment
- Healers
- Negotiate
- Intervention
- Collaborate

E: *Explanation*

- What do you call your problem (sickness)?



- What do you think caused your sickness?
- What do others say about it?
- What does your sickness do to you? How does it work?
- Will your sickness last a short or a long time?

T: Treatment

- What kinds of medicines or treatments have you tried for this illness?
- What kind of treatment do you think you should receive from me?
- What do you hope the treatment will do?
- What concerns do you have about the treatment?
- Some patients believe that doctors in the U.S. prescribe too much medication; some are afraid of becoming “dependent on medication.” How do you feel about taking medication?

H: Healers

- Have you sought any advice from healers, friends, or others?
- What have they suggested? What have they done?

N: Negotiate

- Negotiate options that do not contradict, but incorporate your patient’s beliefs.

I: Intervention

Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers, as well as other cultural practices

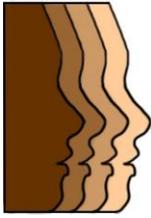
C: Collaboration

- Collaborate with the patient, family members, other health care team members, healers, and community resources.

Understanding the patient’s beliefs, goals, and concerns will help the provider to develop a plan in partnership with the patient and to support the patient in adhering to treatment.

Patient Adherence

According to the World Health Organization, only about 50% of patients with chronic diseases in developed countries take their medication as prescribed.¹⁴ In a later study, the National



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Community Pharmacists Association found that nearly three out of four Americans report not always taking their medications as prescribed.¹⁵

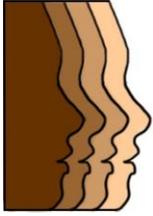
Forms of noncompliance include¹⁶:

- Failing to fill a new prescription
- Failing to refill a prescription as directed
- Skipping a dose
- Taking too much medication
- Prematurely discontinuing medication
- Taking a dose at the wrong time
- Taking a medication prescribed to someone else
- Taking a dose with prohibited foods
- Storing medication improperly
- Improperly using medication administration devices (e.g. inhalers)

Adherence to medical advice is closely tied to the relationship between the provider and the patient – to feelings of trust, partnership, and a freedom to ask questions and openly discuss problems with the plan. Cultural differences can have a profound effect on the patient-provider relationship, and patients who don't trust their providers are less likely to follow the treatment plan.

Many patients leave the health care setting with unanswered questions because they are too embarrassed to admit they don't understand what they have been asked to do. Other patients believe they know what to do but are mistaken. Patients who speak limited English and patients with limited health literacy are most likely to make errors in taking medication or otherwise following the treatment plan. In many cultures, patients nod in agreement, even when they don't understand what has been said. Patients may be limited in their ability to read English, or even to read in their native languages and may not understand written instructions. For patients with limited English proficiency (LEP) it is essential to have a qualified interpreter.

The use of patient-centered communication has been found to improve adherence regardless of cultural differences between providers and patients. Taking a few minutes to engage a patient on a personal level can improve adherence. Asking about the patient's family should be considered part of the therapeutic process. In addition, providers can encourage patients to reveal their true behaviors regarding non-adherence. Getting non-adherence "out in the open" is the only way for the provider and patient to discuss the patient's concerns and to negotiate a treatment plan that the



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patient will follow. This requires the provider to be non-judgmental and collaborative, rather than authoritarian.¹⁷

Many patients from different cultures use herbal or manufactured remedies brought from their home countries. Some remedies have medicinal properties and can be effective; many are ineffective; and some are harmful. Some people feel torn between using the traditional medicines and prescribed medicine. Providers should encourage the conversation by saying, “I understand that some people use medicines brought from their home countries. Is this something you do?” The provider should seek to determine whether the traditional remedy is harmful and whether there are potential adverse interactions with prescribed medicine. The National Center for Complementary and Integrative Health is a good source of information. The provider and patient will ideally discuss the patient’s decision making process when choosing between traditional and prescribed medicine. Patients are more likely to listen to what the providers says if the provider has first listened to the patient.

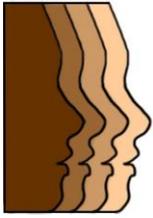
Assessing the Quality of Communication

A good way to assess the quality of communication between the provider and the patient is to ask the patient to respond to the following statements with “Always,” “Sometimes,” or “Never.”

1. I feel that my healthcare provider likes me.
2. I feel that my healthcare provider respects me.
3. When I don’t understand what my healthcare provider says, I ask questions.
4. My healthcare provider understands my concerns about my illness and treatment.
5. My healthcare provider and I have similar goals regarding my health.
6. I talk with my healthcare provider about herbal or natural remedies I use as well as traditional or spiritual healers that help me.
7. My healthcare provider is too busy to talk with me.
8. I leave the visit without understanding what my healthcare provider said.
9. When I don’t agree with my healthcare provider about my illness and treatment, we discuss it.
10. I feel that my healthcare provider does not respect the group of people I belong to.

Health Literacy

Many adults in the United States are unable to read well enough to comprehend the directions on a bottle of medicine. The term “health literacy” goes beyond the ability to read to include other

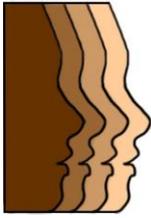


skills necessary to follow medical advice and to navigate the health care system. Health literacy is defined in *Healthy People* as: "The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." This includes a minimal understanding of anatomy and physiology, and the math skills necessary to measure medications, make sense out of nutrition labels, and understand the probability of a suffering a surgical complication. It also includes having the reading and math skills to choose between health plans by calculating premiums, copays, and deductibles.¹⁸ Populations who are most likely to have low health literacy are older adults, racial and ethnic minorities, people with less than a high school degree or GED certificate, people with low income levels, people with limited English proficiency, and those with poor health status.¹⁹ Even well educated people can be included when they have trouble comprehending a medical form or a doctor's explanation of the benefits and risks associated with a drug or procedure.

Individuals with limited health literacy are more likely to make errors when taking medications. One study of English-speaking adults found that patients reading at or below the sixth-grade level (low literacy) were less able to understand label instructions. Although 71% of patients with low literacy correctly stated the instructions, "Take two tablets by mouth twice daily," only 35% could demonstrate the number of pills to be taken daily. Some patients mistakenly believed they were to take a *total* of two pills per day. Misunderstanding was common even among those with the highest literacy levels (5% to 27%).^{20, 21}

Unfortunate medication errors are often due to inadequate communication and education. The following case demonstrates how health literacy, is not limited to the patient's ability to read and write.

"A 9-month-old child was seen by her pediatrician for a fever and decreased appetite. She was found to have otitis media and was prescribed amoxicillin. The doctor gave the first dose to the infant in the office, demonstrating step-by-step how to deliver the medicine via syringe. At home, the father drew up the next dose without removing the syringe cap. He gave the dose to the child who suddenly had difficulty breathing and collapsed. When emergency medical services (EMS) arrived, the child was intubated and transported to a children's hospital. Despite intubation, she could not be adequately ventilated. The tube was removed and intubation was tried again, still without improvement. The infant was then taken to the operating room to undergo bronchoscopy. The syringe cap was found lodged in her trachea. Evaluation in the subsequent days revealed brain death. The infant was removed from life support and died shortly thereafter."



In his commentary on this case, Dean Schillinger recommends that providers use the “teach back” or “show me” method to ensure the patient and family know how to administer medication or other patient care at home.²² With this method, patients are asked to explain in their own words or actually demonstrate how they will take medication at home.

Language Access

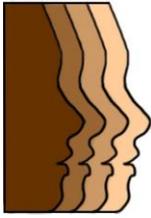
Patients with limited English proficiency (LEP) must be offered the assistance of a qualified interpreter. Studies show that family members, friends, and untrained staff are significantly more likely to make mistakes and to omit valuable information when interpreting than are professional interpreters.²³ This has consequences for patient safety.

For all LEP patients, it should be noted that:

- An inaccurate or incomplete medical history can lead to a misdiagnosis.
- Miscommunication about medication the patient is taking can lead to harmful drug interactions.
- Miscommunication about allergies can be harmful or even fatal.
- LEP patients are more likely to make dangerous mistakes when taking medications at home. For example, “O-N-C-E” in Spanish does NOT mean “once”; it means “eleven”. This can cause confusion when medication is supposed to be taken “once a day”.

The Joint Commission found that LEP patients were more likely to suffer adverse events in the hospital, such as falling.²⁴ This example may be related to the patients’ inability to communicate their intent to get out of bed and to request assistance. In another example of faulty communication with an LEP patient and family, a 2-year-old girl with a clavicular fracture was mistakenly placed in child protective custody for suspected abuse. In the absence of an interpreter, a medical resident who spoke some Spanish misunderstood “*se pegó*” to mean the girl was “hit by someone else” instead of the girl “hit herself” when she fell off her tricycle.²⁵ In this case, a medical resident who spoke *some* Spanish was worse than one who spoke none.

It’s important to note that family members may be even more unreliable than untrained staff as interpreters. In addition to being limited in their *ability* to serve as interpreters, family members may *intentionally* withhold or distort information, because they believe this to be in the patient’s interests. Family members may hide upsetting information from the patient – or they may not



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accurately interpret important information for the provider because they are too embarrassed to talk about the topic.

Case Studies

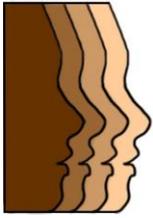
The following case studies illustrate the importance of cultural competence and effective communication with patients and families.

An internist saw a low income Hispanic woman complaining of abdominal pain. The woman was highly emotional, gesticulating and crying. Although the internist was also Hispanic, he was different culturally from his patient. He was a scholarly, quiet person who was somewhat put off by highly expressive displays of emotion. He believed that people who suffer loudly often exaggerate their discomfort. Since the woman did not show classic signs of a serious gastrointestinal disorder, he decided to treat her conservatively. He prescribed an antacid and chose not to order any expensive diagnostic tests. He believed this medical treatment was appropriate and fair given the low probability that the woman had a serious condition. His next patient was a well-spoken Asian American young man who had studied biology in college and who could use correct anatomical terms when describing his symptoms. Although there were no objective findings that would warrant ordering more tests for the young man than the Hispanic woman, he sent the young man for a work-up. The internist, in treating the Hispanic woman and the young man differently, showed an unconscious favoritism for the patient he considered to be more like himself culturally – based on education and social class rather than ethnicity.

Comment: A culturally competent gastroenterologist can notice his discomfort with highly emotive patients and discount his own emotions when deciding whether to order a GI work-up. This requires him to acknowledge and manage his prejudices.

* * *

An American ophthalmologist saw a patient from a rural area of Vietnam for an eye infection. He gave the patient eye drops and told the patient to return in two weeks. At that time, the doctor noted that the infection had not improved. He asked whether the patient had used the eye drops and the response was, “Yes, but it tasted terrible.” The doctor laughed when recounting the story. What is most interesting is not the patient’s error, but the doctor’s amusement. He assumed that his professional responsibility ended after prescribing the correct medication. Whether the patient had the knowledge to take the medication correctly was not his problem. A serious cultural misunderstanding occurred. In the patient's native community, physical ailments are often treated



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with remedies applied directly to the part that hurts. To treat a sore knee, one might rub a balm on the joint. But since coming to the US, he had learned that medicine here is taken orally. In the US, if your knee hurts, you are likely to be given an oral anti-inflammatory. By ingesting the eye drops, this patient believed he was acting like an American. He suffered a more severe infection because his physician did not successfully communicate how to take the medication.

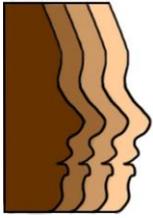
Comment: The ophthalmologist could have used Kleinman's questions and the ETHNIC mnemonic to learn more about the patient's traditional beliefs and customs and, without diminishing the patient's culture, could have discussed how eye infections are treated in the US. He could have considered the health literacy of the patient and asked the patient to demonstrate the proper use of eye drops.

* * *

In 1980, an 18 year old young Cuban man named Willie Ramirez was brought to an ER in a coma. His mother spoke only Spanish but a bilingual family friend said to the medical staff in English and Spanish, that he was "intoxicated." The doctors thought the family was explaining that the boy had taken an overdose of drugs and for 36 hours they treated him based on this diagnosis. The family and the medical staff did not know that they had miscommunicated. Among Cubans, the word, "intoxicado" is NOT equivalent to "intoxicated" in English. It means "sick due to something you ate, perhaps an allergen or something poisonous – literally something "toxic" to your system. The word is generally NOT used to refer to alcohol or drug use. The family believed Willie developed a headache and fell unconscious because he had eaten a bad hamburger from a fast-food restaurant. His real problem was something that the family could not imagine and the doctors had not looked for – a brain hemorrhage. By the time the bleed was diagnosed and surgery was performed, it was too late to prevent the brain damage that left Willie quadriplegic. This tragedy may have been prevented if a qualified interpreter had been available. Neither the family nor the hospital staff requested an interpreter because they believed they were communicating adequately in English.^{26 27}

Comment: This case illustrates the importance of offering a trained interpreter to all patients and families with limited English proficiency (LEP). Patients who bring family members with them to interpret must be required to use qualified interpreters instead, or to at least allow a qualified interpreter to be present to clear up any misunderstandings. Even when the patient or family speak reasonably good English, serious communication errors can occur.

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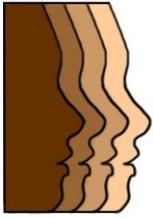
A gynecology resident saw a patient from Somalia. The woman had undergone a form of female circumcision. She had had a clitorrectomy and her vagina had been sutured, leaving only a small opening to allow for menstrual flow. For much of her life, the scar tissue had interfered with the flow of urine. She had recently arrived in the US and, in spite of how deeply personal gynecological problems are regarded in her country, she decided to seek medical help in this new modern country. The young resident had never met anyone from Somalia and never heard of female circumcision. Upon examining her, he exclaimed, “Oh my God! What happened to you?” The woman cringed with shame and tried to explain that this was a traditional rite in her country. The doctor completed his exam and scheduled a follow-up visit, but the woman was never seen at the clinic again. The Somali patient was too ashamed to return to the clinic for normal preventive gynecological care, like pap smears and mammograms. Should she develop cancer, she will likely be diagnosed at a later stage.

Comment: In this situation, culturally competent gynecology resident would say to his Somali patient, “It appears as if you’ve had an operation. Can you tell me about this?” Responding to his non-judgmental question, the patient may be spared a sense of shame and feel more comfortable in telling the resident about the tradition of female circumcision in her country and the resulting gynecological problems. She may then return for follow-up treatment instead of disappearing from the health care system, as so many people do.

* * *

During a routine physical, a school nurse noticed strange striated bruises on the chest of a Cambodian little girl. The nurse asked where the marks had come from and the girl explained that her mother had intentionally bruised her by aggressively rubbing a coin on her skin. The nurse notified the principal and called in Child Protective Services. To the horror of the parents, an investigation was initiated. The nurse was not aware that some Cambodians rub coins on the skin of a sick person to let out the bad spirits and make them well. The practice leaves marks, but no further injury is inflicted. A culturally competent person at Child Protective Services was aware of this practice and dismissed the investigation.

Comment: It is useful to understand the traditional health beliefs and practices of the populations you serve. At the same time, it is important to avoid *assuming* that someone practices a traditional custom. Within any society people have different health beliefs and practices based on education and income levels and personal life experiences. It is helpful to ask Kleinman’s questions or use the ETHNIC mnemonic to learn about each individual patient.



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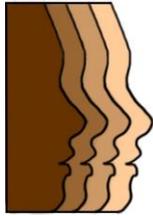
An African American internist was asked to see a Haitian woman with hypertension because the clinic manager thought the patient would be more comfortable with a provider with black skin. The doctor didn't feel any more kinship with a Haitian patient than an Irish patient. The Haitian patient seemed strange to her. Her accent and her mannerisms were different from the American patients the doctor was used to treating. The patient found the doctor to be distant and cold. She was secretly using traditional Haitian herbal remedies and took prescribed medication sporadically. When the doctor asked the patient whether she was taking her pills every day, she lied. Unfortunately, two years later the patient had a stroke.

Comment: The internist treating the Haitian woman with hypertension may have had better results in getting her patient to take prescribed medication if she understood how commonly Haitian immigrants rely on herbal remedies. She might have said, "I understand that many people from your country use herbal remedies. I am not an expert in these remedies; you likely know more than I. Perhaps we can exchange information to make sure that what I prescribe for you works well with what you are using at home. That way we can make sure to get your blood pressure down." Another important lesson from this case is that one should avoid making assumptions about which individuals will feel comfortable with one another.

* * *

Bob, the Director of the billing department in the hospital was interviewing candidates for an accounting position. He offered the job to Joseph, a man in his 30's, who appeared to have the qualifications for the job. He had an MBA from an excellent school, 5 years' experience, and good interpersonal skills. Joseph appeared pleased but said he needed to discuss the offer with his partner. Bob was confused and said, "I didn't know you were in business with someone else." Joseph replied, "I meant my partner in my personal life. I'm gay." Bob was surprised and embarrassed and said, "Oh, I worked with a gay guy once. I don't have any problem with gays. They're just like normal people. Right?" Joseph smiled politely as he left. One hour later, Bob received an email from Joseph declining the offer.

Comment: The remark, "They're just like normal people. Right?" is an example of an unintentional offense, sometimes called a "microaggression". Avoiding microaggressions begins with acknowledging and managing your prejudices.



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² Alexander R. Green, et al., *Implicit Bias among Physicians and its Prediction of Thrombolysis Decisions for Black and White Patients*, *J Gen Intern Med*. 2007 Sep; 22(9): 1231–1238. Published online 2007 Jun 27.

³ Richard L. Street et.al. “Understanding Concordance in Patient-Physician Relationships: Personal and Ethnic Dimensions of Shared Identity” *Annals of Family Medicine*, May/June 2008

⁴ GD Stevens, et.al. “The Parent-Provider Relationship: Does Race/Ethnicity Concordance or Disconcordance Influence Parent Reports of the Receipt of High Quality Basic Pediatric Preventive Services?” *Journal of Urban Health*,. 2005;82(4)

⁵ Lisa A. Cooper, M.D., M.P.H., Debra L. Roter, Dr.P.H. et al. Patient-Centered Communication, Ratings of Care, and Concordance of Patient and Physician Race. *Ann Intern Med*.2003; 139: 907-915

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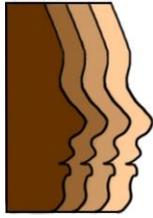
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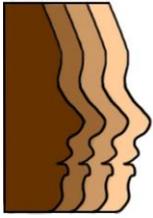
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